Medicare This Week: Private E/M Billing Reports, Two Free Calls on eRx and 5010, Revised Medicare Conditions of Participation

- CMS to Start Accepting Suggestions for PQRS Measures and Measure Groups (jump to story)

- New Rules Finalized by Health and Human Services to Cut Regulations for Hospitals and Health Care Providers (jump to story)

- Denise Buenning from CMS Answers the Industry's Top Questions about the Version 5010 Upgrade (jump to story)

- Last Chance to Register for National Provider Call – Physician Quality Reporting System & Electronic Prescribing (eRx) (jump to story)

- CMS to Release a Comparative Billing Report on Evaluation and Management Services (jump to story)

- **New and Revised Articles Posted to MLN Matters (jump to story)**
- **Updates from the Medicare Learning Network (jump to story)**
- **May is Hepatitis Awareness Month and May 19 is National Hepatitis Testing Day (jump to story)**

CMS to Start Accepting Suggestions For PQRS Measures and Measure Groups

From June 1st, 2012 to 5PM ET on August 1st, 2012, CMS will be accepting suggestions for Measures and/or Measure Groups in the Physicians Quality Reporting System. This is your chance to make your voice heard on the quality measures that will determine performance!

For more information on the PQRS Call for Measures, visit the CMS page here.

(Back to Top)

New Rules Finalized by Health and

Human Services to Cut Regulations for Hospitals and Health Care Provider

HHS Finalizes New Rules to Cut Regulations for Hospitals and Health Care Providers, Savings More Than $5 Billion

Changes Will Reduce Costs and Allow More Focus on Medical Care

On May 9, HHS Secretary Kathleen Sebelius announced significant steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and health care providers. These steps will help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and save nearly $1.1 billion across the health care system in the first year and more than $5 billion over five years.

The new rules were issued on May 9 by CMS. The first rule revises the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). CMS estimates that annual savings to hospitals and CAHs will be approximately $940 million per year.

The second, the Medicare Regulatory Reform rule, will produce savings of $200 million in the first year by promoting efficiency. This rule eliminates duplicative, overlapping, and outdated regulatory requirements for health care providers.

Among other changes, the final rules will:

- Increase flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system;
- Let CAHs partner with other providers so they can be more efficient and ensure the safe and timely delivery of care to their patients;

- Require that all eligible candidates, including advanced practice registered nurses and physician assistants, be reviewed by medical staff for potential appointment to the hospital medical staff and then be granted all of the privileges, rights, and responsibilities accorded to appointed medical staff members; and
- Eliminate obsolete regulations, including outmoded infection control instructions for ambulatory surgical centers; outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of organ procurement organizations.

View the Medicare CoPs final rule and the Medicare Regulatory Reform final rule. For additional information on the Hospital and other CoPs, visit the Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) website.

Full text of this excerpted CMS press release (issued May 9).

(Back to Top)

Denise Buenning from CMS Answers the Industry's Top Questions about the Version 5010 Upgrade

Upgrading to Version 5010 involves significant planning and preparation. The Version 5010/4010A electronic standards upgrade deadline was January 1, 2012. However, CMS enacted an enforcement discretion period through June 30, 2012 for all HIPAA-covered entities. It you haven't upgraded to Version 5010, it is important to begin testing now.

Denise Buenning, MsM, Acting Deputy Director, Office of E-

health Standards & Services (OESS) recently took time to answer some of the industry's top questions on the Version 5010 upgrade.

Is the industry up to date with the Version 5010 upgrade and taking steps to prepare for the ICD-10 transition?

Yes, we are hearing that the industry is progressing with Version 5010 implementation. We also continue to see from the Medicare Fee-For-service (FFS) group consistent increases across the board for 5010 transaction volumes and number of 5010 submitters. We are also hearing that the industry is continuing to take steps to prepare for ICD-10. ICD-10 is a major undertaking for providers, payers, and vendors. It will drive business and systems changes throughout the health care industry, from large national health plans to smaller provider offices, laboratories, hospitals, and more. The updates will go much more smoothly for organizations that plan ahead and prepare now. A successful upgrade to Version 5010 now and transition to ICD-10 later will be vital to transforming our nation's health care system.

What steps should I take if I am behind in the upgrade to Version 5010?

There are a number of things that HIPAA-covered entities should do now. Communication among plans, providers, clearinghouses, and vendors, as well as other trading partners, is critical. Below outlines three steps providers can take now:

- Reach out to clearinghouses for assistance and/or take advantage of any free or low cost software that may be available from payers.
- Check with payers now to see what plans they will have in place to handle incoming claims, and what

interim alternatives are available.

- Consider contacting financial institutions to establish lines of credit to get through any possible temporary interruptions in claims reimbursement as a result of not being Version 5010 compliant.
- CMS has developed a fact sheet for health care providers, which discusses the risk mitigation steps in more detail.

How is CMS helping the industry prepare?

o The Workgroup for Electronic Data Interchange (WEDI) and CMS are holding a webinar on ASCX12 5010 implementation and problem solving on May 23 from 1-2:30pm ET. Registration is free. These online presentations are designed to gather feedback, track challenges and provide guidance to correcting ASC X12 5010 implementation-related issues.

o WEDI and CMS previously held a webinar on ASCX12 5010 implementation, and a replay of the webinar with the slides presented is located online.

o Additionally, the CMS website has official resources to help the industry prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition. Sign up for ICD-10 Email Updates and follow @CMSgov on Twitter for the latest news and resources.

(Back to Top)

Last Chance to Register for National Provider Call – Physician Quality Reporting System & Electronic Prescribing (eRx)

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the 2013 Electronic Prescribing Payment Adjustment and an overview of the 2012 Physician Quality Reporting System Medicare EHR Incentive Pilot.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls webpage. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Providers and suppliers can now submit their enrollment applications 30 days sooner. CMS-855 enrollment applications and Internet-based PECOS applications may now be submitted 60 days prior to the effective date.

NOTE: This does not apply to providers and suppliers submitting a Form CMS-855A application, Ambulatory Surgical Centers (ASCs), or Portable X-ray Suppliers (PXRSs).

(Back to Top)

CMS to Release a Comparative Billing Report on Evaluation and Management Services

On June 4, CMS will release a national provider Comparative Billing Report (CBR) addressing Evaluation and Management Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in the state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Evaluation and Management Services CBR, please visit the CBR Services website or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

(Back to Top)

New and Revised Articles Posted to MLN Matters

Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN) http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1216.pdf

Negative Pressure Wound Therapy Interpretive Guidelines

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1222.pdf

Assigned Codes for Home Oxygen Use for Cluster Headache (CH) in a Clinical Trial (ICD-10)

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7820.pdf

July 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.2

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7841.pdf

July Quarterly Update for 2012 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7822.pdf

Calendar Year 2013 and After Payments to Home Health Agencies That Do Not Submit Required Quality Data

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7833.pdf

Revised: Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7499.pdfs

(Back to Top)

Updates from the Medicare Learning Network

From the MLN: New Fast Fact and Archive on MLN Provider Compliance Webpage – A new fast fact is now available on the MLN Provider Compliance webpage. This webpage provides the latest Medicare Learning Network® (MLN) products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. You can now view previous fast facts on the MLN Provider Compliance Fast Fact Archive page. Please bookmark this page and check back often as a new fast fact is added each month.

From the MLN: "Negative Pressure Wound Therapy Interpretive Guidelines" MLN Matters® Article Released – MLN Matters® Special Edition Article #SE1222, "Negative Pressure Wound Therapy Interpretive Guidelines" has been released and is now available in downloadable format. This article is designed to provide education on CMS-approved guidelines that accrediting organizations can use to accredit suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. It includes a list of relevant local coverage determinations and standards to help DMEPOS suppliers comply with standards and guidelines for NPWT equipment.

From the MLN: "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" Booklet Revised – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards Booklet (ICN 905700)

has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes DMEPOS quality standards as well as information on Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers.

From the MLN: "Quick Reference Information: Preventive Services" and "Quick Reference Information: Medicare Immunization Billing" Revised – The MLN has revised the recently updated Quick Reference Information: Preventive Services (ICN 006559) and Quick Reference Information: Medicare Immunization Billing (ICN 006799) educational tools. We have updated these charts to include the recently released flu code Q2034. All other information remains the same.

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Web-Based Training – New – This Web-Based Training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the MLN Products webpage and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.

(Back to Top)

May is Hepatitis Awareness Month

and May 19 is National Hepatitis Testing Day

The month of May has been designated Hepatitis Awareness Month and May 19 is the first ever National Hepatitis Testing Day. Every year, approximately 15,000 Americans die from liver cancer or chronic liver disease associated with viral hepatitis. Despite this, viral hepatitis is not well known. In fact, as many as 75 percent of the millions of Americans with chronic viral hepatitis don't know they're infected. Please join CMS in support of the Centers for Disease Control and Prevention's "Know More Hepatitis" national education initiative aimed to decrease the burden of chronic viral hepatitis by increasing awareness about this hidden epidemic and encouraging people who may be chronically infected to get tested.

