Part B Insider (Multispecialty) Coding Alert

Physician Notes: Watch Your ASP Coding

The feds are watching place-of-service codes

Physician Practice that perform ambulatory surgical procedures in their offices should make sure their coders know the ropes when it comes to place-of-service codes.

The HHS Office of Inspector General is worried that physician practices are collecting more Medicare reimbursement than they deserve due to place-of-service coding errors, particularly in New England. In a recent audit report titled "Review of Payments Made by National Heritage Insurance Company for Ambulatory Surgical Procedures for Calendar Year 2001" (A-01-02-00524), the OIG points out that Medicare makes higher payments for ASPs performed in non-facility settings (e.g., in the physician's office) than it does for those performed in facility settings such as hospitals or freestanding ambulatory surgical centers. The extra money is designed to compensate doctors for the extra costs they incur by doing the procedures in their offices.

However, the OIG contends that many practices are overbilling for ASPs because physician-billing personnel didn't establish "adequate controls to prevent the incorrect billing of the place-of-service code for ASPs." Those practices are now likely to face overpayment demands, since the OIG urged NHIC to pursue any excessive reimbursement claimed for ASPs.

To see the report, go online to http://oig.hhs.gov/oas/reports/region1/10200524.pdf.

1. Billings for magnetic resonance imaging and electromyography tests have landed a Stuart, Fla., osteopath in hot water with federal enforcers of antifraud laws.

   A grand jury Oct. 10 filed a 25-count indictment against Dr. Paul Elliott, charging him with submitting hundreds of fraudulent claims to Medicare and Blue Cross of Florida between 1998 and 2002. Elliott is the president and co-owner of Doctor's Care Medical Center Inc., through which he operated six clinics in south Florida. The indictment alleges that Elliott billed for MRIs with an injection of contrast mediums when he actually only provided a lower-paying nonintrusive MRI.

   In addition, prosecutors maintain that Elliott billed for EMGs when all he provided were nerve conduction velocity tests. He allegedly collected more than $320,000 by submitting the improper claims. The indictment also says Elliott altered patient records to keep U.S. Secret Service agents who were investigating the case off the scent.

2. New Bedford, Mass., physician Rahim Aghai will repay $40,000 to Medicaid to resolve claims that he failed to properly document the services he billed for.

   Prosecutors say an investigation found instances in which Aghai's progress notes failed to justify the level of office visit he had billed for. Aghai did not admit to any of the allegations brought by prosecutors.