TIPS FROM OUR CONSULTANT

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ARE YOU MAKING THESE MISTAKES?

Lord Harold Samuel, a real estate tycoon in Britain, coined the expression: 'There are three things that matter in property: *location, location, location*.' The three things that matter in a payer audit are *documentation, documentation, documentation.*

Part 1 of this article discusses physician payment errors. Part 2 (in the next issue) will discuss how physicians' documentation affects the payments to other providers, facilities, suppliers, etc.

The Comprehensive Error Rate Testing Program (CERT) was created to calculate the Medicare fee-for-service (FFS) program improper payment rate. The CERT program considers any payment that should not have been made or that was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment.

It is important to note that the improper payment rate **does not measure fraud**. It estimates the payments that did not meet Medicare coverage, coding and billing rules.

2013 Improper Payments Report

The glass is more than half full! According to the Medicare Fee-For-Service 2013 Improper Payments Report, the estimated 2013 Medicare fee-for-service (FFS) compliance rate – the percentage of Medicare dollars paid correctly – was 89.9 percent. According to the report, based on claims submitted during the 12-month period from July 2011 through June 2012, Medicare paid an estimated $321.4 billion correctly for the claims submitted during the sampled timeframe.

If my math is correct, it also means that the percentage of Medicare dollars paid incorrectly was 10.1 percent. Extrapolated, this means that Medicare paid an estimated **$36.0 billion incorrectly** between July 2011 and June 2012.

The most common cause of improper payments during the 2013 report period (accounting for 56.8 percent of total improper payments) was **lack of documentation** to support the services or supplies billed to Medicare.

The complete report is available on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/MedicareFee-for-Service2013ImproperPaymentsReport.pdf

Methodology

After the CERT program identifies a claim as part of the sample, it requests the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim via letter. CERT makes phone calls to validate the provider's or supplier's contact information and to address their questions or concerns about the request. The CERT program sends at least three subsequent letters if the provider or supplier fails to respond to the initial request.

For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), in addition to the initial request sent to the billing provider and supplier, **the referring provider** who ordered the item or service also receives a request for documentation. This is done because sometimes the referring provider **maintains the documentation to support the medical necessity** of the services billed.

Since physicians drive the care of the patient, your documentation **also affects payments** to hospitals, home health agencies, durable medical equipment suppliers, etc. This will be covered in Part 2 of this article (in the next issue).

For Part B claims (excluding claims submitted by suppliers of Durable Medical Equipment, Prosthetic, Orthotic, and Supplies *[DMEPOS]*), the sample included 17,130 claims.

Error Categories

The CERT's medical review professionals, including nurses, medical doctors, and certified coders, reviews the claim and submits documentation to make a determination of whether the claim was paid or denied appropriately.

Before reviewing documentation, the CERT program examines the CMS claims systems to check for (1) Medicare beneficiary eligibility, (2) duplicate claims, and (3) Medicare as the primary insurer.

When performing claim reviews, the CERT program checks for compliance with Medicare statutes and regulations, billing instructions, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and provisions in CMS instructional manuals.

Once an improper payment is identified, the reason for the improper payment determines the error category for the claim. There are **five major error categories**.

No Documentation
Claims are placed into this category when either the provider or supplier fails to respond to repeated requests for the medical records or the provider or supplier responds that they do not have the requested documentation.

Insufficient Documentation
Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the CERT contractor reviewers could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary.

Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a *physician signature on an order*, or a form that is required to be completed in its entirety.

Medical Necessity
Claims are placed into this category when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies.

Incorrect Coding
Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.

Other
Claims are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service).

Results for 2013

The table below outlines the improper payment rate and projected improper payment amount by claim type for FY 2013. The reporting period for this improper payment rate is July 1, 2011-June 30, 2012.

Service Type	**Improper Payment Rate**	**Improper Payment Amount**
Inpatient Hospitals	8.0%	$9.4B
Durable Medical Equipment	58.2%	$5.7B
Physician/Lab/Ambulance	**10.5%**	**$9.5B**
Non-Inpatient Hospital Facilities	8.2%	$11.4B
Overall	10.1%	$36.0B

2013 Improper Payment Rates and Improper Payments by Provider Type: Part B

Provider Types Billed to Part B	Improper Payment Rate	Number of Claims in Sample	Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Family Practice	13.7%	946	1.5%	59.5%	0.4%	36.0%	2.6%
Hematology/Oncology	3.6%	420	3.8%	59.6%	5.5%	31.0%	0.0%
Internal Medicine	15.3%	1,940	4.1%	53.4%	1.7%	40.4%	0.5%
Nephrology	9.5%	297	0.8%	65.4%	0.0%	33.8%	0.0%
Neurology	12.4%	193	0.0%	52.2%	0.0%	47.2%	0.7%
Nurse Practitioner	7.7%	331	8.1%	46.4%	2.5%	42.6%	0.3%
Obstetrics/Gynecology	11.0%	71	0.6%	18.6%	0.0%	80.7%	0.0%
Orthopedic Surgery	10.0%	327	0.0%	54.8%	9.3%	25.0%	10.8%
Physician Assistant	12.1%	218	0.0%	55.7%	0.0%	44.3%	0.0%
Psychiatry	22.1%	257	0.0%	69.9%	0.0%	30.1%	0.0%
Pulmonary Disease	18.1%	288	0.4%	61.3%	0.0%	38.3%	0.0%
Urology	7.5%	259	0.3%	68.6%	0.7%	30.3%	0.0%

CERT Error Examples

WPS (Wisconsin Physician Services), the J8 Medicare Administrative Contractor (MAC) includes great information related to the CERT findings for J8 (Indiana and Michigan) physicians and other qualified health care professionals (new term for NPs, PAs, CNS, etc.). By using this data, physicians can perform self-audits to ensure the practice is not making the same mistakes.

WPS posts specialty specific CERT error examples for various specialties. The most recent CERT information includes the following examples for family practice (specialty 08).

Insufficient Documentation

Note the biggest problem in this section continues to be lack of signature. Sad to think that a large portion of the 59.5% error rate for family physicians could be resolved if the physicians would simply sign progress notes, procedure reports, test orders, etc. Once a missing signature is identified, the documentation is not further reviewed to determine whether other errors are present.

- Billed *CPT* 99215-25
  Missing a valid provider signature to support office encounter. CERT received typed office visit with unacceptable co-signature by an unknown person. Follow-up request returned duplicate invalid co-signed note. No response to request for physician signature attestation statement.

- Billed *CPT* 99222 and 99233
  Missing the signature of the physician who provided services inpatient services for billed dates. Submitted were notes for date of service, unsigned and with no history or physical exam. Requested valid signed progress notes; and received a note dated stating, "Not a patient at this facility," another note stating, "patient was hospitalized on 11/23/11-11/30/11, attached are the records," and also a note stating, "OK send refund request." Received duplicate records and no attestation from request.

- Billed *CPT* 45385 - Lesion removal colonoscopy-ablation and lesion removal colonoscopy by snare technique
  Missing the provider's signature on the procedure report. Following a Medical Review Specialist call for typed notes and attestation, none was submitted.

- Billed *CPT* 85610 - Prothrombin Time.
  Received Coumadin Flow sheet and office visit note that supports medical necessity and received a note from stating, "Lab order under" "next PT/INR" (on flow sheet). ***Missing the physician's*** authentication

on flow sheet to support ***intent to order the test***. No order received to support service billed.

- Billed *CPT* 62311 and J3301 - Epidural steroid injection
  Submitted copy of progress note, describing medical necessity for injection, and procedure note for DOS billed. Notes contained name of provider; however, ***missing signature*** to support medical necessity and documentation of the procedure. No response to follow up request for attestation statement.

How to prevent this type of error
Medicare requires that providers authenticate their medical record entries with a legible handwritten or electronic signature. Without this authentication by the performing provider, services will be denied. However, these errors are avoidable.

In cases where there is a **missing signature**, a signature **attestation statement should be completed** by the performing provider and submitted with the corresponding medical records. For cases of illegible signatures, an attestation or signature log can be used to verify the identity of the author of the medical records.

