

## Part B Insider (Multispecialty) Coding Alert

### Medicare Errors: New Data Highlights Part B Providers' Issues with E/M Claims

#### Downcoded claims account for a billion in missed opportunities.

Put correct coding first on your 2018 practice to-do list, new data suggests. CMS found billions of dollars paid 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 the agency uncovered during its latest audit.

#### Watch Your Documentation, Findings Suggest

CMS's new Comprehensive Error Rate Testing (CERT) results, which were released on Jan. 8, show that practices made fewer errors in 2017 (with a national average error rate of 9.5 percent) than in the previous year (2016's error rate was 11.0 percent). This was the third year in a row with a decline in the overall improper payment rate. Despite the decrease in the improper payment rate, projections were still fairly high with the total improper payments at around \$36.2 billion for 2017.

According to the CERT data, 36.8 percent of Part B providers claims had "multiple universal errors" related to insufficient documentation. Missing or inadequate records accounted for 35.4 percent of improper Part B payments.

The biggest offenders in CMS's eyes were chiropractors, claiming the top spot again this year with 41.7 percent error rate while independent labs came in second with a 29.0 percent improper payment rate, Table J1 of the CERT report noted. Pain management specialists, physical medicine and rehabilitation providers, and psychiatrists rounded out the top five, all logging error rates above 20 percent.

**Reminder:** "If the medical record does not support the service(s) billed, CMS can certainly recoup the funds paid to the provider," explains attorney **John E. Morrone**, a partner at Frier Levitt Attorneys at Law in New York.

#### Avoid These Common Mistakes

You can read the 85-page CERT report on the CMS website, but we've compiled the most common incorrectly-billed services that Medicare providers perform, along with guidance on how to fix these issues going forward.

**Inpatient Hospital Visits:** CMS found a 19.4 percent error rate among inpatient hospital visit codes due to incorrect coding. In fact, the report notes, initial hospital care claims are upcoded 19.2 percent of the time with projected improper payments at over \$564 million.

**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).

**Downcoding:** Practices shorted themselves a whopping \$1.05 billion in 2017 because of downcoded claims. Office visits for established patients (99211-99215) were among the most commonly abused, registering over \$203 million in improper payments and lost revenue for Medicare providers due to downcoding.

**Tip:** A pediatrician diagnoses a newborn patient with K21.9 (Gastro-esophageal reflux disease without esophagitis) and bills a level-two E/M encounter because "it only took me five minutes to figure out what was going on." Coding this way, based simply on the time spent deliberating, is another mistake, according to **Jan Blanchard, CPC, CPMA**, pediatric solutions consultant at Vermont-based PCC.

"While it may be true the diagnosis only took five minutes, the experience behind the thinking, questioning, and certainty for the diagnosis, and the time spent reassuring that new parent and explaining the course of care are also at play there," she says.

Instead, Blanchard argues, you should base your E/M coding either on the information gathered, the diagnosis, and the decision made, or on time if more than 50 percent of the encounter was spent in counseling the patient or parent and the coordination of care.

### **Consider These E/M Visit Issues**

Several evaluation and management (E/M) codes were identified by the agency as error issues. The two at the top included subsequent hospital care code 99233 (Subsequent hospital care, per day, for the evaluation and management of a patient ...), which had a 13.3 percent error rate with over \$242 million in improper payments and emergency visit code 99285 (Emergency department visit for the evaluation and management of a patient, which requires these 3 key components ...), which had an error rate of 12.4 percent with over \$199 million in improper payments.

**Tip:** Improperly coding the higher level ER code 99285 has been an issue and was recently covered by MAC Palmetto GBA in a recent Comparative Billing Report (CBR).

See Palmetto GBA's report at: [www.cbrinfo.net/cbr201709](http://www.cbrinfo.net/cbr201709).

**Endnote:** Going forward, it's always a good idea to review CMS and MAC requirements and guidance, double-check documentation for services and diagnoses on the CERT hot list - and if any glaring errors stand out, set up an educational session at your practice where everyone can catch up on their coding skills and Medicare Part B updates.

**Resource:** For a closer look at the most recent CERT data, visit [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf).