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Part B Insider (Multispecialty) Coding Alert

E/M Coding: Incorrect E/M Coding Is A $6.7 Billion Per Year Problem, OIG Says

These 5 tips ensure that you select the right E/M code.

What's $30 in miscoded claims, you ask? It could amount to big bucks over time—nearly $7 billion annually just on incorrectly-coded E/M claims, the OIG says in a new report.

The government is always on the hunt for ways to save money in the Medicare and Medicaid programs, and that often leads to time-consuming audits of your practice's billing habits. But when the OIG finds a $6.7 billion cause of financial wastage, you can bet that they'll be scrutinizing those types of claims in particular. Such is the case with E/M coding, which the OIG recently identified as a massive drain on the government's payment structure—and this means that your payers will be looking carefully at how accurately you code your E/M claims.

According to recent audit results published in the report "Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010," published on May 29, 55 percent of E/M claims were incorrectly coded during 2010, resulting in $6.7 billion in improper Medicare payments.

The OIG doesn't intend to take the audit results lightly. "We recommended three things to CMS," said the OIG's **Rachel Bessette** in a May 29 podcast on this topic. "First, educate physicians on coding and documentation requirements for E/M services. Second, continue to encourage contractors to review E/M billing by high-coding physicians. Finally, follow up on claims for E/M services that Medicare paid in error." Therefore, you're likely to see an uptick in E/M scrutiny based on these findings.

Following are the biggest issues that the OIG found with documentation, and tips on how you can improve those areas.

1. Upcoded Claims Comprised 26 Percent of the Errors. If you insist that all of your patients are complex cases and therefore deserve 99215s, check the documentation again and make sure you're right. The code that you select is typically driven by the medical necessity of the visit, but the required elements of the visit still need to be documented, or you can't bill.

Remember: If you don't have the history, exam and medical decision-making to support a particular code, you may be able to bill based on time if you meet the criteria. The doctor will need to document the total time spent, as well as the time spent counseling/coordinating care (which should make up 50 percent or more of the visit), and what was discussed.

2. Practices Downcoded 15 Percent of Claims. Just as you don't want to report a higher code than warranted, you also shouldn't ever sell yourself short when reporting E/M visits.

In the example of our patient above who has COPD, diabetes and asthma, the doctor might evaluate all three conditions but still mark 99203 for the visit, even if his documentation supports 99205. There is almost a $100 difference between the payment amounts for these two codes, so if you make this mistake 20 times a month, you just cost your practice $24,000 a year just for that simple error.

Best practice: Educate all practitioners about how to document thoroughly and select the most accurate code based on that documentation.

3. Insufficient Documentation Was Seen in 12 Percent of Claims. If a payer asks for your documentation and you only send part of it, or if it's illegible, you'll be accused of having insufficient documentation. You can also be subject to a

charge of insufficient documentation if you're missing a crucial element.

"For example, the level of the E/M service for one insufficiently documented claim in our sample was based on counseling and/or coordination of care," the OIG said in its report. "However, only the length of time of the encounter was documented in the medical record. The medical record contained no description of the counseling and/or activities to coordinate care."

4. Seven Percent of Claims Had No Documentation. You probably have some type of documentation for every patient visit, but if your insurer requests it and you don't send it, then you'll be counted as having no documentation at all. If you're subject to a documentation request, send the complete file immediately to ensure that you don't fall into the "no documentation" category.

5. Billing the Wrong Code Occurred 2 Percent of the Time. Have you ever performed a vaccination and erroneously reported an E/M code instead of the immunization code? This is an example of billing the wrong code, which the OIG found happened in two percent of cases.

"These errors included wrong codes (i.e., when the documentation in the medical record supported codes for non-E/M services)□and unbundling (i.e. the practice of inappropriately reporting each component of a service or procedure instead of reporting the single, comprehensive code)," the OIG said. "For example, one claim in our sample contained documentation that supported a procedure but not a significant, separately identifiable E/M service."

Remember that E/M services aren't automatically billable every time you see a patient□the documentation must support the need for the evaluation and management visit, as well as the code that you report.

Resource: To read the complete OIG report, visit http://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf.