Part B Insider (Multispecialty) Coding Alert

Compliance: Practices Short Themselves Out of $342 Million, Downcoded E/M Visits to Blame

Documentation woes continue to be a major problem for practices, CERT results reveal.

Though upcoding errors still top the OIG's hit list, it can be easy to forget that downcoding is a problem for many practices as well. And the latest CMS Comprehensive Error Rate Testing (CERT) results show that medical practitioners left over $1.2 billion on the table by undercoding claims in 2016.

Downcoding blunders. CMS's latest CERT results, which were released last month, show that practices forfeited $342.2 million alone just by downcoding established patient office visits (99211-99215). If you're downcoding your office visits, you're not only abandoning money you've earned, but you're also coding incorrectly since your documentation must support the level of service you've chosen to bill.

Subsequent hospital visits, major bowel procedures, coronary bypasses without cardiac, and coma issues were amongst the other most commonly downcoded services. In total, practices forfeited $1.11 billion last year thanks to downcoding errors, a slight decrease from the 2015 total of $1.17 billion.

Tip: To avoid this issue, always determine the criteria for the service you've provided, and then select the most accurate code based on the documentation. As long as your records support the code, you shouldn't be worried about sometimes billing a higher code than you're accustomed to reporting.

Part B Works Both Sides of the Claims Game

Overall, Part B practices had $10.9 billion in improper payments last year, due to both undercoding and overcoding. Amongst the biggest culprits were lab tests, which logged a 35.5 percent error rate and a staggering $1.29 billion—the highest in the Part B improper payments category—and chiropractic visits, which were billed improperly a whopping 46.0 percent of the time. The others that rounded out the top five were: echography/ultrasonography, which stood at a 32.0 percent error rate; initial hospital visits, which saw a 29.6 percent error rate; and psychiatry services, which had a 25.0 percent error rate.

Documentation: Documentation woes continued to be the proverbial thorn in Medicare's side. The majority of the errors that CMS found involved insufficient documentation, which comprised 65.2 percent of the incorrect payments. The next most common issues were medical necessity errors (19.8 percent), incorrect coding (10.2 percent) and no documentation (1.3 percent).

How Do the States Stack Up?

Some states fared better than others this year with the leader—California—leading the U.S. with an improper payment rate of 13.6 percent, which was approximately 11.5 percent of the overall improper payment rate. Texas followed with an improper payment rate of 17.5 percent, and Florida and Pennsylvania tied for the third spot at 12.9 percent. Though it should be noted that Florida impacted the overall improper payment rate at a higher percentage of 8.2 percent of total improper payments than Pennsylvania, who was at 5.3 percent.

All parties represented. The outcome held few surprises with DMEPOS sliding into first place with a 46.3 percent error rate while Part A (without hospital IPPS) came in second at 14.0 percent. Part B rounded out the trio with 11.7 percent error rate with a grand total of approximately $10.9 billion in improper payments with the overall improper payments across all four claims types (including Medicare Part A hospital with IPPS) equaling $41.1 billion.

Of note: With the improper payment rate hitting its peak at 13.6 percent in 2014, the CERT results show that there's been a slight decline over the past two years with the improper payment rate currently at 11.2 percent overall.

To view the CERT results, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf.