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MEDICAL PRACTICE CONSULTANTS, INC.

How To Avoid A RAC Audit

The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program, awarded various contractors contracts to provide recovery audit services mandated by the Tax Relief and Health Care Act of 2006.

The Recovery Audit Contractor (RAC) program is a cost containment effort aimed at reducing improper payments within Medicare programs as well as identifying process improvements to reduce or eliminate future improper payments.

The RAC Program's Mission:
"To reduce Medicare improper payments through efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments."

Contractors publish a list of all the CMS-approved audit issues on their web sites so that audits do not come as a surprise to providers. Knowing what is on that list and making sure that you do not bill for services in the manner addressed on the list will avoid an audit.

The list includes the following issues and descriptions:

Pulmonary Diagnostic Procedures and Evaluation and Management Services
Description: Identification of overpayments associated with evaluation and management services (99211-99215) billed without modifier 25 on the same date of service as a pulmonary diagnostic procedure (94010-94799).

Evaluation and Management Services During Global Surgery Periods
Description: 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. The global surgery fee includes payment for E&M services provided during the global surgery period.

Evaluation and Management Services with Allergy Services
Description: Identification of overpayments made for Evaluation and Management services billed without modifier 25 on the same date of service as allergy testing or allergen immunotherapy.

Left-sided Cardiac Catheterization
Description: CPT Code 93510 (described as:Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous) should only be billed once per patient per date of service. (Excluding claims with Modifiers -73 and -52 and -26)

IV Hydration Therapy
Description: Based on the definition of CPT 90760 (excluding claims modifier-59), the maximum number of units should be one (1) per patient per date of service. Beginning 1.1.09, code 90760 was replaced with code 96360.

Sometimes the most important thing in a whole day is the rest we take between two deep breaths.

~Etty Hillesum

Global Period - Minor Surgery
Description: Additional/subsequent minor surgical procedures performed during the 10 day global postoperative period of the initial procedure are considered an overpayment when billed without modifiers "-58", "-78", or "-79".

MEDICAL PRACTICE CONSULTANTS, INC.
Renee M. Brown, President
50 Penn Place
1900 NW Expressway, Suite 625
Oklahoma City, Oklahoma 73118
(405/848-8558)

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Global Period - Major Surgery
Description: Additional/subsequent major surgical procedures performed during the 90 day global postoperative period of the initial procedure are considered an overpayment when billed without modifiers "-58", "-78", or "-79".

Duplicate Claims - Physician (Carrier)
Description: Exact duplicate data fields submitted for physician (carrier) claims for the same service, same member, and same date of service (not including interim billing or corrected claims) resulting in duplicate payments.

Date of Death- Carrier
Description: Medicare does not pay for services or equipment after the beneficiary's date of death.

Co-Surgery not billed with modifier 62
Description: Improper payments exist when two surgeons perform surgery on the same patient; one surgeon added the co-surgeon modifier -62 and the other did not.

Chemotherapy Administration Codes
Description: When a CPT code reflective of chemotherapy administration is billed, the claim is required to include the code for the corresponding medication administered on the same date to the same patient.

Bronchoscopy Services
Description: CPT Codes 31625, 31628 and 31629 should be billed with a maximum number of units of one (1) per patient per date of service (excluding claims with modifier 59) should only be reported with one unit per date of service.

Add-on codes without primary codes
Description: Certain CPT codes, by their definition (in each respective year of the CPT Manual) require billing to include both the primary and additional component codes. Providers are billing only the add-on codes without their respective primary codes resulting in overpayments.

In addition to the Contractors listing of issues CMS issues the Medicare Quarterly Provider Compliance Newsletter, a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by Medicare Claims Processing Contractors, Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, and other governmental organizations, such as the Office of Inspector General.

So far three Newsletters have been published and they contain the following issues and descriptions:

Recovery Audit Finding: Not a New Patient – Incorrect Coding
Provider Types Affected: Physician

Description: Recovery Auditors determined that providers are incorrectly billing new patient services for reimbursement under Medicare Part B. New patient Evaluation and Management (E/M) services for the same beneficiary within a 3-year period should not be billed to Medicare. A problem exists when multiple new patient E/M services are reimbursed under Medicare Part B inside of this time frame.

The Importance of Correctly Coding the Place of Service by Physicians and Their Billing Agents
Provider Types Affected: Physicians and their billing agents who submit claims to Medicare Carriers or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Description: Incorrectly coding the place of service code on claims could result in overpayments that will need to be recovered. The OIG conducted an audit to determine whether physicians correctly coded non-facility places of service on selected Part B claims submitted to and paid by Medicare contractors.

The OIG found that, in many instances, physicians are incorrectly coding the place-of-service code. Specifically, in a very large portion of the claims audited, physicians used non-facility place-of-service codes on their claims for services that were actually performed in hospital outpatient departments or ASCs. This led to overpayments by Medicare on these claims. Medicare does recover these overpayments so it is critical to code correctly and avoid overpayments.

In March 2011, CMS published a report called "Medicare Fee-for-Service Recovery Audit Program as of March 2011" indicating that the amount of Medicare fee-for-service improper payments collected by Recovery Audit Contractors (RACs) continues to increase. During the program's initial three-year demonstration period, almost $1 billion in overpayments was returned to the Medicare Trust Fund, and over $37 million in underpayments went back to providers.

Over $75 million in overpayments were collected in FY 2010, and that figure was matched in the first quarter of FY 2011 alone. The second quarter of FY 2011 saw total collections jump to $162 million.

A snowflake is one of God's most fragile creations, but look what they can do when they stick together!

~ Author Unknown