Part B Insider (Multispecialty) Coding Alert

Compliance: OIG Sets Sights on E/M Services, Place of Service Coding

The latest Work Plan focuses on several new areas.

This year, you'll want to make sure you button up your E/M documentation, because the OIG has released its long-awaited 2014 Work Plan -- which includes plans to review Medicare claims for everything from anesthesia to place of service coding and beyond.

What the Work Plan is: The OIG Work Plan details issues that the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General will address during the fiscal year. Typically, the OIG releases the document in the fall, but this year the Work Plan was significantly delayed due to "fiscal challenges." However, the document finally went up on the OIG's website on Jan. 31, and we've got the highlights of what the agency will be targeting this year.

E/M Services Under Fire

One of the OIG's 2014 intentions is to evaluate whether E/M services were appropriate or not, as well as reviewing "multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities."

Translation: The OIG appears to be looking for incidences of cloned notes, based on its statement that "Medicare contractors have noted an increased frequency of medical records with identical documentation across services."

How to Button up: To ensure that you aren't vulnerable to this target area, confirm that your practitioners are only documenting the necessary elements in each E/M note, and that each note is based specifically on that patient encounter and the medical necessity required of the visit.

Although this is true of any type of documentation, the problem of cloned notes has become a bigger issue thanks to the use of electronic medical records (EMRs), in which the capability of "carry over," repetitive "fill ins," and cloning has become prevalent, experts say.

Remind your providers and coding/billing staff that only medically necessary information is considered when you are deciding on the code to bill based on supporting documentation.

Copy and paste, cloning, and the act of carrying information forward from another record or another portion of the record has the same effect on the integrity of the medical record. Eventually, there will be contradictions in a patient's record. Payers obviously frown on this type of documentation.

Example: First Coast Service Options, the MAC in Florida, warned providers that "Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment."

First Coast further states that discovery of this type of documentation will "result in denial of services for lack of medical necessity and recoupment of all overpayments made."

Bottom line: Make sure your documentation is unique to each patient and his or her diagnosis.

Differentiate 'AA' From 'QK' Modifier

Another hot spot for the OIG is personally-performed anesthesia services. "We will also determine whether Medicare payments for anesthesiologist services reported on a claim with the 'AA' service code modifier met Medicare requirements," the OIG said in the Work Plan. "Reporting an incorrect modifier on the claim as if services were personally performed when they were not will result in Medicare's paying a higher amount."

Translation: The OIG believes that Medicare might be overpaying for anesthesia services due to misuse of the AA modifier (Anesthesia services performed personally by anesthesiologist). If the anesthesiologist does not personally perform the anesthesia, you should not bill as if he did, and you shouldn't append modifier AA to the service code.

How to Button up: If the anesthesiologist personally performs a case, you must know where he is for the entire procedure and report modifier AA with the procedure code. The carrier pays him for the entire case.

Coding gets trickier when the anesthesiologist oversees other members of the team rather than personally performing cases. If he medically directs one CRNA, report modifier QY (Medical direction of one certified registered nurse anesthetist [CRNA] by an anesthesiologist) with the procedure code; if he directs from two to four anesthetists, report modifier QK (Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals) instead. Physicians who medically direct cases split the procedure fee with the other anesthetist(s) involved.

Know Your Place of Service

If you perform a considerable number of services at ASCs or hospital outpatient departments, double and triple-check your place of service (POS) coding to ensure that you didn't erroneously lead your payer to believe that you performed the service in your office.

"Prior OIG reviews determined that physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors," the OIG says in the Work Plan.

Translation: Because CMS reimburses more money for procedures performed in your office than those performed in hospitals, you're getting overpaid for services that you misidentify with POS 11 (Office) if the service actually took place elsewhere.

How to Button up: If you perform services in an outpatient hospital setting, you should use place of service 22 instead of 11. If the service took place in an ASC, you should instead use POS code 24.

Remember: Even if your physician performs 80 percent of his procedures in the hospital, it's possible that a dermatological procedure here or a fracture setting there will take place in the office, so you can never assume that you know the POS when you read a chart. Therefore, you should always be sure to confirm where a procedure was performed before you file the claim with the POS code.