Part B Insider (Multispecialty) Coding Alert

Compliance: RAC Auditors Frustrated Over Duplicate Claims, Facet Joint Injections

Don't resubmit a claim without checking why it was denied the first time.

Curious about which coding issues the Recovery Audit Contractors (RACs) find most frequently? The answer could lie in the results that RACs recently provided to CMS, which were published in its Jan. 2015 Medicare Quarterly Provider Compliance Newsletter. And if you're one of the many practices that submits duplicate claims, the RACs might be looking for you.

Decrease Those Duplicates

In the publication, CMS covers some of the most problematic issues that the RAC auditors see, and among them is duplicate billing. "Exact duplicate data fields submitted for physician claims, including same member, same provider, same dates of service (not including interim billing or corrected claims), same types of services, same place of service, same procedure codes, same provider and same billed amount were audited for duplicate payments," CMS said in the document.

Because your MAC will only pay the first claim that is approved, you'll see denials for all subsequent claims for the same service, because these are considered duplicates.

The problem: The data suggests that impatience could be the main reason this problem occurs. "Once you submit a claim, do not keep re-submitting until you get paid," CMS says in its Quarterly Provider Compliance Newsletter.

The solution: If you haven't gotten paid for a service after 30 days, contact your MAC to inquire about your claim's status rather than resubmitting the same claim again. If you submitted the claim and received a denial, don't simply resubmit it without changing anything. "Check the remittance advice for the previously processed claim to verify if any amount was applied to the deductible," Part B MAC WPS Medicare said in a recent article about duplicate claims.

Focus Your Facet Joint Injections

Practices that administered facet joint injections were found to frequently bill in error due to missing diagnosis codes on the claims. "The recovery auditors identified claims where the first-listed and/or other diagnosis codes do not match to the covered diagnosis codes in the LCD policies," CMS said in its publication. "An overpayment exists when a provider bills for a facet joint injection with an ICD-9 code that is not included on the list of covered ICD-9 codes."

Another problem: Some practices are confused about when to use a bilateral modifier on facet joint claims vs. using the add-on codes.

The solution: When you report these codes, you should remember to append modifier 50 (Bilateral procedure) if the physician injects both the right and left sides of the same spinal level, CMS says in its Quarterly Provider Compliance Newsletter.

In addition, facet joint injections on multiple levels on the same side of the spine require you to use the add-on codes, even though many practices simply use modifier 50.

Example: Your physician administers injections to the patient's L1, L2, L3, L4, and L5 paravertebral facet joint nerves.

Solution: The primary code is 64493 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal]

joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], lumbar or sacral; single level) reported for the L2-L3 facet joint.

Then add +64494 (...second level [List separately in addition to code for primary procedure]) for the second L3-L4 level injection and +64495 (...third and any additional level[s] [List separately in addition to code for primary procedure]) with only one unit of service for the last two facet joint levels (L4-L5 and L5-S1). It is important to note that the code descriptor for the 64495 add-on code specifies "third and any additional level[s]."

Resource: To read the Jan. 2015 Medicare Quarterly Provider Compliance Newsletter, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN909177.pdf.