Optometry Coding & Billing Alert

Practice Management: Get Ready For OIG Scrutiny of Modifiers and More

Audit yourself before the feds come calling.

Your optometry practice could come under the microscope in 2013 based on the latest work plan for the Office of Inspector General (OIG).

Take a look at six focus areas outlined below so you can straighten out any issues before the auditors are at your door.

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, according to the 2013 OIG Work Plan.

"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 electronic health record use by providers is allowing them to create cloned notes for different dates of service.

Bottom line: If an internal chart audit shows that 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. Resist the temptation to copy and paste notes from previous encounters into the current encounters, too.

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 do 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.

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.

4. Use of Modifiers During Global Period

Your providers may be perfectly justified in adding a modifier to indicate that a patient receives an unrelated service during the global period. But some practices 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," according to Work Plan.

5. Errors in Place of Service Reporting

Because Medicare pays differently for services that your physician provides in a facility versus the optometrist's office (non-facility), the OIG intends to check on your place of service codes especially those used to claim physician services in outpatient departments and ambulatory surgical centers.

"Medicare pays a physician a higher amount when a service is performed in a non-facility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ambulatory surgical center," notes the Work Plan.

6. Questionable Billing of Ophthalmological Services

The OIG will be paying special attention to your past billing. "We will review Medicare claims data to identify questionable billing for ophthalmological services during 2011," the Work Plan says. "We will also review the geographic locations of providers exhibiting questionable billing for ophthalmological services in 2011."

Resource: You can view the Work Plan at oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf