Part B Insider (Multispecialty) Coding Alert

Compliance: OIG to Focus on Incident-to Claims, E/M Services, And More in 2012

New OIG Work Plan offers insight into where the agency will be focusing its reviews next year.

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 2012 Work Plan, released on Oct. 5. Get to know these hot buttons before you press them.

1. 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 represent 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."

Best practice: Don't bill incident to unless you're sure you've met the requirements. 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.

2. Compliance with assignment rules: When a physician accepts assignment with Medicare, he agrees to accept the Medicare-allowed amount from the carrier as the full charge for the service provided. In 2012, the OIG plans to review "to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare."

Best practice: Confirm with your billing department or contractor that you aren't inappropriately billing any excess patient balances to the beneficiary.

3. Trends in E/M coding: The OIG indicates in its Work Plan that it intends to review E/M claims to identify trends between 2000 and 2009, and to determine which providers "exhibited questionable billing for E/M services in 2009." In addition, the OIG will review the number of E/M services that physicians provided during global surgery periods, and will review claims for which physicians appended a modifier so they could separately collect for E/M visits during the global period.

Best practice: Don't bill separately for E/M-related services relating to the original surgery during the global period. The global surgical package includes routine postoperative care during the global period. You should only append modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) to an appropriate E/M code when an E/M service occurs during a postoperative global period for reasons unrelated to the original procedure.

4. 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.

Best practice: Know the differences between the "G" modifiers with the chart below.

5. Hospital observation services: The OIG has determined that improper use of observation services "may subject

beneficiaries to high cost sharing," and intends to review claims for outpatient observation visits to assess the appropriateness of the services.

Best practice: Stay on top of CMS's often-changing observation coding rules. For instance, CMS recently clarified how to use subsequent observation care codes 99224-99226 in MLN Matters article MM7405, in which the agency noted that these codes should only be used by the "treating physician."

To read the OIG's complete Work Plan, visit http://go.usa.gov/93X.