Part B Insider (Multispecialty) Coding Alert

Compliance: OIG Sets Sights on Hospital Admissions, 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 documentation for inpatient admissions, because the OIG has released its long-awaited 2015 Work Plan -- which includes the agency's intentions to review Medicare claims for everything from physical therapy 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. The agency published its latest document on Oct. 31, which outlines the target areas it will be reviewing in 2015, and we've got the highlights below.

Inpatient Admissions Under Fire

One of the OIG's 2015 intentions is to evaluate whether hospital admissions were appropriate or not. "Previous OIG work identified millions of dollars in overpayments to hospitals for short inpatient stays that should have been billed as outpatient stays," the Work Plan notes.

As most practices know, physicians should only admit Medicare patients who are expected to require at least two nights of hospital care (also referred to as the "two midnight policy.")

Translation: The OIG appears to be looking for incidences of inpatient admissions when the patient is actually only expected to be in the hospital for less than two overnight periods, which would constitute a misuse of the admissions policy.

How to Button up: To ensure that you aren't vulnerable to this target area, confirm that your physicians are aware of the two midnight rule, and that they strive to treat patients who don't require two nights in the hospital as outpatients.

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 service code 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. If you report modifier QK, your payment will be limited to 50 percent of the Medicare-allowed amount because

you'll be splitting it with the other anesthetists.

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.

Physical Therapists Should Confirm Medical Necessity

Physical therapists who perform a variety of outpatient services will be under the microscope next year, as the OIG scrutinizes whether the claims were in compliance with Medicare rules.

"Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable or were not properly documented or that the therapy services were not medically necessary," the OIG says in the Work Plan.

Translation: The OIG only wants to see PTs report services that are reasonable and medically necessary, rather than reviewing claims for services that appear to be at a patient's request or for conditions that aren't covered.

How to button up: Go over your documentation to confirm that a provider has ordered the physical therapy for a valid medical reason and that your services meet CMS's requirements.

Ophthalmologists, Chiropractors Also Under the Microscope

The OIG will also be reviewing ophthalmology claims that were submitted in 2012 "to identify potentially inappropriate and questionable billing." Although the agency hasn't said which specific services they're targeting, the Work Plan points out that Medicare paid over $6.8 billion for ophthalmology services in 2010, which is clearly the trigger for this current audit.

In addition, the OIG will be reviewing Part B payment for chiropractic services to ensure that every Part B claim is solely for the purpose of manual manipulation of the spine to treat a subluxation, since that's the only chiropractic service that Medicare covers. In the past, the agency identified a chiropractor with a startling 93 percent error rate who overbilled Medicare by about $700,000, so CMS is ensuring that this is not a common practice.

Resource: To read the entire 2015 OIG Work Plan, visit http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf.