Part B Insider (Multispecialty) Coding Alert

Compliance: OIG to Focus on E/M, Incident-to, and Global Modifiers in 2013

Plus: You'll also see extra scrutiny on anesthesia and ophthalmology claims, among others.

The HHS Office of Inspector General (OIG) has some big plans next year for reviewing Part B claims, and they span the whole spectrum of issues, according to the OIG's 2013 Work Plan, released on Oct. 2. Get to know these hot buttons before you press them.

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. To qualify for incident to, the physician must have seen the Medicare patient during a prior visit and established a clear plan of care. If the non-physician practitioner (NPP) is treating a new problem for the patient, or if the physician has not established a care plan for the patient, then you cannot report the visit incident to. In addition, when meeting the requirements for a follow-up to an established plan of care, if the physician does not directly supervise the NPP, the incident-to rules do not apply. Direct supervision means a supervising physician must be immediately available in the office suite. The supervising physician, however, does not necessarily need to be the same physician who established the patient's care plan.

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. If you'd like a copy of a previous Insider article covering these modifiers in-depth, contact editor Torrey Kim, CPC, CGSC at torreyk@codinginstitute.com.

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

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Work Plan at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.

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