Part B Insider (Multispecialty) Coding Alert

Medicare Errors: E/M Factors Largely in Part B's 2015 Fee-For-Service Error Rate

Though CERT data helped decrease errors, improper payments are still in the billions.

With five distinct components in place garnered from extensive Comprehensive Error Rate Testing (CERT) data, CMS saw a decreased fee-for-service improper error rate from 12.5 percent to 12.1 percent from 2014 to 2015. The adjusted rate did make a difference of about $1.4 billion, but the total outlay of improper Medicare payments still reached around $43.3 billion, a hefty sum by any standard.

Background. To create the CERT report, CMS reviewed 49,603 claims, including Part A with and without the Acute Care Hospital Inpatient Prospective Payment System (IPPS), Part B and DME, according to the "Medicare Fee-for-Service 2015 Improper Payment Report." After checking the details of the claims at length, auditors determined which had no documentation, insufficient documentation, incorrect coding, or reflected a medically unnecessary service.

Five Measures That Helped

The fiscal year (FY) 2015 saw some corrective actions added to help improve the process for the current year, but also with the promise that future years might also see marked decreases with the efforts. Past CERT program research suggested the following ideas would help providers and CMS decrease the outage:

- Focus on addressing issues with home health services' payments.
- Update the "Two-Midnight" rule under Part A.
- Utilize new proposed rule for Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS).
- "Expand the use of prior authorization in the Medicare FFS program."
- Watch the effects of two implementations on the effects of reducing improper payments with prior authorization for "certain non-emergent services."

Stats and details. The outcome held few surprises with DMEPOS sliding into first place with a 39.9 percent error rate while Part A (without hospital IPPS) came in second at 14.7 percent. Part B rounded out the group with 12.7 percent error rate, which "accounted for 25.7 percent of the overall Medicare FFS improper payment rate," the report said, with a grand total of approximately $11.5 billion in improper payments.

Part B Struggles Are Real

Documentation continues to be the proverbial thorn in Medicare Part B's side. Whether it's the lack of any medical notes or just insufficient documentation that renders the claim incorrect, Part B errors are heavy with this prevalent demise. Auditors found 68.2 percent of Part B errors were a result of documentation problems.

Watch your E/M services' claims. If E/M claims are an issue for your practice, you may want to avoid these common pitfalls.

With a 14.6 error rate in 2015, E/M services persist in causing problems for Medicare and account for 10.2 percent of the overall FFS improper error rate. The incorrect payments came in at around $4.6 billion, which is substantial in light of the

total CERT results, considering that E/M services are the bread-and-butter of most providers' incomes.

The biggest E/M error contributors continued to be coding errors and lack of documentation. "Often the physician submitted medical documentation that supported a different E/M code than the one billed. Many other claims were found to have insufficient documentation because the submitted records lacked a physician signature," the report said. "For other claims, physicians provided services in settings other than their own offices and did not submit records maintained by hospitals or other facilities."

Coding blunders. Split/shared E/M services remained high on the list of issues as many claims did not differentiate the care with the proper codes, documentation, and/or both National Provider Identifiers (NPIs), the physician's and the non-physician practitioner's, respectively. "For certain E/M visits and settings, if a physician and a qualified NPP each perform and document a substantive part of an E&M visit face-to-face with the same beneficiary on the same date of service, then the physician can bill this visit under his or her NPI," the report explained.

Both initial and subsequent hospital visits factored into the high percentages of improperly billed claims. Internal medicine and cardiology led the group with 41.6 percent of the errors for E/M services of initial hospital visits while internal medicine was the leader in subsequent hospital E/M service errors at 36.4 percent.

Errors related to established patients were also high at 7.7 percent, and CMS paid out over $1.1 billion in incorrect payments for these incorrectly coded E/M services. Internal medicine, cardiology, and family practices had the most cause for concern with a combined total of 40.1 percent of improper payment rate for established patients.

Texas and Georgia Have the Highest Improper Payment Rates

Texas took the top spot with the highest percentage of improper payment rates at 17.6 percent. Georgia followed closely at 16.7 percent, and Illinois finished third with the rate of 15.0 percent. California came in fourth place with a 14.1 improper payment rate while Pennsylvania and New Jersey tied for fifth at 14.0 percent.

To view the Medicare Fee-for-Service 2015 Improper Payment Report in its entirety, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2015_Improper_Payments_Report.pdf.