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Part B Insider (Multispecialty) Coding Alert

Compliance: Look Out for These New RAC Audit Issues

Tip: Keep the 8-hour observation threshold at top of mind.

If you've been sweating it out, waiting for the recovery audit contractors (RACs) to announce where they'll be focusing their audit efforts for 2014, these companies have finally given some answers.

Background: When CMS started the RAC program, the agency appointed four RAC contractors to implement it, and those companies must post new issues that CMS has approved them to investigate. These companies include Performant Recovery (Region A), CGI Technologies (Region B), Connolly Consulting Inc. (Region C) and HealthDataInsights (Region D). You can visit each RAC's website to see where they're focusing their efforts, but we've listed the most recent review areas that impact Part B practices.

Observation Care for Fewer Than 8 Hours

If your physician sees a patient in observation status but discharges the patient before hitting an eight hour threshold, you could face a tricky billing scenarioand attract RAC attention.

On Dec. 13, Performant Recovery announced that it would be reviewing cases "when a patient receives observation care totaling fewer than eight hours on the same calendar date." In these situations, the physician should report a code from the initial observation care range (99218-99220), but in many cases, doctors erroneously bill 99217, 99234 or 99235 instead. Those claims should be denied, and Performant appears to be poised to collect from any doctors who collected money for this service using those incorrect codes.

In black and white: For Medicare and Medicaid payers, you must confirm that the patient spent at least eight hours in observation before reporting 99234-99236. CMS Transmittal 1466 states "When a patient is admitted to observation status for less than 8 hours on the same calendar date, the physician shall report a code from CPT® code range 99218-99220. Observation Care Discharge (code 99217) shall not be reported."

This audit applies to practices in Connecticut, Massachusetts, Maine, New Hampshire, New York, Rhode Island and Vermont, and covers any claim that was paid within the last three years.

Billing More Than One E/M Code Per Day

Most Part B practices have experienced this situation: You administer an E/M service to a patient, and then see the patient again later that day for a different E/M visit. However, you cannot report both E/M services on the same dateinstead, you need to combine the notes from the two visits and report just one E/M code.

On Dec. 12, Performant Recovery announced that it would be focusing in on claims for initial or subsequent hospital care that are reported more than once per day. This applies to practices in Connecticut, Massachusetts, Maine, New Hampshire, New York, Rhode Island and Vermont for claims that were paid over the past three years.

In black and white: "Contractors pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not," CMS says in Transmittal 2282. "The inpatient hospital visit descriptors contain the phrase 'per day' which means that the code and the payment established for the code represent

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all services provided on that date. The physician should select a code that reflects all services provided during the date of the service."

Blepharoplasty Procedures

If your surgeon performs blepharoplasty (also known as an "eyelid lift"), don't bother reporting it to Medicare if the intention is purely cosmetic, since CMS only covers these services when done for medically necessary reasons.

CGI Technologies announced that it will be performing pre-payment reviews for dates of service Jan. 1, 2014 or after for blepharoplasty services. "These procedures are usually done to correct a deficit in the upper or peripheral field of vision or as noted on forward gaze by skin resting on the upper or lower eyelashes," the RAC notes. "When eyelid/eyebrow repair is done for cosmetic purposes it does not meet the criteria of functional visual impairment parameters and is considered not reasonable and medically necessary; therefore will be denied."

Compounding issue: Although this originally appeared on the RAC Region B's website, the same issue also found its way to Connolly and HDI, which cover Regions C and D. Therefore, this RAC issue will apply to most providers across the country.

In black and white: CMS's Coverage Decision states "surgery of the upper eyelids is reconstructive when it provides functional vision and/or visual field benefits or improves the functioning of a malformed or degenerated body member, but cosmetic when done to enhance aesthetic appearance." It also indicates that the documentation should demonstrate the results of visual field tests that show a "significant loss of superior visual field and potential correction of the visual field by the proposed procedure(s)."

Billing for Multi-Use Vials of Herceptin

Most practices won't be surprised to see that several RACs are reviewing claims for multi-use vials of Herceptin (a cancer drug), since the OIG issued a scathing report last year noting that 80 percent of the claims the agency audited were billed incorrectly.

"When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label," Connolly says on its website. "Multi-use vials are not subject to payment for discarded amounts of drug or biological. The JW modifier cannot be used on claims for multi-use vials."

These claims will be reviewed by several contractors for dates of service within the past three years.

Tip: If you perform any of the listed review areas, you may want to start reviewing those records to ensure that you've billed properly. But keep in mind, if you start looking at records retrospectively and find any problems, you create additional obligations on yourself to self-disclose any wrongdoing.

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