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Meet the Presenter…

Lisa Maciejewski-West, MCS-P
Faculty
Practice Management Institute

On the topic:
Top Compliance Concerns for Medical Coding and Billing Staff
Top Compliance Concerns for Medical Coding and Billing Staff

Presented by:
Lisa Maciejewski-West, MCS-P
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What Is the OIG?

Mission
Office of Inspector General’s (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

Who We Are
Since its 1976 establishment, OIG has been at the forefront of the Nation’s efforts to fight waste, fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs.
HHS OIG is the largest inspector general’s office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs. A majority of OIG’s resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country’s most vulnerable citizens. OIG’s oversight extends to programs under other HHS institutions, including the Centers for Disease Control and Prevention, National Institutes of Health, and the Food and Drug Administration.

What We Do
We carry out our mission using a multidisciplinary, collaborative approach, with each of our six components playing a vital role.
A nationwide network of audits, investigations, and evaluations results in timely information as well as cost-saving or policy recommendations for decision-makers and the public. That network also assists in the development of cases for criminal, civil and administrative enforcement.

SOURCE: http://oig.hhs.gov/about-oig/about-us/
The OIG Website contains a wealth of information pertaining to compliance, including articles and publications on individuals/entities who have committed fraud. Additionally the OIG maintains a database of individuals who have been EXCLUDED from the Medicare program. Individuals who suspect FRAUD in their organizations are also able to report such fraud through the OIG website.

The OIG WORK PLAN is the document used to identify top compliance concerns each year.

The Seven Elements of a Compliance Program

- A brief description of the seven essential elements of an effective Compliance Program as suggested by the OIG is:
  1. Implementing Written Policies
  2. Designating a Compliance Officer/Contact
  3. Conducting Comprehensive Training and Education
  4. Developing Accessible Lines of Communication
  5. Conducting Internal Monitoring and Auditing
  6. Enforcing Standards through well publicized disciplinary guidelines
  7. Responding Promptly to detected offenses and undertaking corrective action

Source: Federal Register / Vol. 64, No. 192 / Tuesday, October 5, 1999 / Notices
Identifying Compliance Issues

• The OIG Identifies Compliance Issues within the Department of HHS in a number of ways:
  – Data Mining
  – Audits (CERT, RAC)
  – Investigations
  – Whistle Blowers (Qui Tam)
  – OIG Work Plan

Penalties for Non-Compliance

• Penalties for Non-Compliance vary, and depend on a number of factors. Penalties may include, but are not limited to:
  – Recoupment of incorrectly paid claims
  – Civil Money Penalties ($3,000 - $10,000 per incident/claim)
    • Example: An organization that allows a provider excluded from Medicare to provide services to patients can incur a $10,000 PER INCIDENT fine.
  – Criminal Fines imposed by Judge (Federal Sentencing Guidelines)
Federal Sentencing Guidelines

• Federal Sentencing Guidelines were established in 1991 to determine the extent of penalties for abuse and fraud.

• Mitigating Factors that could determine the severity of penalties:
  – Did you pay back $$ that you owe?
  – Do you self monitor (do you have a compliance program)

• Culpability Score (what did you do RIGHT?)
  – Helps to calculate sentencing
  – Did upper level employees participate in, or condone, or were willfully ignorant of offense?
  – Did organization report offense promptly?
  – Did organization cooperate with investigators?
  – Did organization accept responsibility?

Data Mining

• Software within Software
  – Tracks information about provider
    • Who rendered services (based on claim form)
    • Who got paid
  – Tracks errors
    • Submission Errors (Clearinghouses and Carriers)
    • Coding Errors
      – Missing/incorrect modifiers
      – ICD coding errors (not coding to highest level of specificity, dx to procedure coding errors)
      – POS Errors
    • NCCI (National Correct Coding Initiative) Edits
      • Looks for invalid coding combinations
      • Tracks codes that have been unbundled

• When claims submission errors reach a certain level on a consistent basis, it could and may trigger an audit.
CERT (Comprehensive Error Rate Testing) Audit

Comprehensive Error Rate Testing (CERT)

Improper Payment Measurement in the Medicare Fee-for-Service Program

www.cms.gov/CERT

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Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012

- Amended the Improper Payments Information Act of 2002 (IPIA)
- Requires the heads of Federal agencies, including the Department of Health and Human Services (HHS), to annually review programs it administers to improve agency efforts to reduce and recover improper payments

**Improper Payment**

- Payments that should not have been made or payments made in an incorrect amount (including overpayments & underpayments)
  - Payment to an ineligible recipient
  - Payment for an ineligible service
  - Any duplicate payment
  - Payment for services not received
  - Payment for an incorrect amount

**The CERT Program**

CMS established the following program... that monitors payment decisions made by... for claims/admissions submitted by...

- Providers
- Diagnostic and Laboratory Facilities
- Anesthesia
- DME MACs
- Acute Care Inpatient Hospitals
- Long Term Care PPS Hospitals
- Outpatient Hospitals
- IRAs
- Hospitals

The CERT Process

- Claim Selection
- Medical Record Requests
- Review of Claims
- Assignment of Improper Payment Categories
- Calculation of the Improper Payment Rate

CERT Claim Selection

- A stratified random sample is taken by claim type:
  - Part A (excluding acute inpatient hospital services)
  - Part A (acute inpatient hospital services only)
  - Part B
  - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

- Claims are selected on a semi-monthly basis

- The final CERT sample is comprised of claims that were either paid or denied by the MACs

CERT Medical Record Requests

- The CERT Documentation contractor requests medical records from the provider or supplier that submitted the claim
  - For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), additional documentation requests are also made to the referring provider who ordered the item or service
- If no documentation is received within 75 days of the initial request, the claim is classified as a “no documentation” claim and counted as an error
- If documentation is received after 75 days of the initial request (late documentation), CERT will still review the claim


CERT Review of Claims

- Upon receipt of medical records, medical review professionals at the CERT Review Contractor conduct a review of the claim and submitted documentation to determine whether the claim was paid properly
  - Nurses, medical doctors, and certified coders review the claims
- Determinations are made regarding whether the claim was paid properly under Medicare coverage, coding, and billing rules
- Improper payment categories are assigned

Assignment of Improper Payment Categories

- Improper Payment Categories
  - No Documentation
  - Insufficient Documentation
  - Medical Necessity
  - Incorrect Coding
  - Other

Corrective Actions

- CMS and Contractors analyze improper payment rate data and develop Error Rate Reduction Plans to reduce improper payments

- Corrective actions include:
  - Refining improper payment rate measurement processes
  - Improving system edits
  - Updating coverage policies and manuals
  - Conducting provider education efforts
Corrective Actions: Increased Presence

- Increase Recovery Audit post-payment review, particularly on inpatient hospital claims
- Allocate additional funds to Contractor Medical Director representation at Administrative Law Judge (ALJ) hearings
- Allocate additional funds to the Medicare Administrative Contractors (MACs) to increase their prepayment review on error-prone claim types


RAC Audits-the Next Step

Recovery Audit Contractors (RACs) and Medicare


What is a RAC?
The RAC Program Mission

- The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments:
- **Providers** can avoid submitting claims that do not comply with Medicare rules
- **CMS** can lower its error rate
- **Taxpayers** and future Medicare beneficiaries are protected

Will the RACs affect me?

- Yes, if you bill fee-for-service programs, your claims will be subject to review by the RACs
- If so, when?
- The expansion schedule can be viewed at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)
What does a RAC do?

The RAC Review Process

- RACs review claims on a post-payment basis
- RACs use the same Medicare policies as Carriers, FIs and MACs: NCDs, LCDs and CMS Manuals
- Two types of review:
  - Automated (no medical record needed)
  - Complex (medical record required)
- RACs will not be able to review claims paid prior to October 1, 2007
- RACs will be able to look back three years from the date the claim was paid
- RACs are required to employ a staff consisting of nurses, therapists, certified coders, and a physician

The Collection Process

- Same as for Carrier, FI and MAC identified overpayments (except the demand letter comes from the RAC)
  - Carriers, FIs and MACs issue Remittance Advice
    - Remark Code N432: Adjustment Based on Recovery Audit
  - Carrier/FI/MAC recoups by offset unless provider has submitted a check or a valid appeal

What are providers’ options?
If you agree with the RAC’s determination:

• Pay by check
• Allow recoupment from future payments
• Request or apply for extended payment plan
• Appeal

Appeal Timeframes

935 MLN Matters

What Can providers do to get Ready?
Know where previous improper payments have been found

- Look to see what improper payments were found by the RACs:
  - Demonstration findings: www.cms.hhs.gov/rac
  - Permanent RAC findings: will be listed on the RACs’ websites
- Look to see what improper payments have been found in OIG and CERT reports
  - OIG reports: www.oig.hhs.gov/reports.html
  - CERT reports: www.cms.hhs.gov/cert


Know if you are submitting claims with improper payments

- Conduct an internal assessment to identify if you are in compliance with Medicare rules
- Identify corrective actions to promote compliance
- Appeal when necessary
- Learn from past experiences

Prepare to respond to RAC medical record requests

- Tell your RAC the precise address and contact person they should use when sending Medical Record Request Letters
  - Call RAC
  - No later 1/1/2010: use RAC websites

- When necessary, check on the status of your medical record (Did the RAC receive it?)
  - Call RAC
  - No later 1/1/2010: use RAC websites


Appeal when necessary

- The appeal process for RAC denials is the same as the appeal process for Carrier/FI/MAC denials
- Do not confuse the “RAC Discussion Period” with the Appeals process
- If you disagree with the RAC determination…
  - Do not stop with sending a discussion letter
  - File an appeal before the 120th day after the Demand letter

Learn from past experiences

- Keep track of denied claims
- Look for patterns
- Determine what corrective actions you need to take to avoid improper payments

Contacts

- RAC Website: www.cms.hhs.gov/RAC
- RAC Email: RAC@cms.hhs.gov

QUI TAM (Whistleblowers)

- Most often someone within your organization
- Sometimes a patient
- Usually Anonymous (Providers won’t know where allegations come from) – however OIG compensates whistleblowers with % of recoupments if fraud is validated and prosecuted
- If employee comes to you with concern, don’t blow it off!
THE OIG WORK PLAN

What Is the Work Plan?

The Office of Inspector General's (OIG) Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The Work Plan includes projects planned in each of the Department's major entities: the Centers for Medicare & Medicaid Services; the public health agencies; the Administrations for Children & Families; and Administration on Aging. Information is also provided on projects related to issues that cut across departmental programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary of Health & Human Services (HHS). Some of the projects described in the Work Plan are statutorily required, such as the audit of the Department's financial statements, which is mandated by the Government Management Reform Act.

What is our responsibility?

Our organization was created to protect the integrity of HHS programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal health care laws. Our mission encompasses more than 100 programs administered by HHS at agencies such as the Centers for Medicare & Medicaid Services, Administration for Children and Families, Centers for Disease Control and Prevention, Food and Drug Administration, and National Institutes of Health.

The amount of work conducted in each category is set by the purpose limitations in the money appropriated to OIG. OIG’s funding that is directed toward oversight of the Medicare and Medicaid programs constitutes a significant portion of its total funding (approximately 75 percent in 2014). The remaining share of OIG’s efforts and resources are focused on other HHS programs and management processes, including key issues, such as the accuracy of financial assistance payments, efficient and effective operation of health insurance marketplaces, safety of the Nation’s food and drug supply, security of national stockpiles of pharmaceuticals for use during emergencies, and integrity of contracts and grants management processes and transactions.
What do we accomplish?

For FY 2015, we reported expected recoveries of more than $3 billion, consisting of nearly $1.13 billion in audit receivables and about $2.22 billion in investigative receivables, which include about $286.6 million in non-HHS investigative receivables resulting from our work in areas such as the States’ shares of Medicaid restitution. We also identified about $20.6 billion in savings estimated for FY 2015 on the basis of prior-period legislative, regulatory, or administrative actions that were supported by OIG recommendations. Such estimates generally reflect third-party projections (such as those by the Congressional Budget Office or HHS actuaries) made at the time the action was taken. Actual savings may be higher or lower.

We reported FY 2015 exclusions of 4,112 individuals and entities from participation in Federal health care programs; 925 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 682 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, CMP settlements, and administrative recoveries related to provider self-disclosure matters.


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FOCUS OF TODAY’S PRESENTATION
Power mobility devices—supplier compliance with payment requirements

We will review Medicare Part B payments for suppliers of power mobility devices (PMDS) to determine whether such payments were in accordance with Medicare requirements. We will focus particularly on whether PMDS are medically necessary and whether Medicare payments for PMD claims submitted by medical equipment suppliers are supported in accordance with requirements at 42 CFR § 405.38. (OIG, W-00-15-35703; various reviews; expected issue date: FY 2016)

Nebulizer machines and related drugs—supplier compliance with payment requirements

We will review Medicare Part B payments for nebulizer machines and related drugs to determine whether medical equipment suppliers’ claims for nebulizer machines and related drugs are medically necessary and are supported in accordance with Medicare requirements. For calendar year (CY) 2006, Medicare paid approximately $632.8 million for inhalation drugs. With an improper payment rate of 42 percent, inhalation drugs were 6th on a list of the top 20 DMEPOS services with the highest improper payments in the 2004 Comprehensive Error Rate Testing report. Medicare requires that items be “reasonable and necessary.” (Social Security Act § 1861(u)(1)(A)). Further, the local coverage determinations (LCDs) issued by the four Medicare contractors that process medical equipment and supply claims include utilization guidelines and documentation requirements. (OIG, W-00-15-35680; W-00-15-35585; expected issue date: FY 2016)

Diabetes testing supplies effectiveness of system edits to prevent inappropriate payments for blood glucose test strips and lancets to multiple suppliers

We will review Medicare’s claims processing edits; special system controls designed to prevent payments to multiple suppliers of home blood glucose test strips and lancets; and determine whether they are effective in preventing inappropriate payments. Prior OIG work found that inappropriate payments were made to multiple medical equipment suppliers for test strips and lancets dispensed to the same beneficiaries with overlapping service dates. The LCDs issued by the pertinent claims processing contractors state that medical equipment suppliers may not dispense test strips and lancets until beneficiaries have newly exhausted the previously dispensed supplies. The LCDs also require that beneficiaries or their caregivers specifically request refills before the suppliers dispense them. Medicare does not pay for items or services that are not “reasonable and necessary.” (Social Security Act § 1861(u)(1)(A)). (OIG, W-00-15-35604; W-00-15-35504; various reviews; expected issue date: FY 2016)

NEW Increased billing for ventilators

We will describe billing trends for ventilators, Respiratory Assist Devices (RAD), and Continuous Positive Airway Pressure (CPAP) devices from 2011-2014 as well as examine factors associated with the increase in ventilator claims. CMS and its contractors have expressed concerns about the increase in billing for ventilators, specifically HCPCS code E0464 [a pressure support ventilator with volume control mode and a noninvasive interface (e.g., mask)]. From 2013 to 2014, there has been a 127 percent increase in allowed amounts for E0464. The number of beneficiaries receiving a pressure support ventilator increased from 8,633 in 2013 to 19,085 in 2014. Suppliers may be inappropriately billing for ventilators for beneficiaries with non-life-threatening conditions, which would not meet the medical necessity criteria for ventilators and might instead be more appropriately billed to codes for RADs or CPAPs. The CMS National Coverage Determination Manual §280.1 stipulates that ventilators are covered for the treatment of severe conditions associated with “neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.” Ventilators would not be considered reasonable and necessary to treat any of the conditions described in the LCDs for either CPAPs or RADs. We will also examine the impact of the Competitive Bidding Program on ventilator billing trends. (OEI; 12-15-00370; expected issue date: FY 2016)
Ambulance services—questionable billing, medical necessity, and level of transport

We will examine Medicare claims data to assess the extent of questionable billing for ambulance services, such as transports to dialysis facilities that potentially never occurred or potentially were medically unnecessary. We will also determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements. Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports. Medicare pays for emergency and nonemergency ambulance services when a beneficiary’s medical condition at the time of transport is such that other means of transportation would endanger the beneficiary. (Social Security Act, § 1861(s)(7).) Medicare pays for different levels of ambulance service, including basic life support, advanced life support and specialty care transport. (42 CFR § 410.40(b).) (OAS; W-00-11-35574; W-00-12-35574; W-00-13-35574; W-00-14-35574; various reviews; expected issue date: FY 2016)

Anesthesia services—payments for personally performed services

We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesia services reported on a claim with the "AA" service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier code to denote whether the service was personally performed or medically directed. (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, Ch. 12, § 50.) Reporting an incorrect service code modifier on the claim as if services were personally performed by an anesthesiologist when they were not will result in Medicare's paying a higher amount. The service code “AA” modifier is used for anesthesia services personally performed by an anesthesiologist, whereas the “QX” modifier limits payment to 50 percent of the Medicare-allowed amount for personally performed services claimed with the “AA” modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due. (Social Security Act, § 1833(e).) (OAS; W-00-13-35706; W-00-14-35706; W-00-15-35706; various reviews; expected issue date: FY 2016)

Selected independent clinical laboratory billing requirements

We will review Medicare payments to independent clinical laboratories to determine laboratories’ compliance with selected billing requirements. We will use the results of these reviews to identify clinical laboratories that routinely submit improper claims, and we will recommend recovery of overpayments. Prior OIG audits, investigations, and inspections have identified independent clinical laboratory areas at risk for noncompliance with Medicare billing requirements. Payments to service providers are precluded unless the provider has and furnishes upon request the information necessary to determine the amounts due. (Social Security Act, § 1833(e).) We will focus on independent clinical laboratories with claims that may be at risk for overpayments. (OAS; W-00-14-35726; W-00-15-35726; various reviews; expected issue date: FY 2016)
Physical therapists—high use of outpatient physical therapy services

We will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable or were not properly documented or that the therapy services were not medically necessary. Our focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, § 1862(a)(1)(A).) Documentation requirements for therapy services are in CMS’s Medicare Benefit Policy Manual, Pub. No. 100-02, Ch. 15, § 220.3. (OAS; W-00-11-35220; W-00-12-35220; W-00-13-35220; W-00-14-35220; W-00-15-35220; various reviews; expected issue date: FY 2016)

Portable x-ray equipment—supplier compliance with transportation and setup fee requirements

We will review Medicare payments for portable x-ray equipment services to determine whether payments were correct and were supported by documentation. We will also assess the qualifications of the technologists who performed the services. Prior OIG work found that Medicare may have improperly paid portable x-ray suppliers for return trips to nursing facilities (i.e., multiple trips to a facility in 1 day). Medicare generally reimburses for portable x-ray services if the conditions for coverage are met. (42 CFR §§ 486.100–486.110.) (OAS; W-00-15-35464; various reviews; expected issue date: FY 2016)
Sleep disorder clinics—high use of sleep-testing procedures

We will examine Medicare payments to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures to assess the appropriateness of Medicare payments for high-use sleep-testing procedures and determine whether they were in accordance with Medicare requirements. An OIG analysis of CY 2010 Medicare payments for Current Procedural Terminology codes 95810 and 95811, which totaled approximately $415 million, showed high utilization associated with these sleep-testing procedures. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, § 1862(a)(1)(A).) To the extent that repeated diagnostic testing is performed on the same beneficiary and the prior test results are still pertinent, repeated tests may not be reasonable and necessary. Requirements for coverage of sleep tests under Part B are in CMS’s Medicare Benefit Policy Manual, Pub. No. 100-02, Ch. 15, § 70. (OAS; W-00-10-35521; W-00-12-35521; W-00-13-35521; W-00-14-35521; W-00-15-35521; various reviews; expected issue date: FY 2016)

NEW Physicians—referring/ordering Medicare services and supplies

We will review select Medicare services, supplies and durable medical equipment (DME) referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements. Pursuant to ACA Sec. 6405, CMS requires that physicians and non-physician practitioners who order certain services, supplies and/or DME are required to be Medicare-enrolled physicians or nonphysician practitioners and legally eligible to refer/order services, supplies and DME. If the referring/ordering physician or non-physician practitioner is not eligible to order or refer, then Medicare claims should not be paid. (OAS; W-00-15-35748; expected issue date: FY 2016, ACA)

NEW Anesthesia services—non-covered Services

We will review Medicare Part B claims for anesthesia services to determine whether they were supported in accordance with Medicare requirements. Specifically, we will review anesthesia services to determine whether the beneficiary had a related Medicare service. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, §1862(a)(1)(A)) (OAS; W-00-15-35749; expected issue date: FY 2016)
NEW Physician home visits—reasonableness of services
We will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Since January 2013, Medicare made $559 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not "reasonable and necessary." [Social Security Act, §1862(a)(1)(A)] (OAS; W-00-15-35754; expected issue date: FY 2016)

NEW Prolonged services—reasonableness of services
We will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion evaluation and management service. The necessity of prolonged services are considered to be rare and unusual. The Medicare Claims Process (MCP) manual includes requirements that must be met in order to bill a prolonged E/M service code. (MCP manual, Pub. 100-04, Ch. 12, Sec. 30.6.15.1)(OAS; W-00-15-35755; expected issue date: FY 2016)


Questions?

Thank you for your attendance!

Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp