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Part B Insider (Multispecialty) Coding Alert

Compliance: RACs Identify 2 Error-Prone E/M Issues

Pay attention to your inpatient, allergy E/M billings.

If the majority of your Part B claims involve E/M services, then you may assume that your practitioners have the E/M coding rules burned into their brains. However, a few recent recovery audit contractor (RAC) findings might challenge that belief.

CMS published two recent RAC findings in its latest Medicare Quarterly Provider Compliance Newsletter, which offers guidance to help you tackle billing issues you might be experiencing.

Check Your Inpatient Office Visits

The first RAC issue that CMS shared involved errors on E/M services provided to hospital inpatients. In many cases, physicians who are clearly accustomed to reporting outpatient hospital codes (99201-99215) erroneously reported these for inpatients. Instead, you should report a code from the 99221-99233 when you perform an E/M service for a hospital inpatient.

How the RACs know: RAC auditors can look at your file and then confirm whether or not a patient was at your practice vs. in the hospital on a particular date of service. For example, one RAC auditor discovered a claim for a 79-year-old patient admitted to the hospital on Oct. 23 and discharged on Oct. 26. The physician reported 99205 on Oct. 24. The RAC auditor confirmed that the patient was not on a leave-of-absence from the hospital on that date, which means that the physician should have reported an inpatient E/M code rather than 99205.

Look for these keywords: If you're about to submit a claim for your physician's outpatient E/M service but you suspect the patient may have actually been an inpatient on that date, look for the following keywords that may indicate that he saw the patient in the hospital rather than in your office. If you see any of these, check with the doctor before submitting that outpatient E/M code.

- Saw the patient on rounds...
- Was on the patient's floor...
- Patient can be discharged after reaching this goal...
- The floor RN indicated...

Use Caution for E/M With Allergy Visit

The RACs identified another problem-prone area when investigating claims for E/M visits with allergy testing or allergy immunotherapy. Billing an E/M with these services is "appropriate only if a significant, separately identifiable service is performed," CMS says in the article. If you are merely seeking informed consent for the allergy testing, you can't count that toward an E/M element because it's included in the immunotherapy service.

If you do perform allergy immunotherapy (for instance, 95117) and you see the patient for a separately identifiable E/M service, you must append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service) to help the payer know that a separate service has been performed in addition to the allergy immunotherapy. Maintain documentation of the separately identifiable service that has been performed.

For example: Your physician assesses a patient suffering from severe pain and fever due to a peritonsillar abscess (475), and the patient receives her scheduled bimonthly series of allergy immunotherapy for allergic rhinitis due to dander (477.2). Your physician performs and documents a level-three E/M service. You may report 95115 and 99213

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(Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components... Typically 15 minutes are spent face-to-face with the patient and/or family) along with the modifier 25 appended to 99213.

Resource: To read the entire Medicare Quarterly Provider Compliance Newsletter, visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908950.pdf.

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