Part B Insider (Multispecialty) Coding Alert

E/M Billing: Hospital Nailed for Billing E/Ms That Should Have Been Included in Procedures

Consider these tips to avoid the same fate.

If you see a patient in the hospital prior to his surgery, you typically can't count that toward reporting an E/M service--instead, your pre-procedure check-in with the patient will be included in payment for the service you perform.

Some hospitals, however, aren't aware of this rule--and the OIG is watching. A recent audit of Georgetown University Hospital in Washington, DC revealed that 21 of 125 selected claims showed errors related to outpatient E/M codes being billed with other services.

The E/M services "were not separately payable because they were part of the usual preoperative and postoperative care associated with a procedure and paid as part of that procedure," the OIG's April 3 audit report said. "Hospital officials stated that these errors occurred because billing documents were improperly sorted during the hospital's transition from paper to electronic medical records. As a result, the hospital received overpayments totaling $1,210."

Check This Tip for Procedure-Day E/M

You cannot simply put a modifier on your E/M visit code to get paid. Make sure your E/M is a significant, separately identifiable service from the minor E/M service that payers associate with the procedure.

CPT® considers minor procedures to have a very small E/M already included with the procedure. Therefore, insurers won't pay an E/M unless it is a significant, separately identifiable service. And Medicare will not pay an E/M separately on the same date of service as a procedure if the purpose of the E/M was for the doctor to decide to do the procedure. "The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25," according to the National Correct Coding Initiative Policy Manual, Chapter 1.

In other words: If your physician captures minimal history, performs a limited exam, and documents low medical decision making (MDM), all of which are associated with the procedure, the E/M does not qualify for modifier 25. Therefore, you should consider the E/M included in the procedure and you should not separately code for it.

Alternative: Some payers may prefer modifier 57 (Decision for surgery) for E/M services during the global period of any procedure, so check with your payer and get this instruction in writing to keep with your compliance materials.

To read the complete audit report of Georgetown Hospital, visit http://oig.hhs.gov/oas/reports/region3/31100010.pdf.