Codify
BY AAPC

Dermatology Coding Alert

Compliance: Watch For Extra Scrutiny of Your Incident-To Billing, E/M Coding, and More

Pay attention to where the OIG will focus to ensure your practice isn't throwing up red flags.

If you are getting ready to start a self-audit but have no idea where to focus, there is good news. Thanks to its 2013 Work Plan, released on Oct. 2, the HHS Office of Inspector General (OIG) points you in a direction.

According to the report, the OIG has some big plans next year for reviewing claims, and they span the whole spectrum of issues. Take a look at some of the areas under the OIG microscope so your practice can straighten out any issues before the auditors come knocking.

1. Potentially Inappropriate E/M Payments and 'Identical Documentation.' The OIG intends to go back in time -- all the way to 2010, to be exact, when reviewing E/M claims. "We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations," the Work Plan states. The OIG also plans to review multiple E/M notes for each provider to determine whether EHR errors are creating cloned notes across services.

Bottom line: If a physician is documenting each patient identically rather than documenting based on the patient's condition and medical necessity, that's a red flag for the OIG.

2. Incident to services: The OIG intends to determine whether payment for incident to services showed a higher error rate than non-incident to services. "Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record," the Work Plan notes. "They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality."

Bottom line: Ensure that you have met all of the requirements for billing incident-to before coding that way. Brush up on your incident-to coding with the article "Shore Up You Incident-to Claims or Face OIG Scrutiny This Year" in Medical Office Billing & Collections Alert Vol. 12, No. 2.

3. **Payment for 'G' modifiers with ABN:** The OIG intends to review Medicare payments for claims that included the "G" modifiers (GA, GZ, GX, GY) to indicate that a Medicare denial was expected. Often, these modifiers are used in tandem with an advance beneficiary notice (ABN). In the past, the OIG has found that Medicare inappropriately paid millions for services or supplies that should have been denied.

Bottom line: Ensure that you are correctly appending 'G' modifiers and that you utilize your ABN appropriately.

4. **Use of Modifiers During Global Period.** In many cases, practices are perfectly justified in adding a modifier to indicate that a patient is in the global period and that a service was unrelated and should be separately paid. Some practices, however, are abusing these modifiers, and the OIG wants to track them down. "Prior OIG work found that improper use of modifiers during the global surgery period resulted in inappropriate payments," the Work Plan notes.

Bottom line: Brush up on your global surgical modifiers and the appropriate use of each.

Other issues: The OIG also plans to review claims for electrodiagnostic testing, ophthalmological services, personally-performed anesthesia, physical therapy, and sleep testing, among other topics. To review the complete list, read the Work Plan at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.

Codify
BY AAPC