Dermatology Coding Alert

E/M: Make Sure Your E/M Claims Aren't Part of the 14.6% Error Rate

NPP claims are part of the problem.

Evaluation and management coding and "incident-to" billing have long been at the top of everyone's audit hit list and that still holds true. With the spotlight on these claims, you would expect practices to be extra careful with E/M coding and NPP billing. But in reality, according to the latest CERT report from CMS, error rates are climbing.

Get the scoop on the CERT findings so you can shore up your own practice's coding and billing, so you can avoid audit scrutiny and possible paybacks.

Medicare Will Want Refunds

The 2014 Medicare Fee-for-Service improper payment rate ratcheted up to 12.7 percent last year, far worse than the error rates logged in 2012 and 2013, according to the latest CERT report, which CMS released last month.

Most of the errors were discovered as overpayments meaning that CMS identified $47.6 billion that went out to Medicare providers in error, and chances are high that MACs will be asking for much of that money back, if they haven't already. In addition, CMS noted that it still owes $1.5 billion to providers who were underpaid in 2014.

To create the CERT report, CMS reviewed 50,544 claims, including Part B, Part A, and DME, according to the "Medicare Fee-for-Service 2014 Improper Payment Report." Auditors then pored over the claims to determine which had no documentation, insufficient documentation, incorrect coding, or reflected a medically unnecessary service.

Documentation: For the second year in a row, Part B practices had a significantly higher error rate than Part A providers when it came to insufficient documentation, with Part B facing a 2.1 percent error rate as compared to 0.2 percent in Part A. "This may be due, in part, to physicians' services (especially E/M services) being billed out without the documentation reviewed by coders prior to submission," says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC,** senior principal at ACE Med in Pittsburgh, Pa. "Part A documentation is usually reviewed prior to submission."

Incorrect coding: Part B providers rated the highest among incorrect coding errors, with a 0.8 percent error rate, which topped the Part A and DME rates. Not all of these errors reflected overpayments to practices in some cases, doctors actually shorted themselves by coding incorrectly.

Avoid These E/M Errors

Interested in avoiding the most common culprits that led to such a high Part B error rate? Then you should nail down your E/M claims going forward.

CMS found that providers improperly billed $4.5 billion in E/M claims, resulting in a 14.6 percent improper E/M payment rate. If you want to avoid that type of error which will most certainly result in auditors requesting refunds double-check your E/M level. "Incorrect coding and insufficient documentation caused most of the improper payments for E/M services during the 2014 report period," the CERT report states.

Often, the errors were due to practices submitting documentation that supported a different E/M level than what they originally billed. Other issues included insufficient documentation, no physician authentication or wrong place of service. "No matter how large or small a practice is, physician education around the documentation requirements should always be incorporated into the day-to-day operations," Hauptman advises. "Physicians must have relationships with their coders. If they don't have a coder, they should hire one. They should hire a coder that will read the documentation, determine the appropriate level of service, and then educate to that point. The physicians want to be able to support the

services they performed. They just need to know what is required for the documentation of those services."

For example, the CERT reviewers audited one Part B claim for code 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity ...) that described a routine follow-up for a stable patient requiring no changes in treatment or medications. The auditors were unable to find justification for 99214, and downcoded the claim, marking it as an incorrect coding error.

"This is a perfect example of how that relationship with the coder and the education of the physician are so critical," Hauptman says. "The physicians want to have confidence that the reimbursement they are getting is substantiated and will not need to be refunded."

Non-physician practitioners: The CMS auditors also found a large number of errors among E/M claims performed by non-physician practitioners. "The CERT program identified many improper payments for E/M services billed using physician's NPIs but provided solely by non-physician practitioners," the report states. "NPPs must bill under their own NPIs if they provide an E/M service (in person) for a physician's patient in hospital and the physician does not also perform (and document) a substantive part of an E/M visit face-to-face with the same beneficiary on the same date of service."

"Non-physician practitioners (NPPs), also known as mid-level providers (MLPs) or advanced practice providers (APPs), are able to perform services on their own," according to Hauptman. "Where the service is performed (hospital versus office) and the extent of the physician's involvement will determine how the service can be billed (MD NPI vs. MLP NPI). These rules must be strictly adhered to in order to capture the appropriate reimbursement for services rendered."

Keep in mind, when an NPP/MLP/APP sees an established patient with an established problem and your physician is in the same office/clinic/suite when the patient is being seen, those are the services that can be billed under your physician. "If the visit is different, then more often than not, the service should be billed using the NPI of the MLP," Hauptman says.

"Shared visits in the hospital setting mean exactly that; the service must be shared," she adds. "Both the physician and the MLP will see the patient and both will document their activity. Additionally, the physician will link to the MLP note in order for the service to be billed under the physician."

To read the complete CERT results, visit http://go.cms.gov/1KlJOas.