Part B Insider (Multispecialty) Coding Alert

Compliance: OIG's Semiannual Report Reveals Place-of-Service Coding Errors, Other Issues

Plus: Investigators found one high-utilization county for Medicare therapy dollars.

If you've ever wondered whether the OIG collects on its audits and investigations, a new report answers that question, to the tune of $25.9 billion.

In its latest Semiannual Report to Congress, which covers OIG activity for fiscal year 2010 (Oct. 1, 2009 through Sept. 30, 2010), the OIG recovered $25.9 billion, which included $1.1 billion in audit receivables.

"Along with our significant work related to a variety of HHS agency programs during this reporting period, we are particularly encouraged by the success of our partnerships with HHS and the Department of Justice through the Health Care Fraud Prevention and Enforcement Action Team (HEAT)," said Inspector General **Daniel R. Levinson** in a Dec. 15 statement.

"For example, our HEAT Strike Force teams yielded 89 convictions and $71.3 million in investigative receivables in the second half of FY 2010 alone."

The following recoveries were among the OIG's reported triumphs over the one-year period, according to the report:

- **Outpatient hospital services:** The OIG found that out of 104 high-dollar Part B payments ($50,000 or higher) made to hospitals between 2003 and 2005, only 27 were appropriate. The remaining 77 payments included over $6 million in overpayments, mostly due to clerical errors or errors in billing systems
- Place-of-Service Coding: The OIG estimated that physicians collected nearly $14 million due to placeof- service code errors in 2007. The investigation discovered that 90 percent of the services it sampled were billed with non-facility place-of-service codes when the physician actually performed the procedures in hospital outpatient departments or ASCs.
- Pain management: The OIG sampled 433 transforaminal epidural injection services billed to Medicare in 2007 and found that 34 percent of the claims did not meet Medicare requirements, totaling $45 million in improper payments. Many of these services were inappropriately billed because they were not medically necessary, had no documentation, or were miscoded.
- Claims for Deceased Patients: The OIG discovered that MACs overpaid $8.2 million in Part B claims for services administered after patients had died. This finding puts a strong emphasis on how important dates of service are on your claims.

The OIG report not only allows you to see where the agency focused its efforts in prior years, but may also shine a light on which services MACs will be scrutinizing going forward. It's a good idea to review the report in its entirety and ensure that you aren't making any of the mistakes that the practices in the report made.

To read the complete OIG report, visit http://oig.hhs.gov/publications/sar/2010/fall2010_semiannual.pdf.

OIG Identifies High-Utilization Therapy Area

Meanwhile, the OIG released a new report on Dec. 22 indicating that Medicare spending on outpatient therapy services in Miami-Dade County, Florida was three times the national average in 2009, leading investigators to question what caused the high charges.

According to the report, Medicare paid nearly $5 billion in outpatient therapy services provided to 4.5 million

CPT® 2023 American Medical Association. All rights reserved.

beneficiaries in 2009, with over $1 million of those payments going to Dade County in South Florida. As a result, the OIG asked CMS to target outpatient therapy claims "with questionable billing characteristics for further review," and to target specific high-utilization areas to determine the reasons for overbilling.

To read the complete report, visit http://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf.

CPT® 2023 American Medical Association. All rights reserved.