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Who Conducts Audits on Behalf of Medicare?

Medicare audits can be triggered by a number of factors. These include: patient complaint, whistleblower information, random audit, an audit reviewing targeted measures, or "outlier behavior".

The intent of an audit is to defend against potential fraud and abuse of the Medicare system. The unfortunate truth is that our method of claims presentation and reimbursement opens the health care industry to the very real risk of fraudulent behavior. According to the Congressional Budget Office, Medicare paid \$528 billion dollars in claims in 2010. Only about 5% of claims are audited annually. This means that 95% are automatically paid based on claim submission.

Medicare's current approach to auditing includes a series of different agencies that focus on specific aspects of billing and potential fraud. The following is a list of some, but not all, of the potential auditing entities:

- MAC (Medicare Administrative Contractor)
This is your local carrier. Audits are likely to be triggered by outlier behavior, or patient complaint. Claims are reviewed both prospectively and retrospectively.
- OIG (Office of Inspector General)
The OIG actively audits claims and patterns of claims looking for fraudulent behavior. The agency annually announces areas on which it intends to focus.
- RAC (Recovery Audit Contractor)
RAC contractors have gained the most notoriety of the auditing entities in recent years because a portion of their funding is gained from their financial recovery of improper billings. RACs are assigned to a specific global region in the United States and they audit for a specific set of defined and approved measures. They can audit on a consistent basis, but the number of records they can request from any physician practice is defined by government guidelines and based on practice size.
- ZPIC (Zone Program Integrity Contractor)
ZPIC contractors were formally known as Program Safety Contractors. They are hired indirectly by CMS or in connection with other CMS affiliated contractors to perform data review. Their target is fraud, and they investigate all aspects of Medicare billing. Their current focus appears to be physicians, DME supplier billing, physical therapy and SNFs.
- HEAT (Health Care Fraud Prevention and Enforcement Action Team)
Established in 2009, HEAT is a joint task force using the combined efforts of Health and Human Services and the US Department of Justice to identify and prosecute fraud. The task force recovered \$4 billion in fraudulent payments in 2010. They publish results of successful investigations online per state. Their website is <http://stopmedicarefraud.gov/index.html>
- FBI (Federal Bureau of Investigation)
The FBI also audits for fraud. This may be in concert with another federal agency or as their own investigation. It was the FBI that identified the largest Medicare fraud scheme to date in 2010, involving federal indictments of 73 individuals in five states and \$163 million in fraudulent billings.

Changes to Laceration Repair Codes

The 17th edition to the CCI (Correct Coding Initiative) Edits was released in January. This release was notable for 29,600 changes to bundling and global guidelines. Among these were changes to the codes for simple laceration repair. Per the updated CCI edits, this code set no longer includes a global period of 10 days. They are now listed as 0 global days.

According to this change, an encounter for the return of a patient for suture removal from a simple laceration repair, is no longer a "no charge" service. Usually, billable suture removal services are billed with low level E/M codes: 99211 is removed by qualified clinical staff, and 99212 if removed by a licensed medical provider.

As per usual, appropriate documentation is required. At minimum, this should include the location of the sutures, the nature of the incident requiring the repair, the current appearance of the wound, the fact that the sutures were removed, and the proper authentication of the provider of service.

No changes have been made to the global days for other minor procedures that might require suture removal. Intermediate and complex laceration repairs, excisions, and destruction codes all continue to have a 10 day global period. Only the global days for simple laceration repair are included in this CCI edit change.

Worker's Compensation Corner: Consultations - The Importance of Complying with Reporting Requirements

In order to optimize your revenue cycle management, as well as to remain in good standing with regulatory boards, it is important to be observant of the various regulations governing consultations, treatment and medical-legal reporting.

Regulation 9785 states that "Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness." If the PTP is confronted with a complaint that falls outside of his/her expertise, then they are to seek a consultation with another physician. The PTP is, within 20 days of receipt of the consultant's report, obligated to incorporate the results of the additional examination into the progress report (PR2). If late, the PTP must present a reason why the review was late. Additionally, if there is a medical provider network (MPN) in place, you may have to use another member of that MPN as your consultant and you may also have to go through utilization review to secure prior authorization.

In medical-legal situations, although the law contemplates the creation of a QME panel for the selection of a consultant, most evaluators take advantage of Regulation 32(c) and choose their own consultant. In these cases, pursuant to Regulation 32(d), the referring QME must arrange the consultation appointment and advise the injured employee and the claims administrator, or if none the employer, and each party's attorney, if any, in writing of the appointment date, time and place by use of QME Form 110. The consulting physician serves the consulting report on the referring QME. This same form of service would be appropriate for treatment consultation reports.

The consulting physician is paid under the Official Medical Fee Schedule, not the Medical-Legal Fee Schedule, whether it is a medical consultation or a medical-legal consultation. Typically, an office consultation is billed in the 9924x series and 99080 for your report.

In addition, you may also be able to charge for any reasonable and necessary diagnostic testing, research, record review (99358) and, in exceptional cases, for prolonged face-to-face time with the patient (99354 or 99355). Furthermore, telephonic or other communications between the referring physician and the consulting physician may be billable. The consultant, the PTP, and the referring evaluator may face PPO discounts when billing for services under the OMFS.

GR Medical Management is committed to providing you with the latest information and facts from the industry. Our goal is to keep you up to date and informed in order to streamline your operation.

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