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

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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)

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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!

The ABN: The Most Misunderstood and Underutilized Document in Healthcare

There's a new ABN form required to be in use in January 2012 – read about it **here in my article "Everybody's Favorite Form: New Advance Beneficiary Notice of Noncoverage (ABN) Form Begins in 2012"**

Note from Mary Pat: The Advance Beneficiary Notice of Noncoverage (ABN) is a collection tool that many medical practices do not know how to implement. It is particularly difficult to determine who has ownership of this process, because the form must be completed and signed by the patient before the service is provided. The patient is in the exam room or the lab, ready for the service or test, and a knowledgeable staff person must step in, explain the rules and pricing and obtain the patient's signature.

*Blogger Charlene Burgett does a great job of explaining the ins and outs of using the ABN, and has agreed to share an article originally published on her blog **"Conundrum"** with MMP*

readers.

The use of the ABN is required by Medicare to alert patients when a service will not be paid by **Medicare** and to allow the patient to choose to pay for the service or to refuse the service.

If the practice does not have a signed ABN from the patient and Medicare denies the service, the charge must be written off and the patient cannot be billed for it. The only exception is for statutorily excluded services (those that Medicare never covers like cosmetic surgery and complete physicals for example). In this case, a practice can bill the patient for the non-covered service despite not having an ABN. It is, however, a good idea to have the ABN signed for non-covered services so the patient is made aware that they are responsible.

If the patient signs the ABN and is made aware of their financial responsibility **you may require the patient to pay for this service on the date the service is provided.** You may also charge the patient 100 percent of your fee. You do not have to reduce your charge to the Medicare allowable.

With a signed ABN, the practice has proof of the patient's informed consent to provide the service and their agreement to be financially responsible for the service. In the past, Medicare had a "Notice of Exclusion of Medicare Benefits" (NEMB) that we could provide to the patient (no signature required) to alert them of Medicare's non-covered services. The ABN has replaced the NEMB.

The typical reasons that Medicare will not cover certain services and that would be applicable are:

1. **Statutorily Excluded service/procedure (non-covered service)**

2. **Frequency Limitations**
3. **Not Medically Necessary**

Statutorily Excluded items are services that Medicare will never cover, such as (not a complete list):

- Complete physicals (excluding Welcome to Medicare Screenings, with caveats)
- Most immunizations (Hepatitis A, Td)
- Personal comfort items
- Cosmetic surgery

For these items, it is a good idea (not a requirement) to complete the ABN and have the patient check the appropriate box under options and sign the ABN. For the sake of the billing department, I strongly encourage the use of ABN's for statutorily excluded items.

Frequency Limitations are for services that have a specific time frame between services. For example, Medicare allows one pap smear every 24 months if the pap is normal. If the patient wants one every 12 months for their peace of mind, Medicare will pay for year one and the patient will pay for year two and that pattern continues. The ABN needs to be on file for the year that the patient is responsible for paying. If the patient fits Medicare's guidelines for "high risk" they are allowed to have the pap every 12 months and no ABN is required.

Services that are not considered **Medically Necessary** are those that do not have a covered diagnosis code based on Local Coverage Determinations (LCD). One example is for excision of a lesion. If the lesion is being removed because the patient just doesn't like how it looks, that is considered cosmetic surgery. If the lesion is showing some changes (i.e. bleeding, growing, changing color, etc), then it is considered medically necessary because it potentially can be malignant. The removal needs to have diagnosis coding to substantiate the medical

necessity and Medicare has Local Coverage Determinations that list all the codes/coding combinations that Medicare will approve for payment.

A rule of thumb in trying to discern the necessity of ABNs is to ask yourself if there may be some times that the service isn't covered by Medicare. The times the service isn't covered, an ABN is required. To illustrate this point, here are two examples:

- *EKGs are covered for certain cardiac and respiratory conditions. The only time an EKG is covered for preventive screening is during the patient's first year enrolled in the Medicare program and when being done during the Welcome to Medicare screening. After that time, Medicare will never cover an EKG for preventive screening. To notify the patient of this and to show that the patient agrees to be financially responsible for the EKG, an ABN should be completed.*

- *Another example is for the Tetanus immunization. Medicare will cover tetanus when medically necessary; if the patient has cut themselves and the tetanus is provided due to that injury. If the tetanus is provided to the patient because it has been ten years since the last tetanus and the tetanus is not in response to a recent injury, then it will be non-covered because it is not "medically necessary"□ and the ABN will need to be on file.*

ABNs need to be completed in their entirety. The "Options"□ box can only be completed by the patient and it states that "We cannot choose a box for you"□. That would appear to be coercion.

A “blanket” ABN, one that is signed by the patient for all services provided within a certain time period, is not acceptable and is illegal.

In addition, there is a small area to provide additional information that can be used by either the patient or the provider’s office. This could be anything pertinent to the information that the ABN covers. The bottom of the form is where the patient signs and dates. We keep the original ABN in the chart behind the progress note for that day. Providers **MUST** provide a copy of the signed ABN to the patient.

The current ABN form with instructions can be found **here.**

If a service is denied by Medicare and the physician does not have a signed ABN prior to the service being rendered, the service can not be billed to the patient and will need to be written off. Sometimes a patient may refuse to sign the ABN – if this happens it is appropriate for the physician to document the refusal and sign, along with having a witness sign. Medicare will accept this and the patient can be billed for the service if denied by Medicare.

How does Medicare know whether or not you have a signed ABN? You tell them, by adding a modifier to the CPT code when completing the claim form. The appropriate modifiers are:

GA: The ABN is signed, but the service may not be covered.

GY: A “statutorily excluded” service.

GZ: The service is expected to be denied as not reasonable or necessary. This is typically used when there is a secondary payer that requires the Medicare denial before they pay benefits.

The use of the ABN is often misunderstood; however, it is the only way a patient can be informed about their financial responsibility prior to agreeing to a service being rendered. This is an issue that the OIG has reportedly been interested in investigating for fraud and abuse.

Charlene Burgett, MA-HCM

Note: Readers, how do you make the ABN work in your practice? Do you train the clinical staff, the physicians, or other staff to recognize the "ABN Moment"? How do you make it work? Please share your ideas by responding with a comment.