Part B Insider (Multispecialty) Coding Alert

Audits: NGS Medicare: "TMI" Does Not Apply to Documentation

Additional notes can be helpful, this MAC's reps say.

If a claims reviewer asks to audit your documentation, send them everything you have for the date of service in question and don't hold anything back.

That was the word from NGS Medicare's **Gail O'Leary** during the Sept. 8 NGS Medicare webinar, Medicare Audit Process. "You've all heard that acronym 'TMI'□well that doesn't apply here, unless of course you send in claim information for dates of service that were not requested," she said. If an auditor asks for all services for a patient on a particular date of service, don't just send one or two line items□send in the documentation for every service you performed that day for that patient, she said.

In addition to that advice, NGS Medicare reps also passed along detailed information about Medicare audits. Read on to find out everything you need to know about potential audits that could impact your practice.

Know the Audit Types

To reduce Medicare errors, the government has put several different audit programs in place, and you should get to know the various audit methods, as follows:

CERT (Comprehensive Error Rate Testing): CMS developed the CERT program to determine national contractor-specific provider compliance error rates, paid claims error rates and claims processing error rates, O'Leary said during the call. "This program creates a way for CMS to ensure that Medicare claims are paid correctly and accurately by consistently reducing the number of errors made in claims processing."

How it works: CERT contractors randomly select a sample of paid or denied claims from all Medicare contractors, then request medical records from the billing and ordering provider via letter, phone or fax, O'Leary said. The CERT reviewer then looks over the claims and compares them against medical records to see whether the documentation supports all of the services on the bill.

Common issues that CERT contractors often see include claims missing signatures and those with illegible signatures, O'Leary said. Other typical problems include missing and incomplete documentation.

RA (Recovery Audit): "The RA review process is similar to CERT, but first they go to CMS with the issues they want to review," O'Leary said. "CMS approves those issues, and then the RA contractor requests the claims or medical documentation to review." There are two types of review: automated (in which just your claims are reviewed), or complex (when the contractor reviews your medical records as well as the claims), she added.

If the RA finds an issue, it sends the MAC an electronic file with the findings, which the MAC then processes via claims adjustments. Once you get a remittance advice alerting you of an adjustment, you'll subsequently get a demand letter asking for money back if applicable. If you disagree with the adjustment, you can appeal immediately, O'Leary said.

The Contractor Medical Review Program: "The primary goal of medical review is to reduce the Medicare payment error rate," O'Leary said about MACs' ability to audit your claims. "They analyze data to identify claims submission

patterns or trends that may indicate a problem. They perform reviews of services billed to Medicare to validate a problem exists, and they calculate a payment claims error rate. They take corrective action and partner with a provider education and outreach department to educate providers on appropriate documentation processes."

These types of audits can take place as pre-payment reviews (in which your claim is held before the contractor will reimburse you for the claim) or post-payment (when the audit happens after you've already been paid by the MAC).

NGS Found These E/M Errors

If your MAC is performing pre-payment reviews on a specific service, the contractor will usually announce it on the MAC's website, said NGS's **Lori Langevin** during the call. For example, NGS Medicare recently performed pre-payment reviews for initial hospital visit code 99223 (Initial hospital care**,** per day, for the evaluation and management of a patient...) and subsequent hospital visit code 99233 (Subsequent hospital care**,** per day, for the evaluation and management of a patient...). "And we're also looking at 99215 (Office or other outpatient visit for the evaluation and management of an established patient...) for all specialties for all of Jurisdiction K," she added.

NGS is reviewing records to ensure that claims billed with these codes are supported by the documentation that the providers submit. When NGS Medicare reviewed code 99223 in January, 73.3 percent of the claims reviewed were reduced or denied after the documentation was compared to the codes billed. This means that the majority of claims were found to be coded in error, Langevin said.

The results for 99233 were not much better, she added, with 74.8 percent of claims reviewed being reduced or denied by NGS. In many cases, auditors recorded the claims as upcodes due to missing documentation, duplicate services, no record of the performing physician or missing medical necessity on the claims.

When it came to 99215, NGS reduced or denied 70.4 percent of the claims it reviewed in January, with most denied due to "illegible documentation, missing and/or incomplete documentation, no exam or history and no content of counseling," she added. "We also found the rendering physician submitted on the claim was often not the physician who actually rendered the service according to the documentation. Physicians who practice in a group are to bill their services using the proper rendering physician number," she added. Many claims were even missing patient names and dates of birth or other identifying information about the beneficiary.

Take These Steps If You're Audited

If you're subject to a pre-payment audit by your MAC, take the following steps to ensure that you're successful and that the audit goes smoothly, Langevin said:

- Submit the documentation in a timely manner, typically within 45 days
- Review all local coverage decisions (LCDs) applicable to your services
- Know the Medicare coverage requirements
- Ensure that your office staff and billing vendors are familiar with claim filing requirements
- Perform self-audits of medical records against billed claims using coverage criteria, LCDs and coding guidelines to ensure you've coded correctly
- Ensure that your documentation is legible and demonstrates that the patient's condition warrants the services you've reported and billed
- Confirm that your documentation includes the reason for the encounter, relevant history, physical examination findings and prior test results, as well as the diagnosis, plan of care, date of service and a legible provider signature

"You can also include an abbreviation key for anything that you think we may not understand when reviewing your claim," Langevin added. For instance, if one of your practice's physicians traditionally writes "AODM" to refer to adult-

onset diabetes mellitus and another doctor in the same practice writes "T2DM" for Type II diabetes mellitus, include an abbreviation key showing how each physician at your office writes these conditions so the reviewer will understand the doctors' notes.