SAVVY CODER

Under Investigation: 7 Activities That the OIG Will Review in 2010

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he Office of Inspector General has announced the activities that it will be scrutinizing this year for fraud and abuse. As an Eye M.D., you should be aware of the seven areas of investigation below, four or which are new areas of inquiry. Three are repeat areas of concern.

Four New Areas Targeted

Medicare incentive payments for e-prescribing. The OIG will review incentive payments made to eligible health care professionals for their 2009 e-prescribing activities to assess if payments were made in error.

Providers' compliance with assign**ment rules.** Physicians who participate in Medicare agree to accept assignment for all items and services. The OIG will investigate physicians' compliance with assignment rules and determine whether—and to what extent—beneficiaries are improperly billed in excess of amounts allowed by Medicare. Take, for example, CPT code 99213 office or other outpatient visit. If the physician's charge is \$80 and Medicare's approved amount is \$58.83, the physician will write off \$21.17. Medicare will pay 80 percent of the allowable (\$47.06). The patient's supplemental insurance or the patient will be responsible for the balance (\$11.77). The OIG also will assess beneficiaries' awareness of their rights and responsibilities regarding potential

billing violations and Medicare coverage guidelines.

Billing with dates of service after beneficiaries' dates of death. The OIG will be reviewing such claims to assess whether the CMS has adequate controls in place either to preclude or else to identify and then recover improper payments.

Comprehensive error rate testing (CERT) program. CERT is an independent medical review organization that audits physician records in order to audit Medicare. You may be interested to know that this year, CERT is getting audited. The OIG will review aspects of the methodology that CERT used when it determined 2008 error rates.

Still Under Investigation

Place-of-service errors. For the third year, the OIG will continue to review physician coding for services that were performed in an ambulatory surgical center or hospital outpatient department but were submitted for payment at the higher, nonfacility rate. For example, CPT code 67961 *Excision and repair of eyelid* has a physician allowable of \$489 when performed in the office vs. \$389 when performed in an ASC or HOPD.

E&M services during global surgery periods. For the fourth year, the OIG will continue to investigate claims submitted with modifier –24, which is used to indicate that an exam per-

formed within the global period of a surgery is unrelated to that surgery.

Before using modifier –24, you should consider this question: Would the patient have this problem if they had not had the original surgery? If the answer is no, do not bill, not even with a new diagnosis code. A diagnosis code different from the one used to justify the initial surgery is insufficient reason. If, however, you are entitled to bill for a service, the first entry of documentation should not indicate "postop." The OIG will continue to study whether the global surgery period, developed in 1992, has changed the number of E&M services provided.

Medicare billings with modifier

-GY. The OIG will again review the appropriateness of physicians' use of modifier –GY on claims for services Medicare doesn't cover. This modifier is to be used for services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable for payment. In fiscal year 2008, Medicare received over 75.1 million claims with modifier –GY.

2010 Coding Update

On Tuesday, Jan. 12, from 11 a.m. to noon PST, the AAOE will host a Web conference that highlights the key coding changes for 2009. Register at www.aao.org/aaoe.