MPC, Inc.
April 2009

CELEBRATING 17 YEARS OF EXCELLENCE

MEDICAL PRACTICE CONSULTANTS, INC.

OIG 2009 WORKPLAN

"Easter tells us that life is to be interpreted not simply in terms of things but in terms of ideals."

~Charles M. Crowe

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 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.

Evaluation and Management Services During Global Surgery Periods
We will review industry practices related to the number of evaluation and management (E&M) services provided by physicians and reimbursed as part of the global surgery fee. CMS's "Medicare Claims Processing Manual" contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services 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.

Medicare Practice Expenses Incurred by Selected Physician Specialties
We will review the actual expenses of selected physician specialties. Physician services include medical and surgical procedures, office visits, and medical consultations.

Physicians are paid for services pursuant to the MPFS, which covers the major categories of costs including the physician professional cost component, malpractice costs, and practice expense.

The Social Security Act, 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. We will determine whether Medicare payments for physician services performed by selected specialties are comparable to the actual expenses incurred by the physicians in providing services and operating their practices.

Services Performed by Clinical Social Workers
We will review services furnished by clinical social workers (CSW) to inpatients of Medicare participating hospitals or SNFs to determine whether the services were separately billed to Medicare Part B. Federal regulations describe services performed by a CSW that cannot be billed as CSW services under Medicare Part B when provided to inpatients of certain facilities. We will examine Medicare Part A and Part B claims with overlapping dates of service to determine whether services performed by CSWs in inpatient facilities were separately billed to Medicare Part B.

Outpatient Physical Therapy Services Provided by Independent Therapists
We will review outpatient physical therapy services provided by independent therapists to determine if they are in compliance with Medicare reimbursement regulations. The Social Security Act 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," contains documentation requirements for therapy services. Previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically nec-

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essary, or properly documented. Focusing on independent therapists who have a high utilization rate for outpatient physical therapy services, we will determine whether the services that they billed to Medicare were in accordance with Federal requirements.

Medicare Payments for Colonoscopy Services
We will review the appropriateness of Medicare payments to physicians for colonoscopy services. A colonoscopy is a complex procedure for examining the entire colon and may include, for example, biopsy to remove polyps, tumors, or other lesions or related services that the physician may deem necessary, such as medical consultations and office visits.

A colonoscopy generally requires that the patient be placed under sedation in an outpatient hospital setting. The Social Security Act, precludes payment to any service provider unless the provider has furnished the information necessary to determine the amounts due such provider. We will determine whether Medicare payments for colonoscopy services were properly supported, billed, and paid in accordance with Medicare requirements.

Physicians' Medicare Services Performed by Nonphysicians
We will review services physicians' bill to Medicare but do not perform personally. Such services, called "incident to," are typically performed by nonphysician staff members in physicians' offices.

The Social Security Act provides for Medicare coverage of services and supplies performed "incident to" the professional services of a physician. However, these services may be vulnerable to overutilization or put beneficiaries at risk of receiving services that do not meet professionally recognized standards of care.

We will examine the qualifications of nonphysician staff that perform "incident to" services and assess whether these qualifications are consistent with professionally recognized standards of care.

Medicare Payments for Unlisted Procedure Codes
We will review the accuracy of Medicare payments for services billed using unlisted procedure codes. Unlisted procedure medical codes are miscellaneous codes used by service providers only when there are no specific Healthcare Common Procedure Coding System (HCPCS) codes that accurately identify the medical service furnished.

The Social Security Act establishes the MPFS, which provides a payment amount for almost all HCPCS codes, as the basis for Medicare reimbursement for physician services. However, unlisted procedure codes are not paid under the fee schedule.

The Medicare contractors that process such claims suspend them for individual review and manual pricing. We will examine provider usage of procedure codes for services not listed in the HCPCS.

Laboratory Test Unbundling by Clinical Laboratories
We will review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Pursuant to the "Medicare Claims Processing Manual," to ensure the accuracy of payments, Medicare contractors must group together individual laboratory tests that clinical laboratories can perform at the same time on the same equipment and then consider the price of related profile tests.

Payment for individual tests must not exceed the lower of the profile price or the total price of all the individual tests.

We will determine whether clinical laboratories have unbundled profile or panel tests by submitting claims for multiple dates of service or by drawing specimens on sequential days. We will also determine the extent to which the Medicare carriers have controls in place to detect and prevent inappropriate payments for laboratory tests.

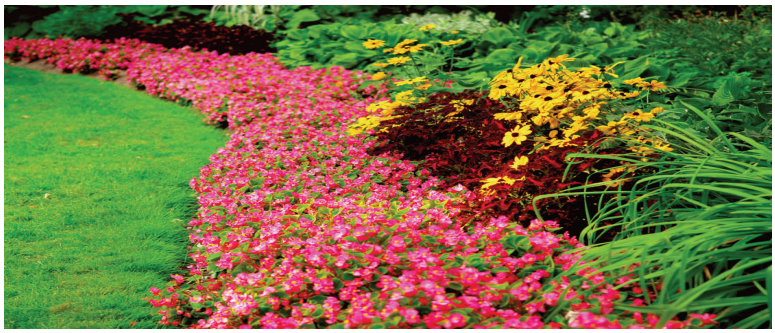
Medicare Billings With Modifier GY
We will review the appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare. CMS's "Medicare Carriers Manual," states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the 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," providers are not required to provide beneficiaries with advance notice of charges for services that are excluded from Medicare by statute.

As a result, beneficiaries may unknowingly acquire large medical bills that they are responsible for paying. In FY 2006, Medicare received over 53 million claims with a modifier GY and denied claims totaling over $400 million. We will examine patterns and trends for physicians' and suppliers' use of modifier GY.

Success
"To laugh often and much;
To win the respect of intelligent people
and the affection of children;
To earn the appreciation of honest critics
and endure the betrayal of false friends;
To appreciate beauty, to find the best in others;
To leave the world a bit better, whether by
a healthy child, a garden patch or a
redeemed social condition;
To know even one life has breathed easier
because you have lived.
This is to have succeeded."

By Bessie Stanley- 1905



"Don't think you're on the right road just because it's a well -beaten path." ~Author Unknown