MEDICAL REVIEW FOCUS AREAS

OFFICE OR OTHER OUTPATIENT VISIT FOR ESTABLISHED PATIENT

- **Specialties:** All
- **CPT Code:** 99214
- **States:** CT, MA, NY

NGS Medical Review department routinely analyzes regional and national data to identify patterns of claims submission and payments that could suggest actual or potential problems. A recent analysis of data indicated CPT code 99214 continues to be one of the top contributors to the CERT error rate, and it has the highest CERT projected errors within the E&M services.

In view of the findings, NGS Medical Review will be conducting service-specific prepayment reviews on the CPT code 99214 targeting E&M services for JK Part B Providers. The primary focus of the audit is to better identify common billing errors, develop educational efforts, and prevent improper payments for CPT code 99214.

The CPT descriptions of the targeted E&M service is as follows:

CPT Code 99214; Office or Other Outpatient Visit for Established Patient for the E&M of an established patient, which requires at least two of these three key components:

- A detailed history
- A detailed examination
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problem(s) are of moderate to high severity; typically 25 minutes are spent face to face with the patient and/or family.

A prepayment review consists of a medical review of claims prior to payment. Request for records are automatically generated and referred to as an ADR. Please note that when medical records are requested, it is only necessary to submit the documentation for the specific date of service notated in the ADR. The supporting documentation would include, but is not limited to physician/NPP's progress notes, orders, medication records, procedure/operative reports, relevant diagnostic/operative reports, or documentation of time that would assist in supporting the service(s) submitted. The notes are expected to be signed per signature guidelines or have a signature attestation included; failure to sign the notes will delay processing times.

Providers can assist in this process by:

- Reviewing all contractor provider publication and LCDs
- Understanding Medicare coverage requirements
- Ensuring office staff and billing vendors are familiar with claim filing requirements
- Performing self-audits of medical records against billed claims using coverage criteria, LCD, and coding guidelines

- Responding to request(s) for records in a timely manner (CMS requires that providers

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Providers will be receiving ADRs asking for documentation to support the service billed. Medical Review encourages providers to respond with the requested documentation in a timely manner to expedite adjudication of these claims. Please keep in mind the overall medical necessity criterion for E&M services according to the CMS Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Section 30.6.1 . (1 MB) which states:

> The medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a level of service is billed. Documentation should support the level of service reported. Providers should select the code for the service based upon the content of the service. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

Additionally:

- Select the code for the service based upon the content of the service
- Duration of the visit does not control the level of the service unless more than 50 percent of the face-to-face time is spent providing counseling or coordination of care as described in CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Section 30.6.1, "Evaluation and Management Service Codes - General (Codes 99201 - 99499) ." (1 MB)
- Providers choosing time as the determining factor must
  - Must document time within the medical record
  - Must document sufficient detail in the nature of the counseling or coordination of care
- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E&M service code unless their presence significantly increases the complexity of the medical decision making.
- All services ordered or rendered to Medicare beneficiaries **must** be signed. Please see guidelines regarding handwritten or electronic signatures, and exceptions for stamped signatures are described in MLN Matters article MM8219 . Do not add late signatures to a medical record, view the signature authentication process outlined in MLN Matters article MM6698 .
- Guidelines regarding signature are located in CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 3, Section 3.3.2.4. (664 KB)

Related Content

- CMS Evaluation & Management Services Guide, 1995 Guidelines and 1997 Guidelines

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