Medicare provides coverage of the hepatitis B vaccine and its administration for certain individuals at high or intermediate risk.

Increased provider knowledge has been shown to improve delivery of preventive services, including those for viral hepatitis. By educating yourself on this hidden epidemic, you can help save lives and decrease this epidemic's burden. As a healthcare provider for people with Medicare, discuss with eligible patients who may be at high or intermediate risk, whether the hepatitis B vaccine is appropriate.

(Back to Top)

Your Guide to the 2012 OIG Work Plan: Does Anything on This List Worry You?

Here are some highlights from the new OIG Work Plan for FY 2012. There are more items that apply to practices, as well as items for hospitals, nursing facilities, home health, and medical equipment and supplies. The link to the complete plan is at the end of the article.

Compliance With Assignment Rules

If you accept assignment with Medicare (i.e. you accept what Medicare allows as payment for a service), the OIG wants to know if you are adhering to the allowable and not collecting more than the patient's deductible and co-insurance.

Physicians-Owned Distributors of Spinal Implants (New)

Do physician-owned distributors (PODs) of spinal implants have a conflict of interest when they sell implants to hospitals? The OIG will investigate.

Place-of-Service Errors

Because there is a payment differential between a service provided in a hospital outpatient department or ASC and the same service provided in the physician's office, the OIG wants to know if you provided the service where you claimed you did.

Physicians: Incident-To-Services (New)

Incident-to services are reported on the honor system – the claim does not reflect that a mid-level provider performed the service under the supervision of a physician. The OIG will dig under the claims to see if practices really understand and follow the incident-to rules.

Physicians: Impact of Opting Out of Medicare (New)

The OIG will be checking that physicians who opted out of Medicare are not filing claims for services, and also monitor disruption of service to Medicare patients due to opt-outs.

Evaluation and Management Services: Trends in Coding of Claims

If you provided E/M services in 2009, you received part of the $32 billion paid out as 19% of all part B payments. Did you pick a code and hope your documentation was up to the task, or did you review your documentation and choose the code that reflected what was there?

Evaluation and Management Services: Provided During Global Surgery Periods

Are physicians correctly ascertaining which services are part of the global surgery period or are they mistakenly charging for services that are wrapped into the procedure or surgery? The OIG knows.

Evaluation and Management Services: Use of Modifiers During the Global Surgery Periods (New)

Check those modifiers used during the global period. This item refers to services provided during the global period that were unrelated to the original service and thereby billable.

Evaluation and Management Services: Potentially Inappropriate Payments

This is the review we've all been talking about. The OIG will be inspecting electronic records to see if identical documentation appears serialized in the records.

The original work plan can be found **here.**

---

10 Ways for Physician Practices to Comply With the 2011 OIG Work Plan

Image by rileyroxx via Flickr

The Office of the Inspector General just unveiled their 2011 Work Plan in a remarkably readable and succinct 159 pages. The Work Plan reveals their review targets for the coming year. The entire plan is **here,** but I've excerpted the parts that I thought would be of most interest to MMP readers. Skip to the bottom to get to my top ten pointers for physician practices for 2011.

Medicare Secondary Payer/Other Insurance Coverage

We will review Medicare payments for beneficiaries who have other insurance. Pursuant to The Social Security Act, § 1862(b), Medicare payments for such beneficiaries are required to be secondary to certain types of insurance coverage. We will assess the effectiveness of procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage. For example, we will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amounts.

(OAS; W"00"11"35317; various reviews; expected issue date: FY 2011; new start)

Medicare Brachytherapy Reimbursement

We will review payments for brachytherapy, a form of radiotherapy where a radiation source is placed inside or next to the area requiring treatment, to determine whether the payments are in compliance with Medicare requirements. Pursuant to the Social Security Act, § 1833 (t)(16)(C), as amended by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 142, Medicare pays for

radioactive source devices used in treatment of certain forms of cancer.

(OAS; W”□00”□10”□35520; W”□00”□11”□35520; various reviews; expected issue date: FY 2011; work in progress)

Place”□of”□Service Errors

We will review physician coding of place of service on Medicare Part B claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments. Federal regulations at 42 CFR § 414.32 provide for different levels of payments to physicians depending on where the services are performed. 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 ASC. We will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.

(OAS; W”□00”□09”□35113; W”□00”□10”□35113; various reviews; expected issue date: FY 2011; work in progress)

Coding of Evaluation and Management Services

We will review evaluation and management (E&M) claims to identify trends in the coding of E&M services. Medicare paid $25 billion for E&M services in 2009, representing 19 percent of all Medicare Part B payments. Pursuant to CMS’s Medicare Claims Processing Manual, Pub. No. 100”□04, ch. 12, § 30.6.1, providers are responsible for ensuring that the codes they submit accurately reflect the services they provide. E&M codes represent the type, setting, and complexity of services

provided and the patient status, such as new or established. We will review E&M claims to determine whether coding patterns vary by provider characteristics.
(OEI; 04”□10”□00180; expected issue date: FY 2011; work in progress)

▪ Payments for Evaluation and Management Services

We will review the extent of potentially inappropriate payments for E&M services and the consistency of E&M medical review determinations. CMS’s Medicare Claims Processing Manual, Pub. No. 100”□04, ch. 12, § 30.6.1 instructs providers to “select the code for the service based upon the content of the service”□ and says that “documentation should support the level of service reported.”□ Medicare contractors have noted an increased frequency of medical records with identical documentation across services. 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.

(OEI; 04”□10”□00181; 04”□10”□00182; expected issue date: FY 2012; work in progress)

▪ Evaluation and Management Services During Global Surgery Periods

We will review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee. CMS’s Medicare Claims Processing Manual, Pub. No. 100”□04, ch. 12, § 40, contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E&M services provided during the global surgery period. We

will determine whether industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992.

(OAS; W”00”09”35207; various reviews; expected issue date: FY 2011; work in progress)

Medicare Payments for Part B Imaging Services

We will review Medicare payments for Part B imaging services. 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 expense. The Social Security Act, § 1848(c)(1)(B), defines “practice expense” as the portion of the resources used in furnishing the service that reflects the general categories of expenses, such as office rent, wages of personnel, and equipment. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. We will determine whether Medicare payments reflect the expenses incurred and whether the utilization rates reflect industry practices.

(OAS; W”00”11”35219; various reviews; expected issue date: FY 2011; new start)

Appropriateness of Medicare Payments for Polysomnography

We will review the appropriateness of Medicare payments for sleep studies. Sleep studies are reimbursable for patients who have symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia in accordance with the CMS Medicare Benefit Policy Manual, Pub. No. 102, ch. 15, § 70. Medicare

payments for polysomnography increased from $62 million in 2001 to $235 million in 2009, and coverage was also recently expanded. We will also examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements.

(OEI; 00”□00”□00000; expected issue date: FY 2012; new start)

▪ Medicare Payments for Sleep Testing

We will review the appropriateness of Medicare payments for sleep test procedures provided at sleep disorder clinics. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.”□ CMS’s Medicare Benefit Policy Manual, Pub. No. 100”□02, ch. 15, § 70, provides CMS’s requirements for coverage of sleep tests under Part B. A preliminary OIG review identified improper payments when certain modifiers are not reported with sleep test procedures. We will examine Medicare payments to physicians and independent diagnostic testing facilities for sleep test procedures to determine whether they were in accordance with Medicare requirements.

(OAS; W”□00”□10”□35521; W”□00”□11”□35521; various reviews; expected issue date: FY 2011; work in progress)

▪ Excessive Payments for Diagnostic Tests

We will review Medicare payments for high”□cost diagnostic tests to determine whether they were medically necessary. The Social Security Act, § 1862 (a)(1)(A), provides that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or

injury or to improve the functioning of a malformed body member.” We will determine the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment.

(OAS; W”00”11”35454; various reviews; expected issue date: FY 2011; new start)

Medicare Part B Payments for Glycated Hemoglobin A1C Tests

We will review Medicare contractors’ procedures for screening the frequency of clinical laboratory claims for glycated hemoglobin A1C tests. CMS’s Medicare National Coverage Determinations Manual, Pub. 100”03, Ch. 1, pt. 3, § 190.21, states that it is not considered reasonable and necessary to perform a glycated hemoglobin test more often than every 3 months on a controlled diabetic patient unless documentation supports the medical necessity of testing in excess of national coverage determinations guidelines. Preliminary OIG work at two Medicare contractors showed variations in the contractors’ procedures for screening the frequency of glycated hemoglobin A1C tests. We will determine the appropriateness of Medicare payments for glycated hemoglobin A1C tests.

