Part B Insider (Multispecialty) Coding Alert

Part B Errors: Prevent MAC Ire With Complete Lab Requests

Plus: Don't skimp on E/M coding documentation.

At your Part B practice, you likely submit plenty of lab orders - and then subsequently turn to more pressing concerns. However, you may want to give a little extra attention to these orders and follow through with your requests because this area frequently causes errors during Medicare processing.

That key piece of advice was shared by CGS Medicare's **Julene Lienard** during the Part B payer's webinar "Top CERT Errors for 2021." Check out a few additional commonly seen errors, along with tips on how to ensure that you don't make the same mistakes these practices did.

Error 1: Inadequate Documentation for Diagnostic Lab Tests

Documentation for lab tests fell short frequently enough that this ranked atop the list of Part B errors that CGS has seen so far in 2021, Lienard said. "These were inadequate due to missing documentation," she noted. "For instance, one claim is missing the treating physician's order, or clinical documentation to support the intent to order the service ... The next claim was missing the clinical documentation to support the medical necessity. What another claim had was the dated order, but it didn't identify the beneficiary, therefore making the order invalid and not being considered in the review."

The physician's documentation reveals the information that should be in the lab order to support medical necessity, Lienard added. "You always want to make sure you get that note from the treating physician as to why they want these tests run."

If your lab order has check boxes where the physician can check off the ICD-10 codes, that isn't typically sufficient to demonstrate medical necessity for the service, she explained. "They would also need to have the physician write out the reason that he wants these services performed. You can put a little comment section on your order form if that's what you're using, and the physician can fill in that little comment section. If it's by hand or if it's an electronic order, you should be able to have a place where the physician can write that information in."

Error 2: Missing Documentation That Would Support Service Frequency

In some cases, Medicare has frequency guidelines that limit how often you can bill for a service or order a particular diagnostic test. These guidelines may also limit what other criteria you must meet before you can administer a particular service or order a test. In certain circumstances, your documentation must support exceeding frequency guidelines, but many claims are missing that information, Lienard noted.

For example, if the physician orders a definitive drug test (G0483, Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers ...), the insurer may be looking for clinical documentation to support the fact that the beneficiary has abstained for 31 to 90 days, Lienard said. Without that documentation, your claim for this service might be denied. "We do see quite a few of these," she said.

Error 3: Missing Documentation That Supports Medical Necessity

"We all know that medical necessity is the overarching criterion for any service provided to a Medicare beneficiary," Lienard said. "So when we review any documentation, that medical necessity has to be supported ... Always be sure that,

with your documentation, you're submitting proof of the medical necessity and the reason that the treating physician wants the service performed."

In addition, when reviewers look at your documentation, they're matching it against the guidelines that were in place on the date of service, Lienard expounded. If they're reviewing claims with a date of service from 2019, they will look at retired local coverage determinations (LCDs) that were in place at the time of service, and not the LCDs that are in place today, she added.

Error 4: E/M Codes Are Often Missing Details

E/M codes represent "a large portion of the Part B errors," Lienard said. For instance, some chronic care management claims are missing the comprehensive care plan required to report these services. Others include modifiers indicating that a distinct, separately identifiable service was performed, but the documentation didn't support anything distinct, she mentioned.

"In other cases, critical care services are not supported," she said. In many of these cases, the documentation supports the use of another E/M code, she said. So a claim might be billed for critical care, but after reviewing the documentation, it gets downcoded to an inpatient service code.

Other common issues among E/M codes include missing dates of service, claims that are coded too high without supporting documentation, and missing signatures.

Error 5: Missing Orders for Diagnostic Tests

"In Part B, we have a lot of trouble with orders that are missing details or contain inadequate information," Lienard said. For instance, the physician might order a CT scan, but fail to complete the reason that the CT scan was required, or the patient's condition necessitating the diagnostic test.

Her final word was to urge practices to ensure that all documentation is complete before submitting any claim. Although you may be feeling hurried when you code claims, submit them, or turn in requested documentation, your best bet is to slow down and ensure that everything is accurate before you submit. That way, you'll save time down the line, and get paid accurately the first time.