Date of Review:

1/28/2025

Patient Name: [redacted]
Patient Account #: [redacted]
Date of Service: 9/04/2024 to 9/9/2024
Provider: [redacted]

Disallowed Charges

Date Of Service	Remark Code	Disallowed Reason	Amount
9/4/2024 to 9/9/2024	CO-16, M127	Inpatient stay - Insufficient documentation provided No acute inpatient medical necessity	10,286.10
9/4/2024 to 9/9/2024	CO-96, N351	Pharmacy charges - Self-Administered Drug Exclusion List (SAD List)	**321.52**
9/4/2024 to 9/9/2024	CO-16, M127	**Lab Charges** Insufficient documentation provided	**3136.13**
9/4/2024 to 9/9/2024	CO-97, M2	Supplies & Bundled Charges - Routine inpatient supplies should be included in room & board and procedural charges.	**1843.54**
9/4/2024 to 9/9/2024	N56, CO-16	Rehab therapy - Missing logs to validate time tracking and progression documentation.	**319.13**
9/4/2024 to 9/9/2024	CO-16, M127	Imaging – Radiology charges lacks justification Insufficient documentation provided	**483.54**
9/4/2024 to 9/9/2024	CO-16, M127	Professional Fee – No documentation Provided	**1477**
9/7/2024	CO-45, N657	Surgery time not supported Operation duration is 37 mins	**$2,096.13**
		Total Disallowed Charges:	**19,963.09**

To address and substantiate the disallowed charges, supporting clinical documentation and analysis covering the full span from patient admission to discharge have been provided.

Detailed Explanations of Disallowances

1. Room & Board Inpatient stay - Insufficient documentation provided No acute inpatient medical necessity

Findings

The claim for an inpatient stay from September 4, 2024, to September 9, 2024, has been reviewed. The only documentation provided by the facility includes operating room (OR) notes, which do not sufficiently support the billed inpatient level of care. There are no admission notes, progress notes, or discharge summary to justify medical necessity for the length of stay or the need for inpatient care.

Regulatory Support:

1. **CMS Guidelines**:

a. Per the **Medicare Benefit Policy Manual (Chapter 1, Section 10)**, inpatient services must be reasonable and necessary for diagnosis or treatment of an illness or injury. The documentation must clearly show the clinical conditions that justify admission and continued stay.

b. The absence of comprehensive medical records, including progress notes, violates CMS standards for justifying inpatient care.

2. **InterQual Criteria**:

a. The clinical criteria for inpatient admission include severe illness, hemodynamic instability, or a need for 24/7 acute medical management. The lack of detailed documentation prevents evaluation against these standards.

3. **NUBC Guidelines**:

a. Proper use of inpatient room and board revenue codes requires substantiating the billed services with adequate documentation. The absence of this documentation violates billing compliance standards.

Key Violations:

- **CO-16**: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- **M127**: Missing patient medical record for this service.

Recommendation:

Disallow Charges: Deny the $10,286.10 billed for the inpatient stay due to insufficient documentation to justify the level of care.

2. Pharmacy Charges

Findings:

- Multiple **Self-Administered Drugs (SADs)** were billed despite being excluded under **Medicare Part A inpatient reimbursement rules**.
- **Oral and topical medications** (e.g., **Pantoprazole, Prednisone, Melatonin, Rivaroxaban, Apixaban**) are classified as **self-administered drugs (SADs)** under CMS guidelines and should not be separately reimbursed.
- **Insulin and certain injectable medications** (e.g., **Regular Insulin, Heparin**) were billed **without clear documentation of inpatient administration**, raising concerns of improper billing.

Regulatory Support:

- **CMS Medicare Benefit Policy Manual (Pub. 100-02, Chapter 6, Section 20.2)** states that **self-administered drugs (SADs) are not covered under Medicare Part A during an inpatient stay** unless they are integral to a hospital service.
- **Medicare Claims Processing Manual (Pub. 100-04, Chapter 17, Section 80.3)** defines **self-administered drugs as those a patient would normally take on their own outside the hospital setting**, which are **not separately reimbursable**.
- **CMS NCD (National Coverage Determination) 110.10** specifies that **SADs should not be billed separately but instead included in hospital bundled charges**.
- **42 CFR § 411.15(i)** explicitly **excludes self-administered drugs** from Medicare inpatient reimbursement unless directly related to acute inpatient treatment.

