

Eli's Rehab Report

3 OIG Hot Spots and How to Steer Clear of Them

Want to avoid OIG scrutiny in 2004? Shore up modifiers, E/Ms

Do you append modifier -59 every time those pesky NCCI edits bundle your services into one another? After the release of the OIG's new Work Plan, you'd better make sure that your services are indeed separately identifiable - and that you've got the documentation to prove it.

The U.S. Office of Inspector General (OIG) recently released its 2004 Work Plan, and as in prior years, the OIG intends to scrutinize consultations, high-level E/M claims, use of modifiers -25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) and -59, incident-to services, certificates of medical necessity, medical necessity of durable medical equipment (DME), and care plan oversight, among other services.

Although the Work Plan includes 90 pages of the OIG's 2004 intentions, PM&R practices are particularly at risk in the following three areas:

1. Distinguish Consults From Transfers of Care.

Medicare paid \$2 billion in 2000 for consultations, and now the OIG wants to determine whether practices are reporting these codes (99241-99263) appropriately.

The most common consult billing error in PM&R practices involves whether patients are transferred (also called "referred") to your practice by a physician who expects you to assume the patient's care (which would warrant a standard E/M code, [CPT 99201 - 99215](#)), or whether the requesting physician simply requests your opinion on the patient's condition, which often warrants an office consultation code (99241-99245).

A consultation requires that the requesting physician ask for your physiatrist's opinion, and that your practice write a report back to the requesting physician explaining your interpretation of the patient's condition and your recommendations for care, says **Heidi Stout, CPC, CCS-P**, coding and reimbursement manager at University Orthopaedic Associates in New Brunswick, N.J.

Section 15506 B of the Medicare Carriers Manual defines a transfer of care: "When the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit ..."

2. Use Modifier -59 With Caution.

The new Work Plan may cause trouble for those practices that submit many claims with modifier -59 (Distinct procedural service). The OIG intends to "determine whether claims were paid appropriately when modifiers were used to bypass National Correct Coding Initiative (NCCI) edits," according to the report. Although several modifiers -including -78 (Return to the operating room for a related procedure during the postoperative period) and -79 (Unrelated procedure or service by the same physician during the postoperative period) - can separate services bundled by the NCCI edits, PM&R practices usually use modifier -59.

"Physicians should be aware that when they append modifier -59, they are representing the fact that they have documentation on file that supports using it," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center. "Therefore, you should always be prepared to submit additional documentation that demonstrates that your procedures were separate and distinct from

one another." If your documentation won't prove the separate nature of the bundled services, don't append modifier -59, Jandroep says.

3. Enter Your Inpatient Rehab Assessments on Time.

The OIG plans to watch whether inpatient rehab stays in specialty hospitals and units were medically necessary, and will "determine the accuracy of Medicare payments for inpatient rehabilitation stays when patient assessments are entered late."

According to the Work Plan, "Under the Inpatient Rehabilitation Facility Prospective Payment System, admission and discharge assessments must be entered and transmitted within defined time limits or payment is reduced. We will determine how fiscal intermediaries make these adjustments."

So how long do you have to send in your assessment? According to Medicare Transmittal A-01-31, "Medicare patient assessment data must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the patient's discharge ... if the actual transmission date is later than 10 calendar days from the mandated transmission date, the patient assessment data is considered late," and Medicare imposes a 25 percent penalty on the expected benefit.

You should confirm the 17-day time limit with your carrier to ensure that it doesn't require the assessments based on a different time period.

CORFs and HHAs, Watch Your Therapy Codes

If you report therapy codes, you should always ensure that you assign the appropriate therapy codes to your claims, because the OIG is watching.

Of interest to therapists, CMS will also determine "whether home health agencies' therapy services met the therapy threshold for higher payments in compliance with Medicare regulations." The OIG intends to analyze the number of therapy visits provided per episode period, and the duration of such therapy visits.

The Work Plan also indicates that the OIG "will determine whether comprehensive outpatient rehabilitation facilities (CORFs) provided and billed physical therapy, speech language pathology, and occupational therapy services in accordance with Medicare eligibility and reimbursement requirements ... Prior OIG reviews found that Medicare paid significant amounts for unallowable or highly questionable therapy services in outpatient rehabilitation facilities and nursing homes."

The OIG Work Plan includes information about all of its investigative focus areas for 2004. You can access the full 90-page document by visiting the OIG's Web Site at www.oig.hhs.gov/publications/workplan.html.