Psychiatry Coding & Reimbursement Alert

Compliance: Know What RACs Are Looking For in Your E/M Reports

You could be the next target for audits by overlooking these common errors.

While reporting E/M codes might be routine to your practice, don't open your doors to recovery audit contractors (RACs) by overlooking simple errors, such using the wrong set of codes for inpatient services.

The Centers for Medicare & Medicaid Services (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 The Location of Your Clinician's 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 and 99238-9923series 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 and 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 hospital 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...

For example, the physician may have thought that the patient was admitted to observation. As a consultant to a patient in observation, your physician would have to report a new or established office/outpatient visit code (99201-99215). However, if the patient was converted to inpatient status prior to your psychiatrist seeing the patient, only inpatient visit codes can be reported. The facility records should be able to confirm the patient status if the codes need to be corrected when a place of service denial is received.

Likewise, the place of service code needs to align as well. Thus, if you originally submitted 99205 and place of service 22 (Outpatient hospital) for the psychiatrist's service to the patient above and the claim was denied because the patient was an inpatient, you will need to change the place of service code to 21 (Inpatient hospital) along with changing the CPT® code.

Use Caution While Reporting Source of Admission Codes

The RACs identified another problem-prone area when investigating claims under the Medicare Prospective Payment System for inpatient psychiatric facilities (IPFs). According to the reviews conducted, the auditors determined that, a majority of the time, overpayments occurred due to faulty submission of "Source of Admission Codes" when patients

were transferred within the same facility.

When patients are transferred from an acute hospital to their own psychiatric distinct part unit (DPU), the Source of Admission Code needs to be "D," whereas in most cases it has been faultily reported with another Source of Admission Code, such as "1" (Physician Referral) or "2" (Clinic Referral), resulting in overpayments.

According to the Medicare PPS for IPFs, CMS will make extra payments to an IPF or DPU on the first day of a patient's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay. If when transferring the patient from the acute care section to the IPF, Source of Admission Code "D" is not indicated, then the IPF could also receive the additional payment resulting in overpayment.

For example, one RAC auditor discovered a claim for a 63-year-old male patient admitted through the emergency room for a two-day stay in an acute inpatient hospital setting on Jan. 19, and on Jan. 21 the patient was transferred to the hospital's inpatient psychiatric facility. The Source of Admission Code was incorrectly listed as "2" (Clinic Referral) rather than "D," resulting in an overpayment to the facility.

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.