2013 OIG Workplan: You're Doing it Wrong

The **2013 Work Plan for the OIG** has been released and here are some of the top items that relate to medical practices. This is a great list to use for review and discussion – ***Is your medical practice doing this correctly?***

Incident-To Services Performed by Nonphysicians

Reasons why practices are not billing these services correctly:

- Lack of understanding of incident-to
- Trying to avoid the 15% reduction in reimbursement for services provided by credentialed nonphysicians
- Difficulty in documenting who provided the services for

charge entry

The OIG Workplan says: We will review physician billing for "incident-to" services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess Medicare's ability to monitor services billed as "incident-to." Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians' billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform. Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality. Medicare's Part B coverage of services and supplies that are performed incident to the professional services of a physician is in the Social Security Act, § 1861(s)(2)(A). Medicare requires providers to furnish such information as may be necessary to determine the amounts due to receive payment. (Social Security Act, § 1833(e).) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

Place-of-Service (POS) Coding Errors

Reasons why practices are not billing these services correctly:

- Confusion over place of service when the practice is owned by a hospital
- Confusion over place of service when the technical and

professional components of a service are performed in two different places (NOTE: this will be somewhat rectified in April 2013 when new POS rules for Medicare will be in effect)
- Confusion over place of service when a nursing facility has several different places of services within one facility
- Providing services (or saying you are) wherever the reimbursement rate is highest

The OIG Workplan says: We will review physicians' coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ambulatory surgical center. (OAS; W-00-11-35113; various reviews; expected issue date: FY 2013; work in progress)

Evaluation and Management Services – Potentially Inappropriate Payments in 2010

Reasons why practices are not billing these services correctly:

- Confusion by physicians and other providers on how to document properly and how to choose a code based on what has been documented
- Over-reliance on EMR templating and macros to paste the same or very similar verbiage into the medical records

of all or most patients seen by the same provider

The OIG Workplan says: We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported. (CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1.) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress)

Evaluation and Management Services – Use of Modifiers During the Global Surgery Period

Reasons why practices are not billing these services correctly:

- Confusion over the length of the global period
- Confusion over what services are included in the global package and what services can be legitimately charged with a modifier as distinct from the global package

The OIG Workplan says: We will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during such a period were in accordance with Medicare requirements. Prior OIG work found that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative

and postoperative E/M services provided during the global surgery period. (CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 40.1.) Guidance for the use of modifiers for global surgeries is in CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 30. (OAS; W-00-13-35607; various reviews; expected issue date: FY 2013;
new start)

Non-Hospital-Owned Physician Practices Using Provider-Based Status (New)

Reasons why practices are not billing these services correctly:

- Confusion over split billing – billing separately for the professional fee and the facility fee
- Confusion over the term "provider-based status"

The OIG Workplan says: We will determine the impact of non-hospital-owned physician practices billing Medicare as provider-based physician practices. We will also determine the extent to which practices using the provider-based status met CMS billing requirements. Provider-based status allows a subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries' coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; 04-12-00381; expected issue date: FY 2013; work in progress)