Part B Insider (Multispecialty) Coding Alert

Compliance: CMS Identifies Most Egregious Errors in New Compliance Report

Compilation of RAC findings, ZPIC audits, and MAC errors shows you which Part B mistakes you should avoid.

Wondering if consolidated billing issues still persist in Medicare's eyes? CMS's "Medicare Quarterly Provider Compliance Newsletter" aims to answer that question by outlining common billing errors, and offers some advice on how to rectify them.

Let Modifier 26 be Your Consolidated Billing Friend

If your practice sees a fair amount of skilled nursing facility (SNF) patients, the way you bill their services could be attracting attention from RACs.

Background: Services provided to SNF patients "are bundled into one package, billed by the SNF, and paid to the SNF," CMS says in its newsletter. "Physicians' professional services are excluded from the SNF consolidated billing (CB), because physicians are responsible for billing for their own services. However, facility-based components of physician services (e.g., those on a salary or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements - the professional component and the provider component."

When it comes to the provider component, some practices slip up on how to report those services. CMS reminds practices in its newsletter that if the physician performs the professional component of these facility-based services, he should report the appropriate code to the Part B MAC with modifier 26 (Professional component) appended. The technical component is bundled into the SNF CB payment.

Caveat: In some cases, a SNF patient may report to your office with a problem and your physician will order an x-ray to be performed on-site at your practice. In these cases, the MAC will bundle the technical component into the SNF CB payment, so you'll have to recoup that portion of your reimbursement directly from the SNF.

Example: A patient recovering in an SNF after surgery to repair a hip fracture (733.14) presents to her orthopedist for a follow-up visit, where the practice's radiology technician x-rays two views of the patient's hip (73510). The orthopedist reads the x-rays and writes his report, then examines the patient during a level-three E/M service.

The coder should submit the following claim to the patient's Medicare carrier:

- 73510-26
- 99213 (Office or other outpatient visit ...).

The coder should send a separate claim directly to the SNF listing 73510-TC as the procedure code and 733.14 as the diagnosis, with a letter explaining the situation.

Keep An Eye on Place of Service Codes

As most coders know, Part B typically reimburses physicians at a higher rate for services performed in their offices versus those performed in facility settings. The extra payment accounts for the cost of doing business in the office and covers things like non-reimbursable supplies. However, if you bill a service you performed at the hospital using the site of service code for your outpatient practice, you'll be erroneously collecting dollars that you don't deserve.

The CMS newsletter offers the following example: A physician reports 99292 (Critical care, first hour) with place of service code 11 (Office). He collects $260.50 for the service. The RAC later reviews the patient's file and discovers that the service was actually performed during an inpatient hospital stay--so the physician should have billed using service code 21 (Inpatient hospital) and should have collected only $208.40. This means that the physician earned over $52 more than he should have collected.

Most common errors: CMS most frequently sees this type of site of service error with codes 99292 (Critical care, first hour), 85097 (Bone marrow interpretation), 96118 (Neuropsychological testing), and 90801 (Psychiatric diagnostic interview examination), the newsletter reports.

Best practice: If your physician ever does rounds at the hospital or sees patients at any other off-site location, review each medical record carefully before you bill so you can ensure that you've reported the correct site of service location code on your claim.

Resource: To read the entire CMS document, visit www.cms.gov/MLNProducts/Downloads/MedQtrlyComp_Newsletter_ICN907163.pdf.