Part B Insider (Multispecialty) Coding Alert

Compliance: OIG Revisits Recommendation to Adjust Global Surgery Fees Based on E/M Services

OIG discovered inconsistent billing for global surgery and believes adjustments could save CMS over $97 million.

When the OIG talks, not everyone listens, according to a new report.

The OIG makes hundreds of recommendations each year, advising practices and carriers to tighten up documentation, correct their modifier use, or implement other programs. On Dec. 5, the OIG released its Compendium of Unimplemented Recommendations, which revealed that practices and facilities have ignored many OIG suggestions.

Case in point: In 2009, the OIG found that global surgery fees for eye procedures included a set number of E/M services, but that physicians did not actually provide that many E/M visits. Therefore, the fees were calculated to be higher than they should have been, the Compendium notes. "Similar audits of musculoskeletal and cardiovascular global surgeries that were issued in 2012" also caused the OIG to pay closer attention to the issue of appropriate E/M visits with global surgeries.

In response to those audit findings, the OIG recommended that CMS should adjust the estimated number of E/M services included in these services, or consider the audit findings when setting RVUs in the Medicare Physician Fee Schedule. CMS told the OIG that it would continue to monitor the number of E/M services required when setting and adjusting global fees, but noted "that the process for identifying, reviewing, and updating values of a misvalued code takes years."

The OIG plans to "monitor CMS's actions" to address the recommendations, the new report indicates.

OIG Also Pursuing ED Radiology Services

Another issue targeted in the Compendium involves wasteful diagnostic radiology services that the OIG has identified to be taking place in the emergency departments (EDs).

"In hospital emergency department settings, professional diagnostic radiology services (such as interpretations and reports by physicians) that are billed to Part B must be identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient," the report notes. However, "OIG found many interpretations and reports, particularly those performed after the patients'' discharge, did not contribute directly to the patients' diagnosis and treatment and were not allowable under the Part B Fee Schedule methodology."

For example, an April 2011 OIG report found that Medicare paid for interpretations and reports performed for 16 percent of x-rays (accounting for $10 million) and 12 percent of CTs and MRIs ($19 million) that were performed after the patients had already left the ED.

The OIG has therefore asked CMS to adopt a uniform policy to help avoid waste in this sector. In addition, the agency requested that Medicare contractors "institute service code modifiers for further analysis of instances in which emergency department diagnostic interpretations were performed after patients were discharged from emergency department care."

Resource: To read the full list of unimplemented OIG recommendations, see the OIG Web site at https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2012.pdf.

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