



AMERICAN OSTEOPATHIC ASSOCIATION

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Dear AOA Members and Affiliates:

Insurance carrier claims reviews and audits are more prevalent now than ever. The recent focus on hospital billing practices and Medicare Recovery Audit Contractor (RAC) audits does not diminish the threat of other types of audits to your practice. Private payers, Medicare and Medicaid actively pursue several types of audits and these activities may negatively impact your practice.

The AOA provides its members with expert guidance through its Division of Compliance and Payment Advocacy to assist you in the audit or review process. Our goal is to achieve accurate outcomes. In most instances, you must adhere to a strict timeline or you may possibly jeopardize your right to due process. The AOA ensures that the audit or review process is effective and efficient. However, we must work with you as early as possible to achieve the results you desire.

The AOA has a record of success in achieving positive outcomes for its many reviews.

Members who provide us with information at the outset of an audit have the best chance to resolve their issue in a timely fashion. You do not have to be the DO directly impacted by review or audit activity, any DO negatively impacted by a policy or practice is our concern.

We wish to alert you and provide guidance regarding three extremely active payment and compliance issues:

1. Audit requests regarding OMT services reported on the same date of service as an office visit, along with the use of the Modifier-25.
2. Audit requests related to coding higher level Evaluation and Management (E/M) services; often linked to the increase in use of electronic health records, and;
3. Pay-for-performance and other quality recognition programs requirements for physicians to justify any practices that may cause them to be considered practice (cost) outliers.

Issue number 1:

Carriers closely review E/M services and use of Modifier -25. In 2005, the Health and Human Services Office of Inspector General (OIG) released a report that raised concerns regarding physician compliance with coding and reporting of separate services provided on the same date of service as an office visit. A key finding of the report was that in 2002, Medicare allowed \$538 million in improper payments related to E/M services and Modifier -25. CMS should not have allowed payment for these claims for two reasons, either because the E/M services were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure; or because the claims failed to meet basic Medicare documentation requirements.

The report recommends that CMS work with carriers to reduce the number of claims submitted using Modifier -25 that do not meet program requirements. The report also recommends that CMS:

- Reinforce the requirements that E/M services billed using Modifier -25 be significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure;
- Encourage carriers to emphasize that appropriate documentation of both E/M services and procedures must be maintained to support claims for payments using Modifier -25 even though the documentation is not required to be submitted with the claims; and
- Emphasize that Modifier -25 should only be used on claims for E/M services, and only when these services are provided on the same day as another procedure.

CMS should also encourage carriers to reexamine their Modifier -25 outreach activities and include Modifier -25 reviews in their medical review strategies where appropriate.

Even though the OIG recommendations specifically apply to Medicare, private carriers apply the study's recommendations to their review of the use of E/M services and Modifier -25 for both their Medicare and non-Medicare subscribers.

You can proactively guard against such audits by performing periodic internal audits of your billing process to ensure that it is accurate and efficient. To do so you should review your coding and documentation, this would include your use of the Modifier -25. Your

documentation should be clear and legible, and the services provided should be separately identifiable when using the Modifier -25. Anyone reviewing your record should be able to identify where the E/M service ends and what separately constitutes the OMT.

As you conduct your internal review, seek documented answers to the following questions to support that the service was separately identifiable:

- Are the somatic dysfunction diagnoses listed?
- Are the corresponding regions treated noted?
- Is the treatment technique(s) utilized noted?
- How was the treatment(s) tolerated?
- Were patient instructions documented?

Attached is a free Medicare-Trailblazer audit tool that may be used to assist you, one of many tools located on the Internet. You are encouraged to proactively assess the appropriateness of your claims reporting by reviewing a representative sample of records.

Consider the total number of services billed to a carrier and review at least five to ten percent of those records. As a benefit of your AOA membership, you or members of your practice may contact the AOA with billing questions to clarify your findings. Another option is to hire a consultant that will perform this service periodically for your practice.

Also for your reference, attached are the pages of the November 2011 Federal Register which details the review and revised 2012 payment policy for the OMT codes. CMS made a concerted effort to adopt physician work values that reflect OMT typically reported with an E/M code.

Ultimately, audits of the Modifier -25 have increase substantially. Osteopathic physicians who perform and bill for OMT may feel that they are disproportionately affected. Yet, other specialties such as dermatology are similarly impacted. The AOA will continue to work with the carriers to develop a reasonable solution to decrease the impact on osteopathic physicians

Issue number 2:

Higher level E/M services are being reported. In other words, CPT Codes 99214 and 99215 are reported more frequently, and these codes typically require 25 to 40 minutes of time for the established patient. Attached please find a copy of the May 2012 OIG report on this trend. The report found that from 2001 to 2010, physicians increased their billing of higher

level E/M codes in all visit types. Established patient office visits represented the largest amount of Medicare payments for E/M services in 2010. While the middle code (99213) was billed most often during the 10-year period, there was a shift in billing from the three lower level E/M codes to the two higher level codes. Combined, physicians increased their billing of the two highest level E/M codes (99214 and 99215) by 17 percent from 2001 to 2010.

The three key recommendations of the 2012 OIG report were:

- Continue to educate physicians on proper billing for E/M services
- Encourage contractors to review physicians' billing for E/M services
- Review physicians who bill higher level E/M codes for appropriate action

As all insurers seek to contain costs, they may audit physicians for billing higher level E/M codes. Given the current environment, physicians are encouraged to be proactive and perform internal reviews. If you have received a request to send in charts, you may want to perform your own internal review, or consider seeking an external audit. Lastly, some practices appropriately report higher level codes and will always be considered outliers. In the case that your practice is appropriately deemed an outlier, you should contact the insurer's provider relations department and request that your name, and/or NPI number be removed from the general outlier review pool for an agreed upon time. Such action will limit economic disruptions to your practice.

Issue number 3: Pay-for-performance programs and quality payment programs review physicians using quality metrics that include costs. Quality providers are distinguished from practice outliers using metrics such as the use of Modifier -25. Those physicians involved in such programs should not only request the data metrics used to identify outliers and quality providers, but should also provide a copy of the attached AOA E/M and OMT position paper, and the 2011 Federal Register documents to substantiate the appropriate use of the Modifier-25.

In addition, make sure that you are appropriately credentialed with each insurance carrier and that you are correctly listed in your specialty peer group. The AOA continues to work with carriers to ensure appropriate peer groups for osteopathic physicians who regularly perform OMT.

Recently, Anthem Blue Cross and Blue Shield contracted with EquiClaim to review the Evaluation and Management (E/M) codes with Modifier -25 for all physicians participating

in the network as part of ongoing claim review activities. EquiClaim analyzed the Modifier -25 claims paid between May 2011 and April 2012 for the purpose of "identifying those physicians who are billing E/M codes with modifier 25 significantly more often than other physicians within the same specialty."

Anthem shared the EquiClaim report findings with physicians who were identified as outliers from their peer group. If you received this document, you should use the EquiClaim customer service number listed on your letter to find out what peer group you are listed in.

Many family physicians that perform a great deal of OMT will likely be an outlier because your peer group includes allopathic family physicians that typically do not perform OMT. Ask them to reclassify you into a more appropriate peer group if possible. If that is not possible, then please notify the AOA Division of Compliance and Payment Advocacy.

Finally, the AOA clarified that EquiClaim reports are neither payment demands nor notice that the claims were paid inappropriately. Instead, EquiClaim maintains that its letters were sent as an alert to provide you with notice of your billing practices as associated with the use of Modifier -25. In addition, EquiClaims' analysis provides you and Anthem with an estimate of the amount of improper payments that may have been made during the review period.

As mentioned above, the AOA recommends that you work proactively to perform internal reviews of Anthem claims submitted with the Modifier-25. An internal review will help to ensure that you are recognized as a physician providing quality care, and this includes submitting appropriate claims for your services. The AOA is actively working with Anthem and EquiClaim to make sure that osteopathic physicians will not unnecessarily be inconvenienced further as they seek to meet their program goal.

The AOA will continue to be a resource and provide advocacy and education on these compliance and payment issues. If you have further questions or concerns please contact the AOA Division of Compliance and Payment at (312) 202-8282.

Best Regards,

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