Part B Insider (Multispecialty) Coding Alert

Audits: RACs Are Now Checking Your Modifier 25, Injection Claims

Plus: Contractors are also auditing place of service, bilateral services, and consolidated billing.

Your practice may have grown accustomed to the presence of recovery audit contractors (RACs) in the Medicare world, but it can still be hard to follow the issues that the RACs are investigating. Check out the following five recently-posted RAC focus areas so you know what they're seeking, and find out how you can stay out of the auditors' crosshairs.

Consolidated Billing

Region D RAC, Health Data Insights, announced on Jan. 28 that it will be reviewing claims for SNF consolidated billing for therapies provided during a patient's Part B skilled nursing facility (SNF) stay.

Background: Medicare's "consolidated billing" is a payment methodology that reimburses nursing facilities in a lump sum payment for all facility services the patient may need during the course of a Part A stay. Because Part A typically covers nursing facility patients and consolidated billing rules apply, you can only report certain services to Medicare. When patient visits your office, if the patient is in a covered Part A stay, the facility is liable for paying the technical component services. These services include medications, lab work, x-rays (the technical portion, not the interpretation), the technical portion of EKGs, billable supplies, DME dispensed from office, etc.

Tip: Contact the facility to confirm whether the patient is in a Part A or Part B stay. For services with both a technical and a professional component that your physician performs for a nursing facility patient in your office, you should report only the professional component -- such as the written interpretation of an x-ray -- to your Medicare carrier/MAC. You should seek reimbursement from the nursing home directly for the technical component of the service.

Modifier 25 With Dialysis

On Feb. 10, Health Data Insights was approved to begin auditing claims when an E/M services is billed without modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the same day as dialysis. "Except when reported with modifier 25, payment for certain evaluation and management services is bundled into the payment for dialysis services 90935, 90937, 90945, and 90947."

Medicare will reimburse the E/M charge (with modifier 25 appended) if the documentation shows that the E/M services "are significant and separately identifiable and meet any medical necessity requirements," according to a policy by Trailblazer Health, a Part B payer in four states.

Remember that modifier 25 should always be appended to the E/M code, never the dialysis code.

Inpatient vs. Outpatient

Region B RAC, CGI Federal, announced in November that it intends to evaluate overpayments issued to physicians who report the incorrect place of service code when services are rendered in a facility.

Physicians collect higher payments for services rendered in the physician's office, a patient's home, an ASC, a nursing facility, or another non-hospital facility versus those services performed in a hospital. Therefore, entering the correct place of service on a claim is essential to appropriate reimbursement.

For a complete list of CMS's place of service codes, visit www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf.

Pain Management Injections

Region C RAC Connolly announced on Jan. 27 that it will be reviewing claims for "transformational epidural injections." This appears to be a spelling error, with the RAC referencing articles about transforaminal epidural injections (rather than "transformational").

The RAC notes that "claims have been identified where the first-listed and/or other diagnosis codes do not match to the covered diagnosis codes in the LCD policies."

Keep in mind: When the physician administers transforaminal epidural injection (such as 64479-64484), the documentation must include the patient's pain history, descriptions of failed conservative measures, and details of the patient's facet joint pathology. For more on how to correctly report these services, read MLN Matters article SE1102 at www.cms.gov/MLNMattersArticles/Downloads/SE1102.pdf.

Bilateral Billing

For the past year, DCS Healthcare, the region A RAC, has been reviewing "overpayments associated with providers incorrectly billing services with bilateral indicator 3 (100 percent payable for each side) on multiple lines;

once with modifier 50 (resulting in 200 percent payment) and once without modifier 50 (resulting in 100 percent payment), resulting in a 300 percent total payment."

Keep in mind: If you use modifier 50 (Bilateral procedure), you'll report it on one line item, with the CPT code appended with modifier 50 just once. If your MAC prefers that you report the codes on separate line items, you'll report two listings of the same CPT code, but you won't append modifier 50.