Key Violations:

- **CO-96**: Non-covered charges – These medications fall under **Medicare's self-administered drug exclusion policy** and are **not payable** under Part A.
- **N351**: Not covered when performed/billed by this provider type – Self-administered drugs **must be covered under the patient's outpatient prescription drug plan (e.g., Part D), not as an inpatient charge**.

Recommendation:

- Disallow all Self-Administered Drugs (SADs)

3. Lab Charges

Findings: The claim includes charges for laboratory services; however, no supporting documentation was provided to verify these charges. Specifically:

- **No Laboratory Results:** The claim lacks lab test results to confirm that services were performed and necessary.
- **No Physician Orders:** Documentation does not include valid orders from a licensed provider directing the tests.
- **Missing Service Logs:** No evidence is available to show that the laboratory services were carried out during the billed period.

Regulatory Support

1. **CMS Guidelines**:

a. The **Medicare Program Integrity Manual (Chapter 3, Section 3.3.2.5)** requires that providers maintain and submit sufficient documentation to justify billed services, including orders and test results for laboratory services.

b. Claims that do not include supporting documentation are subject to denial under CMS and payer policies.

2. **NUBC Standards**:

a. Proper billing of laboratory charges requires detailed documentation, including the specific tests performed, physician orders, and corresponding results to substantiate medical necessity and service completion.

3. **AHA and InterQual Standards**:

a. Laboratory services should meet defined clinical criteria for medical necessity, which must be supported by clear documentation. Missing results and orders violate these standards.

Key Violations

1. **Violation of Documentation Requirements:**

a. Missing critical records such as lab results, test orders, and service logs violates CMS guidelines for proper claim submission.

2. **Non-Compliance with Medical Necessity Standards:**

a. The absence of orders and results precludes verification of medical necessity, rendering the charges unsubstantiated.

3. **Inadequate Billing Practices:**

a. Billing laboratory services without supporting documentation violates payer policies and NUBC standards for claim adjudication.

Recommendation

1. **Disallow Charges:**

a. Deny the laboratory service charges due to insufficient documentation to verify the medical necessity and performance of the services.

4. Supplies & Bundled Charges - Routine Inpatient Supplies

Findings:

- Routine inpatient supplies were separately itemized.

Regulatory Support:

- **CMS Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, Section 40.3)** – While DRG-based reimbursement does not apply in Guam, **TEFRA reimbursement** also includes routine hospital supplies within the **all-inclusive per diem rate** and does not allow separate billing for routine items.
- **42 CFR § 412.50** – Although this regulation primarily addresses bundling under DRG, similar bundling principles apply to **TEFRA-based facilities**, where routine inpatient hospital services are incorporated into the **prospective per diem payment**.
- **NUBC UB-04 Guidelines** – Routine hospital supplies are **not separately billable** unless classified as high-cost, patient-specific items. Under TEFRA, routine items are covered by the **facility's all-inclusive rate**, unless an exception applies.

Key Violation:

- **Unbundling of services** – routine supplies separately charged when they should be included in room & board.
- Overbilling by charging for **standard hospital supplies**.

Recommendation:

- Deny charges for supplies that fall under bundled inpatient services.
- Request itemized supply justification for any high-cost items that may be **outside standard bundling**.
- Ensure compliance with **NUBC guidelines** for future inpatient supply billing.

5. Rehab Therapy

Findings

The claim includes charges for rehabilitation therapy services during the inpatient stay. However, the required

documentation to validate these charges is missing. Specifically:

- **No Time Logs:** Logs tracking the duration of therapy sessions are absent, making it impossible to verify the units billed.
- **No Progression Documentation:** Clinical notes documenting the patient's progress or therapy outcomes are not provided.
- **No Service Confirmation:** Logs or service summaries that confirm the therapy sessions occurred are missing.

