PUBLICATION

It's Time to Bill Medicare: Do You Know Where Your Physicians Are? [Ober|Kaler]

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The Department of Health and Human Services Office of Inspector General (OIG) recently reported that Medicare contractors overpaid physicians $33.4 million in incorrectly coded physician services between January 2010 and September 2012. OIG found that physicians billed and received payments for services performed in physician offices and/or independent clinics, but the services were actually provided in ambulatory surgery centers (ASCs) and/or hospital outpatient centers.

To understand how this might happen, it helps to understand how Medicare pays a physician for a professional service. Medicare reimburses physician services in accordance with the prospective Physician Fee Schedule (PFS). The PFS payment includes three categories: (1) practice expense, including office overhead; (2) physician work, often called work relative value units or WRVUs; and (3) malpractice insurance. When a physician bills Medicare for services performed in the physician's office, Medicare pays the physician under the PFS for the WRVUs, the physician's professional liability insurance and the overhead expense of maintaining a physical office. When a physician provides an office-based service, the service should be billed with the correct place of service (POS) code, generally a POS code 11 modifier.

The difference between a physician's reimbursement for services performed in the office and services performed in a facility is significant. Physicians are paid more for their professional services performed in their offices than those performed at hospital outpatient centers and ASCs. When a physician performs in a facility like an ASC, Medicare pays the facility, not the physician, for the facility's overhead expense. In turn, Medicare pays the physician less under the PFS because the physician did not have the overhead expense of the location of service. When a physician provides a facility-based service, the services should be billed with an appropriate modifier depending on the type of facility, for example, a POS code 22 for hospital outpatient centers or a POS code 24 for ASCs.

OIG provided the following root causes for the coding errors:

- Billing personnel were confused about the definition of “physician's office” or other non-facility locations and a general practice of applying the non-facility codes;
- Billers were unaware that the non-facility code meant larger Medicare payments;
- Isolated data entry errors; and
- Billing systems that are designed to submit all physician professional service claims with a non-facility place of service code.

OIG also determined that Medicare contractors' inadequate post-payment reviews contributed to the overpayments. In response, OIG stated that contractors need to strengthen their efforts to identify physician services at high risk for place of service coding errors and recover overpayments.

Ober|Kaler's Comments

Given OIG's focus on place of service coding, we recommend physicians educate their billing staff on proper coding methodologies and implement internal controls to identify potential coding errors before claim submission. Proper identification of the location as a facility-based or non-facility based entity is critical. OIG determined that $7.3 million of the $33.4 million represented over 100,000 services performed in ASCs; and $26.1 million represented more than 1.1 million services performed in hospital outpatient locations. This suggests that the ASC site of service reimbursement differential will draw more scrutiny on a per claim basis in the future. This is not OIG's first inquiry into place of service billing. The OIG explained that previous OIG reports (see OIG reports for 2005-2006, 2007, and 2009) concluded Medicare contractors overpaid physicians $62.7 million for incorrectly coded physician services. As such, physicians can expect continued scrutiny into place of service coding in years to come.