Briefings on APCs

MACs reveal 8 mistakes that still endanger your office E/M revenue

by Julia Kyles, CPC

Protect your office/outpatient E/M claims from front-end denials and post-payment recoupments with the freshest information from Medicare administrative contractors (MAC). An August 1 presentation on office E/M services included the top denial reasons for visits (CPT codes 99202-99215) with dates of service from March 1 to May 31, 2024. These mistakes will bring your revenue cycle to a halt and require the additional work of an appeal, said presenter Ellen Berra, a member of the provider outreach and education department for Part A/B MAC WPS GHA. Fortunately, a practice can avoid these denials if it spends some time and effort before it submits claims, she explained.

Stop 3 pre-payment denials

Take note of three mistakes that will stop payment for your office E/M claims and implement the solutions to keep them from clogging your revenue stream:

1. **Too many new patient claims for the same patient.**
   Before you submit a claim with a new patient code (CPT codes 99202-99205), you should make sure that no other provider of the same specialty in your group has seen the patient within the past three years. If you only check the billing provider for the latest encounter, you might miss a visit with a different provider. Spending a few minutes on a comprehensive check before you submit a claim can save you a lot of time, Berra explained.

If you accidentally submit a new visit code for an established patient, it might be two weeks before you receive a denial, she said, but "if you look for that initially within your records then it saves you all that time and then you get paid faster." In addition, when you receive the denial "you have to start backwards, looking for that original service [and] finding when did Medicare pay that initial service," Berra said.

2. **More than one E/M claim for the same patient on the same day.** "If you're providing multiple services within the same day, you want to combine those services into one E/M service," Berra said. You can code based on time by combining the documented times for the visits. When appropriate, you can append prolonged service add-on code (CPT code G2212), she said. If you use medical decision-making (MDM) for your coding decision, you'll select a code based on the combined documentation for each visit, Berra added.

This rule applies whether the same provider sees the patient more than once on the same day or multiple providers of the same specialty in the group see the patient on the same day. The only exception is when the documentation clearly shows the visits were not related.

Your practice can decide how it checks new patient status and multiple same-day visits. You might instruct coders to search your billing system or you could upgrade your software system to alert coders when a patient is established or was seen by more than one provider of the same specialty on the date of service.

3. **Bundling errors.** Berra advised webinar listeners to review global surgery and National Correct Coding Initiative (NCCI) rules to avoid denials caused by bundling errors.

CGS Administrators has detailed guidance for avoiding and appealing denials of E/M visits during the global surgery period. The Part A/B MAC lists this error as one of the top five modifier coding errors in claims that it receives. Practices can avoid remittance advice remark code CO-97 (Global surgery denials) by checking the global surgery period for any procedures the practice performed for the patient. The MAC recommended CMS' Medicare physician fee schedule look-up tool. You can enter the code or codes you want to search, select "Payment Policy Indicators" and the global period will be in the sixth column of your search result.

Providers should also be familiar with the rules for reporting modifiers 24 (Unrelated evaluation and management service by the same physician during a post-operative period) and 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), CGS Administrators said.

5 post-payment recoupment risks

Front-end claim denials of your E/M services will catch problems with information you submit with a claim. But post-payment reviews such as a targeted probe and educate (TPE) audits will uncover problems with the documentation for the visit. Because these problems can go undetected until an outside auditor looks at them, they can accumulate for years and generate the unpleasant surprise of a hefty overpayment demand.

First Coast Service Options (FCSO) and Novitas have released the results of TPE audits for established E/M visits. FCSO’s report covers claims for CPT code 99214 submitted between August 2023 and February 2024. Novitas has released reports on claims for CPT codes 99213 and 99215 submitted between March 2024 and July 2024 and claims for CPT code 99214 submitted between April 2024 and July 2024. The MACs found the following documentation errors for these claims:

1. Providers submitted documentation that did not meet the medical necessity requirements outlined in Medicare’s coverage requirements.
2. The documentation did not support the medical necessity for the reported level of medical decision-making, and some providers left money on the table. According to Novitas, providers are downcoding as well as upcoding their claims.
3. The documentation did not support the level that the practice billed.
4. The documentation did not support the E/M service that the practice billed.
5. The documentation did not support billing the visit “incident to” a physician’s services.

Even though practices have been using the updated E/M coding guidelines for office visits since Jan. 1, 2021, these errors show that providers and coders still need training reinforced by internal review of documentation and claims.

Staff responsible for training and compliance should make sure everyone is using Medicare’s current rules for documenting and reporting E/M visits from CMS 100-04, chapter 12, §30.6. Your staff must also follow additional guidance your MAC has issued on documenting office visits. In addition, they should be trained on the guidelines in the 2024 CPT Manual and know when Medicare’s rules diverge from what’s in the manual. You should continue regular internal reviews of claims with additional education until staff show they’re fluent in the latest requirements.

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