Regulatory Support

1. **CMS Guidelines**:

a. Per CMS documentation standards, therapy claims must include records verifying session times and progress toward established goals.

2. **Medicare Policy Manual**:

a. Therapies billed without documentation of time and clinical relevance are considered non-compliant and subject to denial.

Key Violations

- Lack of time tracking and therapy notes violates documentation requirements for rehabilitation services.
- The claim fails to establish that the therapy services were reasonable, necessary, and rendered.

Recommendation

- **Disallow Charges:** due to insufficient documentation.

6. Imaging

Findings

The claim includes radiology charges, but no supporting documentation was provided to justify the services billed.

- **Missing Clinical Justification:** No clinical notes or physician orders support the need for imaging services.
- **Absence of Reports:** No radiology results or findings were included in the submitted records.

Regulatory Support

1. **CMS Guidelines**:

a. Imaging services must be supported by documentation, including physician orders and test results, to verify necessity and completion.

2. **NUBC Guidelines**:

a. Billing for radiology requires specific codes supported by detailed documentation, including test findings.

Key Violations

- Lack of physician orders and imaging results violates CMS standards for medical necessity and service validation.
- Insufficient records to justify the radiology charges render them unsubstantiated.

Recommendation

- **Disallow Charges:** Deny imaging services due to lack of justification and supporting documentation.

7. Professional Fee

Findings

The claim includes charges for professional services, but there is no documentation to substantiate these fees.

- **No Clinical Notes:** Documentation for services provided by professionals (e.g., consultations, evaluations) is absent.
- **No Records of Interaction:** There is no evidence of professional interactions, evaluations, or orders during the inpatient stay.

Regulatory Support

1. **CMS Guidelines**:

a. Professional fees require detailed notes documenting the nature of services provided, including assessments and interventions.

2. **InterQual Standards**:

a. Charges for professional services must be tied to documented interactions and clinical necessity.

Key Violations

- Missing documentation for professional services violates payer requirements for substantiating charges.
- The claim lacks evidence of the services rendered by professionals during the stay.

Recommendation

- **Disallow Charges:** Deny due to the complete absence of documentation for professional services.

8. Surgery time

Findings

The claim includes a charge for **Major Surgery – 1st Hour** (Code 7000047) at $2,096.13. Upon review of the documentation, the actual surgery duration is noted as 37 minutes. The billed service exceeds the supported time, as it is typically applied to surgeries lasting a full hour.

- **Discrepancy in Operation Time:** The operating room notes indicate that the procedure duration was only 37 minutes, not the full 60 minutes billed.
- **No Time Justification:** The submitted records lack additional details or explanations to justify the full hour charge, such as preoperative preparation or extended recovery time in the operating suite.

Key Violations

1. **Overbilling Based on Duration:**

a. The billed service for a full hour of surgery is not supported by the documentation, which shows only 37 minutes of operation time.

2. **Incomplete Justification for Time:**

a. The records fail to provide supporting details for any additional surgical or preparatory activities that would extend the procedure to a full hour.

3. **Non-Compliance with Time-Based Billing Standards:**

a. The charge does not meet CMS and NUBC documentation standards for time-based surgical billing.

Recommendation

1. **Adjust Charges:**

a. Disallow the full hour charge due to insufficient time support. Recommend billing at a prorated rate or using a code appropriate for surgeries under an hour, if applicable.

References

1. **CMS Claims Processing Manual, Pub. 100-04, Chapter 3 - Documentation for inpatient care**
   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
2. **42 CFR §410.32 - CMS Billing Rules for Medical Necessity**
   https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.32
3. **Medicare National Correct Coding Initiative (NCCI) Manual - Documentation Requirements for Therapy Claims**
   https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd
4. **CMS NUBC Guidelines - Routine Supply Bundling**
   https://www.cms.gov/Medicare/Billing/NUBC
5. **CMS Claims Processing Manual, Pub. 100-04, Chapter 13 - Imaging Services**
   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf