Eli's Rehab Report

OIG Cracks Down on Bone Density Screening Claims

In October, the Department of Health and Human Services Office of Inspector General (OIG) released its 2002 Work Plan, outlining the investigative focus areas the OIG intends to monitor this year. PM&R practices will be interested to know that the OIG will be targeting bone density screening, one-day hospital stays, the necessity of durable medical equipment (DME), and consultations.

Every PM&R practice should review the work plan to determine where their risk areas are and how they can perfect their coding in these areas.

"I am always alarmed by the number of practices that don't review the OIG's annual work plan," says **Joseph R. Batte, CFE,** an independent compliance consultant and former supervisory special agent with the OIG. "It is a free and invaluable resource for practices to identify whether the OIG is targeting anything they do."

If practices find that the OIG is scrutinizing claims for their services, Batte recommends that they perform self-audits to find where they stand on such procedures and, if any problems are found, develop corrective action.

For example, if you perform a self-audit and realize that one of the physicians in your practice has been consistently coding for consultations but rarely sends a report to the requesting physician, you should formulate a corrective-action strategy immediately. Collect the erroneous claims and write a letter to the insurer alerting them to the correction. Then establish a plan in your office to avoid doing it again. Your plan should include items such as staff meetings on the requirements for billing consultations or printing quick reference cards with the rules for coding each level of consultation and E/M codes.

The following is a breakdown of the OIG's work plan contents that most affect PM&R practices, and advice on how to avoid undue scrutiny in these areas.

Bone Density Screening

In its work plan, the OIG says it "will evaluate the impact of the recent standardization and expansion of Medicare coverage of bone density screening ... As the number of claims for bone density screening increases, there are questions about the appropriateness and quality of some services."

Because the appropriateness of these services is being scrutinized, coders should know the basics about bone density screenings. Six codes describe the procedure:

1. 76075 dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
2. 76076 ... appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
3. 76078 radiographic absorptiometry (photodensitometry), one or more sites
4. 76977 ultrasound bone density measurement and interpretation, peripheral site(s), any method
5. **CPT 78350** bone density (bone mineral content) study, one or more sites; single photon absorptiometry
6. **CPT 78351** ... dual photon absorptiometry, one or more sites.

All of these codes refer to "one or more sites," which means studies of several sites in the same area should be reported as one unit of service. For instance, if the physiatrist scans a patient's hip and pelvis, the coder should report only one unit of the appropriate scan code.

Insurers can dictate frequency guidelines for these tests, but most Medicare carriers require that the patient have at least one of five conditions:

1. The patient is estrogen-deficient and at clinical risk for osteoporosis (733.00-733.09), based on medical history and other findings.

2. The patient has vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass) or vertebral fracture (733.13).

3. The patient receives glucocorticoid (steroid) therapy of 7.5 or more milligrams of prednisone (J7506) per day for more than three months.

4. The patient has primary hyperparathyroidism (252.0).

5. The patient is being monitored to assess the response to any FDA-approved osteoporosis drug therapy.

PM&R providers should keep documentation that proves the patient has one of these five conditions in case the scan is negative for osteoporosis. Thus, if the OIG audits your practice's bone density scanning claims, you will be able to substantiate that the patient was sufficiently "at risk" for the service.

DME Necessity

The OIG intends to investigate practices that have been overpaid for Medicaid claims for durable medical equipment, and states, "Since the beginning of 1998, one state's federal share of payments to DME providers has exceeded the allowable rates by $8 million. Both the state statute and the state Medicaid plan prohibit Medicaid DME payments that exceed allowable Medicare rates. These excess payments occurred because the state improperly based DME reimbursement rates on the 1993 Medicare fee schedule, rather than on the Balanced Budget Act of 1997, which significantly reduced some Medicare reimbursement rates."

Although individual practices cannot dictate what their state carrier pays them for DME claims, such overpay-ments are being investigated and, in turn, those practices chosen for a DME audit will find that their DME claims are carefully scrutinized. So you must be sure that all DME claims and prescriptions are filled out completely and properly.

The most important point for practices to remember is that when requesting DME for a patient, the physiatrist is responsible for determining whether the device is medically necessary and for filling out the certificate of medical necessity.

For example, if a patient with multiple sclerosis (340) needs a motorized wheelchair (E1210-E1213), the physiatrist must determine whether the chair is necessary for moving around in the patient's home. If the physician marks on the certificate of medical necessity (CMN) that the device is not needed for this purpose, the claim will obviously be denied. Therefore, CMNs should not be viewed simply as "customary," but as a contract declaring that the product is medically necessary. If such devices are found to be unnecessary, the physiatrist who signed the CMN not the DME provider will have to answer to the carrier and the OIG.

"Be sure that office documentation supports the medical necessity indicated on the CMN," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H,** consultant and CPC trainer for A+ Medical Management and Education, a national coding and reimbursement school and consulting firm in Absecon, N.J. "If your office notes indicate that the patient is able to walk, but with a limp, and the CMN says the patient requires a motorized wheelchair for mobility, you have demonstrated

a discrepancy in your records. The CMN and the patient's office visit notes should always be consistent with one another."

One-Day Hospital Stays

The OIG says it will evaluate "the reasonableness of Medicare inpatient hospital payments for beneficiaries discharged after spending only one day in a hospital. Recent data indicate that approximately 10 percent of all Medicare patients admitted are released the following day."

Many practices will recall that Medicare revised its payment policy for one-day hospital stays in January 2001.

Often patients with conditions such as a mini-stroke (transient ischemic attack, 435.9), sciatica (722.10) or temporary paralysis (344.0-344.9) are moved from the emergency room to observation status so the physiatrist can watch them and ensure that the symptoms do not recur. Other times, physicians admit patients into inpatient status for a day, when observation status (which is classified as "outpatient") would have been more appropriate, Jandroep says. The OIG will investigate this because inpatient-status patients are more costly than those in observation care. (Observation care normally reimburses between $75 and $170, but one-day hospital stays for inpatients usually collect between $80 and $250.)

The following tips can help ensure that your practice is coding correctly for observation and one-day hospital stays:

Observation Care

7. When a patient is admitted for observation care for **more than eight hours** and is then discharged on the same day, report 99234-99236 (observation or inpatient hospital care).

8. When a patient is admitted for observation care for **less than eight hours** and is then discharged on the same day, use 99218-99220 (initial observation care) to report the admission, but do not report a discharge code.

9. When a patient is **admitted for observation care and discharged on a different date,** use 99218-99220 to report the admission and 99217 (observation care discharge) to report the discharge.

One-Day Inpatient Hospital Stays

10. When a patient is admitted for inpatient hospital care for **more than eight hours** and is discharged on the same day, use 99234-99236, which have an admit and discharge component.

11. When a patient is admitted for inpatient hospital care for **less than eight hours** and is then discharged on the same day, use 99221-99223 (initial hospital care) to report the admission, but do not report a discharge code.

12. When a patient is **admitted for inpatient hospital care and discharged on a different date,** use 99221-99223 to report the admission and 99238-99239 (hospital discharge day management) to report the discharge.

Consultations

The OIG states in its work plan that it intends to "determine the appropriateness of billings for physician consultation services and the financial impact on the Medicare program from any inaccurate billings. In 2000, total allowed charges to Medicare for consultations were $2 billion."

Consultation codes (99241-99245 outpatient; 99251-99263 inpatient) should be billed only when another physician requests the physiatrist's opinion or advice. However, because consultation codes pay more than standard E/M codes, Medicare loses money when practices erroneously report consult services when office visit services were performed.

To report a consultation, you need a request for an opinion from another provider, a review (exam) of the patient, and a

written report sent to the requesting physician stating the opinion of the consulting physician. These rules are known as the "three R's" of consultation coding.

Even if the two physicians work in the same practice, the consult rules apply, but practices should be positive that they have appropriately documented such service in the practice records so everything will go smoothly in case of an OIG audit. For instance, if an orthopedist in a multispecialty group requests the written opinion of a physiatrist in the same group to determine whether a patient has ALS (335.20), the practice can bill a consult.

Although a written request for a consult is not required, the request should be documented in the patient's medical record, and a written report must be furnished to the requesting physician, even if the two physicians are partners. However, such a consult normally requires that the physicians specialize in different areas of expertise. Even if they are both physiatrists, the consult can be acceptable. For instance, the requesting physician might specialize in athletic injuries, while the consulting physiatrist might specialize in neurological disorders.

The OIG's 2002 Work Plan can be accessed at http://oig.hhs.gov//wrkpln/2002/work_plan_2002.htm.