Part B Insider (Multispecialty) Coding Alert

Compliance: CMS: Initial Hospital Visit Claims Riddled With Errors

The agency also points to 99214 as a sore spot.

Nobody likes to be told that they're coding incorrectly, but when CMS talks, it's time to listen. The agency found billions of dollars paid to Part B practices in error over the last year, and you could be forced to send your MAC a refund if you're one of the offenders. Read on for tips on how to avoid the most common errors that CMS uncovered during its latest audit.

Documentation Sorely Lacking

CMS's new Comprehensive Error Rate Testing (CERT) results, which were released on Dec. 15, show that practices made more errors in 2014 (with a national average error rate of 12.1 percent) than in the previous year (2013's error rate was 10.1 percent). The biggest offenders in CMS's eyes were chiropractors, social workers, independent labs, intensivists, private practice physical and occupational therapists, allergists, psychologists, psychiatrists and neurologists, all logging error rates above 18 percent.

Avoid These Common Mistakes

You can read the 73-page CERT report on the CMS website, but we've compiled the most common incorrectly-billed services that Part B practices perform, along with tips on how to fix these issues going forward.

Inpatient Hospital Visits: CMS found a startling 31.3 percent error rate among inpatient hospital visit codes, which most frequently stemmed from incorrect coding issues. In fact, the report notes, initial hospital care claims are upcoded 20.8 percent of the time.

Tip: Many coders believe they can bill for initial inpatient care (99221-99223) just because the doctor performed a face-to-face visit with the patient in the hospital on the day he was admitted. But if he has already been admitted by another provider (his attending physician), you should instead select a subsequent hospital care code (99231-99233).

Minor Musculoskeletal Procedures: This category logged a 10.2 percent error rate, with the vast majority (97.9 percent) of the claims paid in error having issues with insufficient documentation.

Tip: CPT® includes dozens of minor musculoskeletal procedure codes, but we'll use 20550 (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar "fascia"]) as an example of a common one. Many practices report multiple units of this code because the physicians administer the injections bilaterally or in multiple sites, often for trigger fingers but failing an important step could mean you won't collect for the service due to insufficient documentation. It's important for the provider to specify which joints he injected, both in the documentation and on the CMS-1500 form. You can report this in box 19 of the claim form to let the payer know the joints in question.

Chiropractic Visits: CMS's highest error rate of all was seen for chiropractic services, which logged a startling 54.1 percent error rate, costing the Medicare program over $300 million.

Tip: Most of the chiropractic errors were the victims of insufficient documentation, which means that providers failed to complete their notes thoroughly enough to justify the services. Medicare only covers "manual manipulation of the spine to correct a subluxation, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function," CMS says in its Chiropractic Services Booklet. Therefore, your documentation should include all of this information to support the manipulation codes.

Major Joint Replacements: Arthroplasty for major joints was the source of over $236 million in improperly paid claims due to insufficient documentation, the CERT report noted.

Tip: This issue has been on the minds of CMS for a while now—when the agency issued a related MLN Matters article in 2012, CMS made clear that cursory rationales for surgery wouldn't pass muster. Bolding for emphasis words including "detailed" and "progress notes," CMS stressed that physicians should steer clear of "[notes] consisting of only conclusive statements."

Open to denial, for example, might be a justification that said simply, "Mrs. Smith is a female, age 70, with chronic right knee pain. She states she is unable to walk without pain and pain meds do not work. Therefore, she needs a total right knee replacement." When it comes to documenting medical necessity in the physician record, evidence of failed prior conservative treatments is a must. A simplistic statement such as "bone on bone" definitely won't fly. Rather, tell each patient's clinical story in detail, including relevant clinical diagnoses and observations ("end-stage osteoarthritis of the right knee"), progress over time ("worsened over the past ten years, NSAIDs began to cause gastric distress in December 2014, no functional improvement with physical therapy").

Subsequent Hospital Visits: Practices left $18.5 million on the table last year thanks to downcoded claims for subsequent hospital visits, the report noted.

Tip: If your practice repeatedly reports the same subsequent hospital care code, you should perform a chart review to ensure you're accurately coding the visits. Take a random sampling of charts where you reported 99231, and on each file you should determine the history, exam and medical decision-making levels and identify whether they actually met the requirements for a 99232 or 99233. If so, educate the providers on how to properly code these claims so they don't lose money.

Hip Replacements: A 3.2 percent error rate was logged for hip replacement surgeries, which cost the Medicare program $8.6 million.

Tip: Make sure that your physicians and coders know the differences in coding between primary partial hip replacements (27125), primary arthroplasties (27130), conversions (27132), revision surgeries (27134-27138), prosthesis removal (27090-27091), and any other services in this very complex section of CPT®. Confusing just one term for another could be all it takes to incorrectly report these high-paying procedures.

E/M Visits Among 'Problem Codes'

CMS also honed in on several "problem codes" that the agency identified, including subsequent hospital care code 99233 (which has a 58.3 percent error rate) and established office visit code 99214 (which has an error rate of 14.5 percent).

As for problematic diagnoses, CMS found that 34 percent of claims for osteopathies, chrondropathies and acquired musculoskeletal deformities had errors, while 32 percent of claims for metabolic and immunity disorders were billed with errors. Other diagnoses with a significant number of issues were heart disease, arthropathies, endocrine diseases, eye disorders, dorsopathies, hypertensive disease and patients presenting for "specific procedures and aftercare," the report indicated.

Going forward, you should be sure to double-check your documentation for these services and diagnoses, and if any glaring errors stand out, set up an educational session at your practice where everyone can catch up on their coding skills.

Resource: To read the complete report, visit www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2014ImproperPaymentsReport.pdf.