COMMON ERRORS IN OUTPATIENT EMERGENCY HOSPITAL BILLING

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The Texas Health and Human Services Office of Inspector General (OIG) collaborates with Texas health care providers to prevent and investigate fraud, waste and abuse in Medicaid and CHIP services delivery. OIG actions help providers minimize billing mistakes and ensure Texas tax dollars are used for their intended purposes.

Through the course of its audits, inspections, reviews and investigations, the OIG sometimes sees the same errors repeated across the system by multiple providers. The OIG has been working with outpatient emergency hospital providers to share observations of improper payment trends in Medicaid reimbursement data. The scenarios below represent six types of reimbursements that are not allowable in the Texas Medicaid program, per the Texas Medicaid Provider Procedures Manual (TMPPM). Many of these trends involve duplicate reimbursements, or what essentially results in two payments for the same services.

In managed care, program integrity is a shared responsibility between the federal government, the state and the MCOs. When potential improper payments are observed, the OIG collaborates with MCOs to understand their applicable policies and operations, including whether the MCO offers exceptions or allowances to TMPPM requirements related to the OIG's area of focus for a particular activity. The OIG considers information obtained from the MCO in its assessment of potential improper payments by providers in the MCO's network.

The OIG shares these observations as a resource for providers, in hopes of preventing future errors.

INJECTIONS AND INFUSIONS

Reimbursement to the outpatient hospital facility for the administration of injections or infusions in an emergency room setting, the cost for which is already included in the reimbursable Emergency Department Evaluation and Management (E/M) rate.

TMPPM Reference

Inpatient and Outpatient Hospital Services Handbook, 4.2.2, Emergency Department Services:

"The administration of an injection may be reimbursed to the provider who administers the injection. The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility."

Procedure Codes

- Administration of Injection: 96371, 96372, 96373, 96374, 96375, 96376, 96377
- Administration of Infusion: 96360, 96361, 96365, 96366, 96367, 96368, 96369, 96370, 96379
- Evaluation and Management: 99281, 99282, 99283, 99284, 99285

Revenue Codes

0450, 0451, 0456, 0459 *(Other revenue codes may also apply when billed by an outpatient emergency hospital facility in combination with one of the above procedure codes.)*

CRITICAL CARE

The outpatient emergency hospital facility bills and receives reimbursement for minutes of the direct delivery of medical care for a critically ill or injured patient, which are authorized to be paid only to the provider (physician) rendering the service. The hospital may be reimbursed for its resource expenses through an emergency department E/M code, but the minutes of critical care service may only be paid to the physician (group or individual) who provided critical care services.

TMPPM Reference

Medical and Nursing Specialists, Physicians, and Physician Assistants' Handbook, 9.2.58.5.4, Critical Care:

"Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis... Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous."

Procedure Codes

- 99291 – A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day).
- 99292 – A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.

EMERGENCY DEPARTMENT DUPLICATE PAYMENTS

Payment for the same Emergency Department (ED) services twice — either exact duplicates or multiple E/M procedure codes for the same member and date of service.

TMPPM Reference

Volume 1, General Processing | Section 6, Claims Processing, 6.4.1.2, CPT and HCPCS Claims Auditing Guidelines:

"Duplicate claim - A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier, and number of units. Duplicate claims or procedure code details will be denied. Note: Modifiers may be used to identify separate services.

"Only one E/M procedure code may be reimbursed for a single date of service by the same provider group and specialty, regardless of place of service."

Procedure Codes

99281, 99282, 99283, 99284, 99285

EMERGENCY DEPARTMENT SERVICES BILLED WITHOUT AN ASSOCIATED HCPCS PROCEDURE CODE

All services rendered in the emergency room under revenue codes 450, 456 and 459 must be reported with the appropriate procedure code referencing the service provided.

TMPPM Reference

Inpatient and Outpatient Hospital Services Handbook, 4.2.2 and 4.5.5

- **4.2.2, Emergency Department Services:**
  "All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code."

- **4.5.5, Outpatient Hospital Revenue Codes:**
  "UB-04 CMS-1450 revenue codes must be used to submit claims for outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:"

Emergency Room		
450	*Emergency room*	*Procedure code required*
451	*Emergency medical screening services (EMTALA)*	
456	*Urgent care*	*Procedure code required*
459	*Other*	*Procedure code required*

Revenue Codes
0450, 0456, 0459

OBSERVATION TREATMENT ROOM SERVICES REIMBURSED WITH OTHER OBSERVATION ROOM/ TREATMENT SERVICES

Revenue Code 0761 cannot be reimbursed when Revenue Codes 0760, 0762, or 0769 are also paid for the same member and date of service.

TMPPM Reference
Inpatient and Outpatient Hospital Services Handbook, 4.2.4.6, Reporting Hours of Observation:
"Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769."

Revenue Codes
0760, 0761, 0762, 0769

OBSERVATION SERVICES REIMBURSED WITH EMERGENCY ROOM SERVICES

E/M services and Observation Services reimbursed for the same member and date of service. The hospital may get reimbursed for only one of the resource expenditures.

TMPPM Reference
Inpatient and Outpatient Hospital Services Handbook, 4.2.4.2, Observation Following Emergency Room:
"If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges. Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit."

Procedure Codes
99281, 99282, 99283, 99284, 99285 with G0378, G0379

Revenue Codes
0760, 0761, 0762, 0769

Excludes
Claims with diagnosis codes from ICD-10 related to chest pain, asthma, or congenital heart failure.