Part B Insider (Multispecialty) Coding Alert

Compliance: CMS: Stop Reporting Hospital E/M Codes for SNF Visits

Plus: Laparoscopic hernia repairs are under the agency's microscope.

Many providers are so accustomed to either reporting outpatient or inpatient E/M codes that they don't realize other such codes exist for encounters that fall outside of those two categories. This may have been the cause of a recent audit finding revealing that many practitioners are billing inpatient codes when performing skilled nursing facility (SNF) evaluations.

According to the January 2016 Medicare Quarterly Provider Compliance Newsletter, RACs are reporting to CMS that they have seen this issue multiple times. "The Recovery Auditors are finding that physicians and non-physician practitioners (NPPs) are reporting incorrect codes for E/M services provided to SNF Medicare patients," CMS says in the 26-page document. "CMS reminds physicians and NPPs that they must not use CPT® codes 99221-99223, 99231-99233, 99238 and 99239 to bill for E/M services supplied to SNF patients."

Instead, you'll report a code from the 99304-99306 range for initial nursing facility care, or 99307-99310 for established nursing facility care. Keep in mind that you can report a hospital discharge code (99238-99239) in addition to a nursing facility admission service when applicable, but just because the patient happened to be in the hospital earlier in the day doesn't mean you should report hospital codes even for the SNF service.

Step up Hernia Documentation

Also in the latest compliance report were CMS's concerns about how to appropriately report laparoscopic hernia repairs (49650 and 49652), since many of these claims were billed incorrectly.

"The vast majority of the improper payments were due to insufficient documentation," CMS said in the report. For instance, the medical reports were missing items such as a signed operative report, the correct date of service or a signature log/attestation for an illegible signature.

Other issues that auditors found involved claims for hernia services that weren't performed and those that included mesh placement when the documentation didn't include any references to mesh.

If your surgeons are making these types of errors, it's time to sit down and conduct a hernia coding training session with them. Considering that 49650 pays over $443 and 49652 reimburses about $772, your practice can't afford to return the money you've earned for these claims simply because your physician didn't document properly. Explain to the doctors what the notes must include and the nuances that differentiate one level of repair from the others.

Resource: To read the entire compliance newsletter, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN909199.pdf.