Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Check Out These Six Ob-Gyn 2014 OIG Work Plan Hot Spots

Tip: Your practice's expenses for ultrasound procedures should be in line with your costs.

Reviewing the Office of Inspector's (OIG) 2014 Work Plan for potential problem areas is a wise plan for ob-gyn practices. If you want to avoid getting caught in an auditor's crosshairs, examine these sections of the Work Plan and adopt these expert strategies.

1. Check Out These Diagnostic Radiology Potential Minefields

According to the 2014 Work Plan, the OIG will be looking at the medical necessity of high-cost tests. They don't identify which tests they think are high cost, but you can assume they will look at CTs, MRIs, 3D, and PET scans. The Work Plan states:

"Billing and Payments. We will review Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which utilization has increased for these tests. Medicare will not pay for items or services that are not 'reasonable and necessary.' (Social Security Act, § 1862 (a)(1)(A).) (OAS; W-00-12-35454; W-00-13-35454; various reviews; expected issue date: FY 2015; work in progress)."

Best strategy: Make sure your ob-gyn claims featuring diagnostic radiology services show medical necessary with supporting documentation and diagnoses.

Ob-gyns are using 3D scans, which are becoming a useful diagnostic tool, more frequently. They use them for things such as the evaluation of tumors to differentiate between them being benign or malignant and to observe details of fetal anomalies, says **Melanie Witt, RN, CPC, COBGC, MA**, an ob-gyn coding expert based in Guadalupita, N.M.

However, Medicare has stated CPT® codes 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation) and 76377 (...requiring image postprocessing on an independent workstation) may be considered medically unnecessary and denied if:

a) equivalent information to that obtained from the test has already been provided by another procedure (magnetic resonance imaging, ultrasound, angiography, etc.) or

b) equivalent information could be provided by a standard CT scan (two-dimensional) without reconstruction.

Therefore, it will be crucial that the referring physician provides a written request indicating the clinical need for the additional 3-D imaging, and the interpreting physician maintains a copy of that request. The interpreting physician's report must address the specific clinical issues that required the 3D modality.

2. Dodge These Electrodiagnostic Testing Mistakes

Does your urogynecologist report 51785 (Needle electromyography studies [EMG] of anal or urethral sphincter, any technique)? If so you may want to review the following OIG Work plan item for questionable billing of electrodiagnostic testing:

"Billing and Payments. We will review Medicare claims data to identify questionable billing for electrodiagnostic testing and determine the extent to which Medicare utilization rates differ by provider specialty, diagnosis, and geographic area

for these services. Context Electrodiagnostic testing, which assists in the diagnosis and treatment of nerve or muscle damage, includes the needle electromyogram and the nerve conduction test. Coverage for diagnostic testing is provided by the Social Security act, § 1861(s)(2), and 42 CFR § 410.32.) The use of electrodiagnostic testing for inappropriate financial gain could pose a growing vulnerability to Medicare. (OEI; 04-12-00420; expected issue date: FY 2013; work in progress)."

Best strategy: Medicare's coverage rules are fairly clear with regard to reporting code 51785 and by following them, you can avoid questionable billing, Witt says. EMG of the anal or urethral sphincter (51785) is a diagnostic test that measures muscle activity and that is used to assist in evaluating fecal or urinary incontinence, dysfunctional elimination of bowel and bladder and neurogenic bladder dysfunction leading to functional abnormalities of the muscular sphincter.

Medicare covers EMG studies of the anal or urethral sphincter only for conditions of fecal or urinary incontinence where it is clinically necessary to rule-in or rule-out diagnoses of stress or urge incontinence, mechanical or functional incontinence, or other forms of incontinence. A test is clinically necessary when there is appropriate evaluation and justification prior to the test and when the test is also likely to affect the course of therapy. Medicare would expect to see 51785 billed during the initial diagnostic evaluation only when:

a) the cause of the fecal incontinence or urinary incontinence cannot be determined from the physician's evaluation and b) the physician has determined that diagnostic testing is needed to make a diagnosis.

3. Implement This Imaging Services Advice

The OIG will be using this work plan item to find out if Medicare is paying too much for imaging services and whether they are overused. They say:

"Billing and Payments. We will review Medicare Part B payments for imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. Context Practice expenses are those such as office rent, wages, and equipment. Physicians are paid for services pursuant to the Medicare physician fee schedule, which covers the major categories of costs, including the physician professional cost component, malpractice costs, and practice expenses. (Social Security Act, § 1848(c)(1)(B).) (OAS; W-00-12-35219; W-00-13-35219; various reviews; expected issue date: FY 2014; work in progress)."

Best strategy: Review your payments for practice expenses. "Basically, make sure your practice expenses for your ultrasound procedures are in line with your costs. Heavy mark-ups will be viewed unfavorably by the OIG," Witt says.

Also, make sure that each ultrasound that is ordered for a Medicare patient is supported by a clinical indication that will support improved outcomes or treatment for the patient. Ultrasounds performed for "nice to know" reasons would be viewed in a negative light, Witt warns.

4. Launch These Laboratory Test Inquiries

The OIG will be examining the billing characteristics and questionable billing of laboratory tests. The Work Plan states:

Billing and Payments. We will review billing characteristics for Part B clinical laboratory (lab) tests and identify questionable billing. Context Medicare is the largest payer of clinical lab services in the Nation. Medicare's payments for lab services in 2008 represented an increase of 92 percent over payments in 1998. In 2010, Medicare paid about $8.2 billion for lab tests, accounting for 3 percent of all Medicare Part B payments. Much of the growth in lab spending has resulted from the increased volume of ordered services. Part B covers most lab tests and pays 100 percent of allowable charges; Medicare beneficiaries do not pay copayments or deductibles for lab tests. Medicare should pay only for those lab tests that are ordered by a physician or qualified nonphysician practitioner who is treating a beneficiary. (42 CFR § 410.32(a). (OEI; 03-11-00730; expected issue date: FY 2013; work in progress)

Best strategy: The issue here is asking, what constitutes a medically indicated test? Providers who order a set battery of tests when one would have done may find themselves under scrutiny. They will also likely not want to pay for a test an ob-gyn orders when any abnormal results would not be treated by the physician who ordered the test. For instance, if an

ob-gyn orders a follow-up cholesterol test on his patient during a visit but is not the physician who is actually treating the high cholesterol, Medicare would say the ob-gyn incorrectly billed this test.

5. Fix This Physician and Supplier Problem Area

The OIG will be looking at noncompliance with assignment rules and excessive billing of beneficiaries:

"Billing and Payments. We will review the extent to which physicians and suppliers participated in Medicare and accepted claim assignment during 2012. We will also assess the effects of their participation and claim assignments on the Medicare program (such as noncompliance with assignment rules) and on beneficiaries (such as excessive billing of beneficiaries' share of charges). Context Physicians participating in Medicare agree to accept payment on 'assignment' for all items and services furnished to individuals enrolled in Medicare. (Social Security Act, § 1842(h)(1).) CMS defines "assignment" as a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to allow the physician or other supplier to request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the physician or other supplier. The physician or other supplier in return agrees to accept the Medicare-allowed amount indicated by the carrier as the full charge for the items or services provided. (OEI; 07-12-00570; expected issue date: FY 2014; work in progress)."

Best strategy: When billing Medicare, make sure you know the allowable for each service you charge and that you do not bill the Medicare patient more than the explanation of benefits (EOB) allows after payment. If you are not participating, it will be especially important that you ensure you are not exceeding the limiting charge. All ob-gyn practices should have at least one person in billing monitoring this, Witt says.

6. Pick Apart Payments For Outpatient Drugs and Administration of the Drugs

If your physician is one who specializes in gynecological oncology, then you should note this particular item of the 2014 OIG Work Plan:

"Billing and Payments. We will review Medicare outpatient payments to providers for certain drugs (e.g., chemotherapy drugs) and the administration of the drugs to determine whether Medicare overpaid providers because of incorrect coding or overbilling of units. Context Prior OIG reviews have identified certain drugs, particularly chemotherapy drugs, as vulnerable to incorrect coding. Providers must bill accurately and completely for services provided. (CMS's Claims Processing Manual, Pub. No. 100-04, ch. 1, §§ 70.2.3.1 and 80.3.2.2.) Further, providers must report units of service as the number of times that a service or procedure was performed. (Chapter 5, § 20.2, and ch. 26, § 10.4.) (OAS; W-00-12-35576; various reviews; expected issue date: FY 2014; work in progress)."

Best strategy: Following CPT® guidelines for the administration of chemotherapy will help to avoid incorrect billing, Witt says. Medicare has published their rules in the Claims Processing Manual (100-04, Chapter 12, Section 30.5). You should also consult local carrier as to which drugs may be considered to be chemotherapy drugs under Medicare and how to correctly report the units for these drugs.