Of note, attestation statements are **not acceptable for unsigned physician orders**. Orders will not be considered for review if they are missing a provider signature. In these cases a progress note which documents the intent for the services to be performed should be submitted. If a progress note is missing a signature, an attestation statement should be submitted with the record.

Medically Unnecessary Service or Treatment
Great news - Medical necessity accounted for only 0.4% of the family physician errors in the latest information published by WPS.

- Billed *CPT* 36415
  Missing orders for any laboratory testing that would require the performance of venipuncture on the billed date of service. Submitted documentation included laboratory report for hemoglobin A1C and TSH. Requested valid orders and medical necessity from the ordering provider and received problem report, phone note signed and dated by the RN who ordered a TSH and hemoglobin A1C for but no signature from the ordering provider. Also received office visit note that supports medical necessity, test form signed by an RN, and laboratory reports. No valid signed and dated order by the billing provider to support venipuncture were submitted.

Per Medicare regulations, only the "treating physician" or "treating practitioner" (nurse practitioner, clinical nurse specialist or physician assistant) can request that a diagnostic test be performed for a beneficiary.

WPS recommended educating your clinical staff of these requirements and performing periodic self-audits of your medical record documentation to avoid these denials.

For more information regarding physician orders, refer to the Chapter 15, §80.6.1 of the CMS *Internet-Only Manual*, 100-2 (*Medicare Benefit Policy Manual*).

How to prevent this type of error
There was no order or progress note submitted to support the intent for the laboratory services. Therefore, the related venipuncture will also be denied. To avoid this type of error, verify that all documentation and medical necessity requirements are met prior to billing these services to Medicare. When responding to CERT requests, perform a thorough review of the records prior to submittal to be certain all elements are included to support the services billed.

Service Incorrectly Coded
This is where the rubber hits the road. Physicians need to understand coding and the documentation needed to support the service rendered. This category represented 36.0 percent of errors made by family physicians for the recent reporting period.

Evaluation and Management (E/M) Services Coded to Lower Level by CERT Reviewer

- Billed *CPT* 99205 requires 3 of 3 key components (comprehensive history, comprehensive exam and high complexity MDM). Documentation supports code change from 99205 to 99203, with detailed history, detailed exam and moderate complexity medical decision making (MDM).

- Billed *CPT* 99214 requires 2 of 3 key components (detailed history, detailed exam and moderate complexity medical decision making). Documentation supports a down code from 99214 to 99213, with expanded problem focused history (limited HPI/1 ROS) per 1995 and 1997 E/M guidelines, no exam performed, and low complexity MDM per 1995 and 1997 E/M guidelines.

- Billed 99214 requires 2 of 3 key components (detailed history, detailed exam and moderate complexity medical decision making). Submitted documentation supports down code to 99213 with expanded problem focused history, problem focused exam and low complexity MDM.

- Billed *CPT* 99215 requires two of three key components: comprehensive history, comprehensive exam and high complexity MDM. Documentation supports down code from 99215 to 99214 with detailed history and exam and moderate MDM.

- Billed *CPT* 99223 requires three key components: comprehensive history, comprehensive exam and high complexity MDM. Submitted documentation supports down code from 99223 to 99221 with a detailed history, comprehensive exam, and moderate complexity MDM.

- Billed *CPT* 99233 requires two of three key components: detailed history, detailed exam and high complexity MDM. Received inpatient progress note which documents expanded history and exam and low complexity MDM. This supports down code from 99233 to 99232 (requires 2 of 3: expanded history and exam and moderate MDM).

- Billed *CPT* 99233 requires two of three key components: detailed history, detailed exam and high complexity MDM. Documentation supports down code from 99233 to 99232 with expanded history, expanded exam and moderate MDM.

- Billed *CPT* 99239 - Hospital discharge management, more than 30 minutes. Missing time spent in discharge management. Provider submitted copy of discharge summary for billed hospital discharge day management service with no time documented. Code depends on time spent. Down code to 99238, discharge day management 30 minutes or less.

- Billed *CPT* 99306 requires 3 of 3 key components: comprehensive history, comprehensive exam and high complexity MDM. Documentation supports down code to *CPT* 99304 with detailed history, detailed exam and moderate complexity MDM.

