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Part B Insider (Multispecialty) Coding Alert

E/M Coding: NGS Medicare: Majority of 99215 Claims Were Coded in Error

Use our expert tips to avoid the issues that plagued high-level claims.

When payers announce that they're planning to run pre-payment reviews, many practices never find out what results were gleaned from the audits. In the case of Part B payer NGS Medicare, however, several recent audits have become an open book and the results were startling.

NGS performed a pre-payment review on code 99215 (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 comprehensive history; A comprehensive examination; Medical decision making of high complexity) for claims submitted between October and December of 2015, and this week, the payer revealed that over 65 percent of the claims for this code were reduced or denied during the study period.

NGS noted that it reduced or denied these claims for these key reasons, which are followed by the Insider's analysis of how to fix these issues:

- **Medical decision-making did not support the level of service billed**.

  The Insider's tip: To report 99215, you need to have at least two of the following: comprehensive history, comprehensive exam, and/or high complexity medical decision-making (MDM). If you are using MDM as one of your two components, you must ensure the provider meets high complexity. You need to meet or exceed two of the three elements to choose that MDM level. So, if the clinician documents that he saw a new problem with additional workup scheduled and high risk of complication, but only a moderate amount of data to be reviewed, you meet two of the three requirements for high MDM, which is sufficient. Remember that medical necessity does not equal MDM. Regardless of the history, exam and MDM levels, the medical necessity for the encounter must support billing a level five code.

- **Illegible documentation.**

  The Insider's tip: While it might seem like a stereotype to say that many clinicians have handwriting that's difficult to read, but payers don't have much patience for it. "When determining the medical necessity of an item or service billed, Medicare's review contractors must rely on the medical documentation submitted by the provider in support of a given claim," CMS says in MLN Matters article SE1237. "Therefore, legibility of clinical notes and other supporting documentation is critical to avoid Medicare FFS [fee-for-service] claim payment denials." If your physician's documentation is difficult to read, you should consider employing a dictation system.

- **Missing and/or incomplete documentation (i.e., no exam or history, no content of counseling)**.

  The Insider's tip: Medicare pays nearly $150 when you report 99215, so payers are not very flexible in letting you off the hook if your notes don't support the code. For example, if you bill based on time and you remember to document the time spent on counseling or coordination of care and what you discussed, but you forget to document the total time of the visit, you could face recoupments on audit.

- **The rendering physician submitted on the claim was not the physician who actually rendered the service according to the submitted documentation.**

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The Insider's tip: Providers that practice in a group should report their services using the proper rendering physician number if you use your partner's NPI instead of your own, then you risk problems down the line when it looks like he performed the service even though you signed the documentation.

- **No response to request for documentation.**

  The Insider's tip: When a MAC, recovery audit contractor (RAC) or other entity requests your medical documentation in support of your claims, that entity will give you a timeline of when to submit the records. Always send in your documentation by the prescribed deadline to avoid recoupments.

- **Missing or illegible provider signature on documentation.**

  The Insider's tip: Medicare requires that services provided/ordered be authenticated by the billing physician for medical review purposes, and it typically has to be a hand written or an electronic signature. "Stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of an inability to sign due to a disability," CMS says in the MLN Matters booklet Complying with Medicare Signature Requirements. "If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record," the agency advises.

- **The documentation lacked the beneficiary identification**

  The Insider's tip: Even if the patient's insurance hasn't changed, sometimes his or her address, last name or phone number can change. Therefore, it's important to get a copy of the insurance card at every visit or at least compare the card to your copy of it and verify that nothing has changed. You should copy the card at least once a year. Then double-check the beneficiary information that you enter on the claim and ensure that everything is correct so that the claim will process quickly.

- **Duplicate services/claims were submitted.**

  The Insider's tip: If your claim seems to be taking a long time in processing, don't simply resubmit it both claims could be denied as duplicate services. Instead, contact your MAC to find out the cause of the delay. If you legitimately performed the same service twice on the same date, use modifiers such as 76 (Repeat procedure or service by same physician or other qualified health care professional) or 77 (Repeat procedure or service by another physician or other qualified health care professional) to show the payer that you meant to bill the service twice.

Resource: To read NGS's complete prepayment audit results for 99215, visit www.ngsmedicare.com.

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