Part B Insider (Multispecialty) Coding Alert

Coding Errors: CERT Data Highlights Providers' Struggles with E/M Services

Tip: Boost your code choice with strong notes.

It's no surprise that practices struggle with properly documenting and coding E/M services. After all, these popular codes are the foundation of many providers' Medicare pay. But some codes pose more of a challenge than others, and the latest Comprehensive Error Rate Testing (CERT) numbers may come as a shock.

Background: In coordination with the CERT program, the Centers for Medicare & Medicaid Services (CMS) recently issued the report, "2019 Medicare Fee-for-Service Supplemental Improper Payment Data." The brief highlights the most prevalent errors in the different parts of Medicare, including the biggest E/M coding issues.

See What's at the Heart of E/M Services' Issues

The three codes at the top of the E/M services improper payments' list have one thing in common - high error rates caused by incorrect coding - indicate the statistics from Table K1 of the CERT report. All three were also in the top five in 2018 and are fixtures on most Medicare carriers' Targeted Probe & Educate hot topics' lists.

Read on for code specifics and tips to improve your E/M service coding in 2020.

1. 99223 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity ...) remained in the top spot for a second year in a row, making the biggest impact under E/M services. It accounted for $433 million in improper payments with an improper payment rate of 24.1 percent and a 1.5 percent impact overall on improper payments. In 2019, incorrect coding ranked as the main issue for this confusing CPT® code with 79.9 percent of claims falling into that error category while insufficient documentation was a secondary problem for providers with a 17.6 percent error rate.

Tip: Remember, you use this code to report the first hospital inpatient encounter with a Medicare patient, and the admitting physician appends the AI modifier (Principal physician of record) to indicate the services provided are distinct from other providers who may furnish specialty care.

Plus, you can only report a code from the 99221-99223 range once per day for physicians of the same group/specialty; however, you can add up the documentation for the day to determine the best level of service based on the collective documentation from the physicians of the same group/specialty who saw the patient.

If physicians of different groups/specialties are consulted, they would also report codes from the 99221-99223 range as Medicare no longer recognizes consultation codes. But remember, these services would be reported without the AI modifier. As with the other E/M codes, you will decide the appropriate level of the initial hospital care code based upon history, examination, and medical decision making.

2. 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 ...) took the second spot in 2019 with an error rate of 5 percent and an overall impact of 1.4 percent on improper payments. This popular E/M office visit code was improperly paid to the tune of $423 million - up from $389 million in 2018. Plus, 99214 increased in two error categories: The oft-used CPT® code lacked sufficient documentation in 28.4 percent of the claims and was incorrectly coded 66.8 percent of the time.

See How CERT Stats Affect Your Practice

Whether your notes, coding, and compliance policies are spot on or your Medicare claims could use a little help, it is a good idea to review the annual Comprehensive Error Rate Testing (CERT) data.

Why? The Centers for Medicare & Medicaid Services (CMS) uses the information garnered from the CERT program in three different ways. First, it utilizes providers' data to "protect the Medicare Trust Fund by identifying errors and assessing error rates, at both the national and regional levels," indicates Part B Medicare Administrative Contractor (MAC) CGS Medicare in its CERT guidance.

Second, the government tracks error trends amongst certain provider types, codes, and services through the CERT program. These findings help CMS pinpoint problem areas that are perennially an issue and ratchet up the improper payment rate, costing taxpayers billions. The agency then uses this valuable information to rein in outliers, rectify issues, and promote program integrity, CGS suggests.

Lastly, CMS uses the information garnered from the report to measure how MACs are doing. The CERT data helps to determine regional programming and education, including tools like the Targeted Probe & Educate (TPE) program and Comparative Billing Reports (CBRs) in a jurisdiction.

Tip: If you're constantly reporting the same E/M code - such as 99214 - for every E/M encounter performed, then you're inviting trouble. In fact, as the feds crack down on incorrect coding, you could end up facing an unnecessary audit and other problems for reporting the same E/M code for every E/M encounter.

Even though you might find that most of your E/M encounters point toward a specific code, you shouldn't automatically fall back on that same code each time your physician performs an E/M service. Instead of just blindly reaching for the most convenient E/M code, look through the patient's documentation, properly account for all the components of the E/M service, and then arrive at the proper code for the encounter.

"It would be a very rare situation in which the history, exam, and medical decision making of every patient seen by a physician led to the same E/M code," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "A review of the documentation should generally reveal some variation in the level of service provided to different patients."

Though you might have to spend more time in identifying the appropriate code for the encounter, you will save your practice precious time and money in the long run by avoiding the risk of a visit from a Medicare claims auditor.

3. 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...) jumped up to the third most improperly paid E/M code in 2019 with an error rate of 6.9 percent, an overall 1.2 percent impact to improper payments, and more than $366 million in improper payments. Surprisingly, more than 81 percent of 99213's improper charges were attributed to incorrect coding in 2019, a dramatic increase from 2018's rate of 64.3 percent.

Tip: Lackluster notes factors heavily into 99213 snafus, too, with 18.6 percent of the mid-level E/M service claims in error due to insufficient documentation. And that's why you should check through patient documentation to see if the clinician has captured all the pertinent components of history, examination, and medical decision making before you submit your Medicare claims.

If the physician fails to properly document any of the components, you might have to report a lower level of E/M service even though the provider actually performed a higher level. "As the old adage goes, 'If it wasn't documented, it didn't happen,'" Moore notes.

Resource: Review the rest of the errors CMS discovered in 2019 claims at www.cms.gov/files/document/2019-medicare-fee-service-supplemental-improper-payment-data.pdf.

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