How to prevent this type of error

Documentation for Evaluation and Management (E/M) services must support the level of service billed and the medical necessity of the level. It is also important that handwritten progress notes are legible for review purposes. For timed codes, providers should document the face-to-face time spent with the patient to avoid claims denials or reductions.

WPS closely monitors CERT errors in order to identify problem areas contributing most significantly to the jurisdiction's (Indiana and Michigan) error rate. As a result of CERT review findings, WPS Medicare **may implement pre-payment** claim edits across the jurisdiction for review of problematic codes.

If you bill these services to Medicare, WPS highly recommends performing a self-audit of your billing and documentation processes. If Medicare overpayments are discovered, you can find instructions for submitting voluntary refunds on the Payment Recovery web page.

General Tips to Consider When Performing a Self-Audit of E/M Services:

- Medical necessity is the overall criterion for payment in addition to the specific technical requirements of a *CPT* code.
- It is not appropriate to bill a higher level of E/M service when a lower level of service is warranted.
- The volume of documentation should not be used to determine the level of service.
- Documentation must support the level of service reported.
- In order to maintain an accurate record, document during or shortly after rendering the service.

Visit the WPS Medicare Evaluation and Management web page for articles, CMS resources, and Frequently Asked Questions (FAQs) to assist you in the proper documentation and billing of these services.

The WPS Medicare Training web page is also a great resource for upcoming educational teleconferences, on demand sessions, or in-person seminars in your area.

Also view the CMS MLN Fact Sheet: Evaluation and Management (E/M) Services: Complying with Documentation Requirements

1st Quarter 2014 (January through March) - CERT Error Summary - Not Specialty Specific

The examples of findings below are reported based on the type of documentation, coding, or billing error assessed by the CERT Contractor. WPS Medicare received error findings for J8 providers in the following categories during the first quarter of 2014.

Insufficient Documentation - 80% of Total Errors
Reasons for errors:

- Billed *CPT* 99285. Claim billed for emergency department evaluation and management service. Submitted documentation is missing the documentation by the billing provider to support services. Documentation initially submitted included emergency room note written by resident and concurrence statement by billing physician.

- Claim billed for office visit evaluation and management service. Submitted documentation is missing an attestation statement to support unauthenticated progress note for billed dated of service.

- Billed for hospital discharge day management; more than 30 minutes (*CPT* 99239). Missing treating physician's clinical documentation that **supports a face-to-face encounter** with the beneficiary documenting time spent performing discharge day management.

- Billing 99226 subsequent observation care. Missing the physician's order for Observation stay and clinical documentation by the billing provider to support billed observation service. Submitted is a progress note by the Resident physician, with a notation by the teaching physician, indicating the beneficiary examined, information reviewed and a discussion with interdisciplinary team. Claim was submitted without the -GC modifier. **No order for Observation care. No GC modifier by the teaching physician**. Documentation is insufficient to support service billed.

- Billed initial observation care (*CPT* 99220). Missing signed and dated physician's orders regarding the observation services the beneficiary received. Submitted documentation includes history and physical. Requested additional documentation from the billing provider and received duplicate documentation.

- Provider billed for subsequent nursing facility visit (*CPT* 99307). Missing provider's name or signature on the Physician Progress Note. Some entries in record were dated prior to this visit; whereas, other entries were undated. Unable to determine which entries were made for the billed date of service.

- Billed office visit E/M (*CPT* 99215). Missing the billing provider signed and dated attestation statement for log. Submitted documentation includes a handwritten visit note that has an illegible identification of the individual who provided or documented the service.

- Insufficient documentation to support the Evaluation and Management service (*CPT* 99212) billed. Missing legible identification of the person who documented for services provided on submitted progress note for this date. Submitted physician's office note has the typed name of the billing provider but no handwritten or electronic signature as required by Medicare regulations.

- Billed *CPT* 99239 - Hospital Discharge Day Management (more than 30 minutes). Missing documentation to support face-to- face evaluation encounter between the billing physician and the beneficiary. Submitted includes electronically signed discharge summary note by the billing provider but does not support a face to face encounter.

- Billed G0431-drug screen quantitative, multiple drug classes by high complexity test method, 80152-Amitriptyline, 80154-Benzodiazepines, 80160-Desipramine, 80174-Imipramine, 80182-Nortriptyline, 80299-Quantitation of drug, 81003-Urinalysis, by dipstick or tablet reagent, 82145-Amphetamine or Methamphetamine, and 82520-Cocaine or Metabolite. Submitted documentation included, order with no beneficiary name, lab results, lab requisition, office notes that support physician's medical management of the beneficiary with chronic pain, and lumbar disc disease, taking OxyContin and Lortab but no specific record of what specific drug/tests the physician had ordered. Missing physicians order or intent to order the above labs.

- Missing the physician order or clinical documentation of intent of ordering the billed alcohol (ethanol), amphetamine or methamphetamine, quantitation of drug times 3, and barbiturates that includes all drugs/drug classes to be tested. Received laboratory reports, unsigned requisition for urine drug screen panel, and progress notes.

- Billed is *CPT* 82607 Vitamin B-12 and *CPT* 82746 folic acid. Missing a valid order or progress notes with plan to order billed lab test.

- Billed multiple lab tests. Missing the physician order or clinical records to support intent to order. Submitted unsigned lab requisition, ABN, lab results and office notes that support medical necessity for lab testing, but no order/intent received.

- Billed is *CPT* 81005 Urinalysis; Qualitative or semiquantitative. Missing the following documentation; 1) an order or progress notes with intent/plan to order billed urinalysis; 2) clinical documentation to support medical necessity.

- Billed for urinalysis, qualitative, creatinine, other source and Methadone drug screen performed by an independent laboratory. Missing the treating practitioner's order or plan/intent to order the specific tests billed on this claim. Submitted includes an urine drug screen report with multiple drug class results, urine PH and urine creatinine results, an authenticated office visit note for the billed DOS that supports the beneficiary history of post laminectomy syndrome, lumbar disc degeneration, radicular syndrome of lower limbs and chronic pain with medications as methadone with the start of Vicodin to be added to treatment regimen, unauthenticated letter to the primary physician and a "Follow-up Report that documents the plan for a "UDS" but does not specify the drugs or classes of drugs to be tested. Unable to determine which drug classes are to be screened an if the services billed are for confirmation or validity.

- Missing documentation of intent to order and supporting the need for the urinalysis and urinalysis results. Patient was seen for medication management. Documented under "Other Problems" is urinary tract infection. There is no documentation in the physician's progress note of intent to order and there are no urinalysis results. Submitted lab results include drug screen tests.

- Billed *CPT* 98942-GA-AT. **Missing the specific areas of subluxation** per PART exam to support 5 regions of the spine that are involved and a treatment plan applicable to billed DOS which includes the recommended level of care (duration and frequency of visits), specific treatment goals and objective measures to evaluate treatment effectiveness.

- Billed Anesthesia for diagnostic or therapeutic nerve blocks and injections (01991). Missing: 1) Billing provider signed and dated pre-anesthesia examination and evaluation; and 2) post-anesthesia record. Submitted documentation included anesthesia record, procedure note, illegible signed pre-anesthetic evaluation with no beneficiary name on the page, and consents.

- Billed is *CPT* 33249 (Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous leads, single or dual chamber) with modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study). Missing the following requested documentation: 1) documentation that the Beneficiary is enrolled in either a FDA-approved category B investigational device exemption (IDE) clinical trial (42 CFR Â§ 405.201), a trial under the CMS Clinical Trial Policy (National Coverage Determination (NCD) Manual Â§310.1) or a qualifying data collection system including approved clinical trials; 2) Clinical documentation of Non ischemic dilated cardiomyopathy (NIDCM) >3 months; 3) Physician signed and dated diagnostic reports supporting a QRS duration greater than .120 and Sinus Rhythm; 4) clinical documentation supporting the Beneficiary was on stable CHF medical regimen prior to implant: ACE or angiotensin receptor blocker, beta blocker or angiotensin receptor blocker, digoxin and or a diuretic.