(OAS; W”00”11”35455; various reviews; expected issue date: FY 2011; new start)

Independent Diagnostic Testing Facilities’ Compliance With Medicare Standards

We will review selected IDTFs enrolled in Medicare to determine the extent to which they comply with selected Medicare standards. IDTFs received payments of about $860

million in 2009. Federal regulations at 42 CFR § 410.33, require IDTFs to certify on their enrollment applications that they comply with 17 standards. Such standards include requirements that IDTFs comply with all of the Federal and State licensure and regulatory requirements that are applicable to the health and safety of patients, provide complete and accurate information on their enrollment applications, and have on duty technical staff members who hold appropriate credentials to perform tests. We will also identify billing patterns associated with IDTFs that were not compliant with selected Medicare standards.

(OEI; 05”09”00560; expected issue date: FY 2011; work in progress)

Image by ciotka via Flickr

Medicare Providers’ Compliance With Assignment Rules

We will review the extent to which providers comply with assignment rules and determine whether and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare requirements. Pursuant to the Social Security Act, § 1842(h)(1), physicians participating in Medicare agree to accept payment on an “assignment” for all items and services furnished to individuals enrolled in Medicare. 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 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. We will also assess beneficiaries’ awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines.

(OEI; 00”00”00000; expected issue date: FY 2012; new start)

Medicare Payments for Claims Deemed Not Reasonable and Necessary

We will review Medicare payments for Part B claims in 2009 that providers note as not reasonable and necessary on claim submissions. The CMS Claims Processing Manual states that providers may use GA or GZ modifiers on claims they expect Medicare to deny as not reasonable and necessary. A recent OIG study found that Medicare paid for 72 percent of pressure”reducing support surface claims with GA or GZ modifiers, amounting to $4 million in potentially inappropriate payments. We will determine the extent to which Medicare paid for Part B claims with these modifiers, as well as the types of providers and the types of services associated with these claims. We will also assess the policies and practices that Medicare contractors have in place with regard to these claims.

(OEI; 02”10”00160; expected issue date: FY 2011; work in progress)

Medicare Billings With Modifier GY

We will review the appropriateness of providers’ use of modifier GY on claims for services that are not covered by Medicare. CMS’s Medicare Carriers Manual, Pub. No. 14”3, pt.

3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS's Medicare Claims Processing Manual, Pub. No. 100”04, ch. 1, § 60.1.1, providers are not required to give beneficiaries advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills for which they are responsible. In FY 2008, Medicare received over 75.1 million claims with a modifier GY totaling approximately $820 million. We will examine patterns and trends for physicians' and suppliers' use of modifier GY.

(OEI; 00”00”00000; expected issue date: FY 2012; new start)

To Re-Cap, here's YOUR Work Plan for 2011:

1. If you're not using the **MSP questionnaire** in your practice for Medicare patients, start. Here's a **fact sheet** (pdf) to get up to speed.
2. If your practice provides brachytherapy, ensure that you are following the **MIPPA guidelines** for diagnoses.
3. Check your **place of service codes** and make sure they are absolutely correct on all counts.
4. Don't wait for Medicare to audit your documentation, **audit it yourself** or hire a professional to audit for you. Make sure the coding is correct for what was documented. If you are using an EMR, beware of **over-dependence on templates!** If your practice performs surgery, track that global period like a hawk and make sure you understand when you may or may not bill an E & M code during the global period.
5. Sleep studies – if you do them, make sure the **diagnosis and medical necessity** support them.
6. Does your practice provide imaging services? Are your utilization rates above the national average for your

specialty? Was the service medically necessary? It's a good time to find out. Oh, and don't forget to **disclose any financial interest** your practice has in any imaging center and to **provide the patient options** for other centers.

7. Hemoglobin A1c – first we weren't doing enough, now we're doing too many! Medicare will pay for a hemoglobin A1c every three months for diabetic patients. Make sure to have an electronic or manual system in place for tracking this. Most practices use a **diabetic flow sheet** in a paper chart – start using one if you aren't now.
8. Do you have an IDTF? Do you comply with the **17 standards you certified upon enrollment?**
9. Are you "par" (participating) or "non-par" (non-participating) with Medicare? Are you collecting the appropriate amount from Medicare patients?
10. My favorite – the ABN – Advanced Beneficiary Notice. Are you using the ABN correctly and advising Medicare patients of their rights? Or are you just telling them to "Sign here, please"? Here's an **article** about ABNs published on MMP.

Will you be called to task in 2011 for the above 10 items?

There is tremendous pressure on Medicare and other government-sponsored payers to weed out fraud and eliminate waste. It is the responsibility of the professional administrator to protect the practice from risk, as well as guide the office in all things legal and ethical. You may be the only one in your practice who understands the liability that non-compliance can expose the practice to – make sure your practice does it right!