- Provider billed *CPT* 96401, chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic on 1/18. Missing the documentation of the administration of a chemotherapy drug. Received a copy of the order/intent to order Neulasta on day 2 of chemotherapy. Also received documentation of the administration of Neulasta (Pegfilgrastim) on 01/18, and documentation of chemotherapy administration on 01/17. Claim history shows chemotherapy services billed for 01/17.

- Billed neuromuscular reeducation (*CPT* 97112-GP-59). Missing the signed and dated therapy progress note that documents treatment modalities that were performed on this date. Submitted documentation included treatment log with only dates and times documented. Submitted documentation is insufficient to support the indications and limitation and documentation requirements in the governing LCD and Medicare guidelines.

- Billed Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber; and Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (*CPT* 33249, 33225, 93640). Missing clinical documentation to support the medical necessity for a biventricular defibrillator.

- Billed HCPCS J2469, for Palonosetron HCL, 25 mcg (10 UOS). Missing the treating physician's signed and dated orders for the billed medication.

- Billed is *CPT* J1030 and 20610 - Methylprednisolone 40 MG injection. Missing order and documentation of Methylprednisolone 40 MG injection was administered. Received a partially illegible office visit note that list B-12 as the injection, and office visit notes.

- Billed for total hip arthroplasty with or without autograft or allograft; and insertion of non-biodegradable drug delivery implant (*CPT* 27130, 11981). Missing the following: 1) Treating physician's **clinical documentation that supports hip pain has been progressive despite any attempt at conservative treatment**; and 2) Treating physician's documentation to support pain **interferes with ADL functions**, including the ability to ambulate or to go up and down stairs; or beneficiary's lifestyle; or has nocturnal pain interfering with sleep; **or requires narcotics for pain** control.

- Billed for the physician interpretation of, polysomnogram; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway therapy or bilevel ventilation, attended by a technologist (*CPT* 95811-26). Missing physician's order for the study or intent to order the study and the required signature on the documentation supporting the billed service

- Billed Polysomnography Testing (PSG) *CPT*- 95811-26. **Missing**: 1) **referring physician's legible, signed and dated order/referral** to sleep clinic for PSG testing, 2) referring physician's **legible, signed**

and dated progress notes/clinical evaluation prior to sleep test to assess beneficiary for signs/symptoms/complaints of obstructive sleep apnea (OSA). Received only signed PSG attended overnight CPAP titration study. No response to requests for valid orders and progress notes.\

- Billed is shaving of epidermal or dermal lesion (single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less – *CPT* 11300). Missing is; 1) treating physician's authenticated procedure note; 2) physician's signature attestation to the unsigned procedure note. Received authenticated progress note which **indicates shave biopsy was to be performed yet does not support service was provided** and unauthenticated procedure note which supports biopsy.

- Billed *CPT* 52332 - Cystourethroscopy. Missing is **documentation to support the medical necessity**. Submitted is only the operative report. Requested additional documentation and received duplicate of the Op. procedure report, Operative report for Laparoscopic procedure and progress notes.

- Insufficient documentation to support allergy immunotherapy 2 or more injections (*CPT* 95117). **Missing the treating physician's plan of treatment and dosage regimen**, including treatment schedule & length of therapy. Received the allergy immunotherapy flow sheet, progress note from 1994 which does not document a plan of care and is not signed, allergy testing results from 1994 which are not signed and a progress note dated May 2013 with the only reference to AI documented as "(1) AR- AI. (Increase) AI to 0.6 then new order." Documentation does not meet Medicare guidelines that state in part "... (2) the physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen. Antigens must be administered in accordance with the plan of treatment" and "A plan of treatment and dosage regimen must be documented in the patient's medical record."

- Billed is CT scan of the neck (*CPT* 70490-26) for date of service 04/23. Missing a valid order for the specific diagnostic test or clinical records supporting the treating physician's intent to order a CT scan of the neck. Received are: a) an office visit note dated 03/01 supporting medical necessity for beneficiary presenting with ear pain, possible diagnosis of TMJ, instructions to use warm compresses & soft diet, with plan for "imaging" if no improvement; and b) an office visit note dated 04/19 showing beneficiary with continued ear pain and plan to consider imaging for referred otalgia.

Incorrect Coding - 14% of Total Errors
Reasons for errors:

- Billed CPT 99203 requires 3/3 components (detailed history, detailed exam, and low complexity MDM). Documentation supports a down code from 99203 to 99202 as billed with detailed history, expanded problem focuses exam, and moderate MDM per 1995 E/M guidelines.

- Billed *CPT* 99204 (Requires 3/3 components; comprehensive history, comprehensive exam, and moderate MDM). Documentation supports code change to *CPT* 99203 with comprehensive history, detailed exam, and high MDM.

- Billed *CPT* 99205 requires 3/3 components; comprehensive history, comprehensive exam, and high complexity MDM. Documentation supports down code to 99203 with a detailed history, comprehensive exam, and moderate complexity MDM.

- Billed *CPT* 99214 requires detailed history, detailed exam, and moderate MDM with 2 of 3 key components. Review of note supports code change from 99214 to 99212 with problem focused history, problem focused exam, and low MDM.

- Billed 99215, which requires 2/3 components: comprehensive history and exam and high complexity MDM. Submitted office note supports code change from 99215 to 99214 with problem focus history (discuss abnormal ECHO), comprehensive exam and moderate complexity MDM (Ordered US carotids, B/P controlled, Lipids at goal, reviewed ECHO results with possible further work up later after discussing with patient and family.)

- Billed *CPT* 99215. Documentation supports code change from 99215 to 99214 with a comprehensive history, detailed exam and moderate MDM. This meets 2 of 3 components for 99214.

- Billed initial inpatient care, 99222, which requires a comprehensive history, comprehensive exam and moderate MDM. Documentation supports code change from 99222 to 99221, with comprehensive history, detailed exam and moderate MDM

- Billed *CPT* 99223 (requires 3/3 key components; comprehensive history, comprehensive exam, and high complexity MDM). Documentation supports down code to *CPT* 99222 with comprehensive history, comprehensive exam, and moderate MDM.

- Billed *CPT* 99223. Documentation supports down code from 99223 to 99221 with detailed history, detailed exam and moderate MDM, with progress note by a PA-C with signed addendum by attending hematologist/oncologist supporting evaluation and management of beneficiary who has been hospitalized for complaints of pain after infusion, possible pneumonia and pancreatic cancer.

- Submitted is an initial hospital care visit, *CPT* 99223, which requires 3 of the following 3 components: comprehensive history, comprehensive exam, and high MDM. Documentation supports down code to 99222 with comprehensive history, comprehensive exam, and moderate MDM. Beneficiary to ER post fall resulting in severe chest pain and sob. Treated with left thoracostomy, pain control via PCA, respiratory therapy and pulmonary consult.

- Billed *CPT* 99233 (requires 2/3 key components; detailed history, detailed exam, and high complexity MDM). Documentation supports code change from 99233 to 99232 with expanded problem focused history, expanded problem focused exam, and moderate MDM meeting 2/3 of the required key components.

- Billed *CPT* 99233 (subsequent hospital care) requires 2 of 3 key components (detailed history, detailed exam, and high MDM). Submitted documentation supports down code from 99233 to 99232 which requires 2 of 3 key components (expanded history, expanded exam, and moderate MDM). Documentation meets 99232 with (problem focused history, expanded exam, and moderate MDM) per 1995 evaluation and management guidelines.

- Billed *CPT* 99291. Critical care services are paid when there is a high probability of imminent or life threatening deterioration in the patient's condition and when high complexity decision making is involved in assessing, manipulating and supporting vital system functions to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration. Submitted documentation describes beneficiary who presented to ER with left leg swelling and tachycardia. Found to have acute MI; CE elevated. One episode of V Tach which resolved spontaneously. Documentation of treatment was careful IVF administration. Patient was described to be without respiratory distress, negative CP and palpitations, oriented x 3. Admitted to CCU, but does not meet requirement for critical care code. Meets ER visit *CPT* 99285 with comprehensive history and exam and MDM of high complexity.

- Billed *CPT* 99306 (initial SNF visit) requires 3/3 components; comprehensive history, comprehensive exam, and MDM of high complexity. Medicare guidelines state that when documentation and medical necessity do not meet the requirements for billing an initial nursing facility care code the code will be rated based on the subsequent SNF visits. Documentation supports down code from 99306 to 99308 subsequent SNF visit requiring 2 of 3 components; expanded problem focused history and exam, and low complexity MDM. Submitted is an expanded problem focused history {no allergies, no meds}, expanded problem focused exam, and MDM of low complexity. **Although the beneficiary has several diagnoses, the provider did not order any medications or treatment**.

- Billed for Initial Nursing Facility Care (*CPT* 99306) requiring 3/3 key components (comprehensive history, comprehensive exam, and moderate MDM). Submitted includes: authenticated visit note supporting an expanded history, expanded exam (limited exam of 2-7 organ systems) and moderate MDM. It is noted the signature is partially illegible but matches that found on the visit note for another

DOS. Down code from 99306 to 99308 (subsequent visit) based on the documentation in the visit note for billed DOS.

- Provider billed for *CPT* 99310 requiring 2/3; comprehensive HPI and exam and MDM of high complexity. Submitted documentation supports a code change from 99310 to 99309 with detailed HPI, comprehensive exam, and MDM of moderate complexity.

- Billed 85025 for CBC with differential. Submitted physician's progress supports intent to order CBC without differential. Change code to 85027.

- Billed for therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push (2 UOS) (*CPT* 96375). Missing the signed and dated orders for one of the intravenous push medications that were given on the billed date of service. Submitted documentation consists of an authenticated progress note supporting beneficiary with "squamous cell carcinoma of the lung receiving definitive chemotherapy and radiation"; authenticated nursing flow sheet supporting the administration of two intravenous push medications; and orders for only one of the intravenous push medications given on the billed date of service. Documentation supports changing UOS from 2 to 1.

- Billed *CPT* 11721 - debridement of nails; 6 or more. **Missing Class Findings Modifier** Q8 indicative of (2) clinical findings identified on physical exam that support severe peripheral involvement. Received podiatry encounter for evaluation of beneficiary in wheelchair for painful thick toenails that documents Class B findings of bilateral non- palpable pedal pulses, shiny skin texture, cool skin temp, and absent hair growth. Diagnosis-Onychomycosis, separate procedure debridement of toenails. Per the **LCD criteria**, modifier Q8 would be appropriate for meeting (2) or more of the Class B findings. Support code change from 11721 to 11721 with modifier Q8.

Medically Unnecessary Service or Treatment – 5% of Total Errors
Reasons for errors:

- Billed creatinine other source (*CPT* 82570). This test is for validity testing and is not done to treat the beneficiary. This validity test is not reasonable and necessary.

- Billed laboratory tests are not medically necessary for lack of the physician's order; therefore, the venipuncture is not medically necessary.

- Provider billed for Phencyclidine (PCP), Meprobamate & Methadone drug testing by column chromatography/mass spectrometry (*CPT* 83840, 83805, 83992, 82541). Documentation does not meet Medicare guidelines to support the medical necessity of routine drug screen testing. Per Medicare guidelines drug screening as not reasonable and necessary when performed as a routine screening measure as part of a physician's protocol for treatment in the absence of **indications as noted in LCD**. Medicare does not cover diagnostic testing used for routine screening.

No documentation Was Received – 0.5% of Total Errors
Reasons for errors:

- Billed Insertion of ventricular assist device, implantable intracorporeal, single ventricle with AS modifier (*CPT* 33979). Missing: 1) Billing provider signed and dated operative report; and 2) Signed and dated clinical documentation to support medical necessity for billed procedure. No documentation submitted to support billed services. Received a letter that states "We are unable to honor this request for the following reason(s); a thorough search of our files failed to reveal any record of this patient".

Service Provided, But Not by Billing Provider – 0.5% of Total Errors
Reasons for errors:

- Billed subsequent hospital care visit (*CPT* 99233). Missing the billing provider signed and dated progress note. Submitted documentation included a note that states there was no visit documented by this

physician. The progress note they have is for another provider and he is not associated with the same group.