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Novitas Solutions, Inc., Improperly Paid Approximately $19.5 Million for Selected Medicare Part B Services Provided to Patients Residing in Nursing Homes

REPORT HIGHLIGHTS

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Novitas Solutions, Inc., Improperly Paid Approximately $19.5 Million for Selected Medicare Part B Services Provided to Patients Residing in Nursing Homes

Why OIG Did This Audit

- Medicare Part B (Part B) covers many medical services provided to patients, including those residing in nursing homes. Providers of these medical services submit separate claims from the nursing homes to Part B for the services rendered.
- For the period October 1, 2018, through September 30, 2019 (audit period), our data analysis found that evaluation and management, psychotherapy, podiatry, and wound care services (collectively referred to as "selected services") were the most common Part B services provided to patients residing in nursing homes.
- This audit assessed whether Novitas Solutions, Inc. (Novitas), a Medicare contractor, made payments to providers in one of its two jurisdictions for selected Part B services provided to patients residing in nursing homes that met Medicare requirements and guidance.

What OIG Found

- Of the 150 sample items, 91 did not meet Medicare requirements and guidance for evaluation and management, psychotherapy, or podiatry services provided to patients residing in nursing homes.
- During our audit period, Novitas's oversight of provider billing and provider education was not sufficient to ensure that the providers fully understood Medicare coding and documentation requirements for the selected services.
- On the basis of our sample results, we estimated that Novitas improperly paid approximately $19.5 million for the selected services that did not meet Medicare requirements and guidance.

What OIG Recommends

We made two recommendations to Novitas, including that it implement additional oversight to prevent improper payments associated with provider billing of the selected services, which could have saved an estimated $19.5 million for our audit period, and provide annual education to providers and their billing staff specific to the Medicare requirements and guidance for billing the selected services.

Novitas concurred with our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare Part B (Part B) covers medical services provided to patients, including those residing in nursing homes. Providers of these medical services (e.g., physicians, non-physician practitioners, therapists, podiatrists) submit separate claims from the nursing homes to a Medicare Administrative Contractor (MAC) for the services rendered.[1]

OIG research and preliminary analysis identified various Part B services provided to patients residing in a nursing home that were not reasonable and medically necessary. For the period October 1, 2018, through September 30, 2019 (audit period), our data analysis found that evaluation and management (E/M), psychotherapy, podiatry, and wound care services (collectively referred to as "selected services") were the most common Part B services provided to patients residing in nursing homes, with paid claims totaling $187 million nationwide.[2, 3] We selected Novitas Solutions, Inc. (Novitas), the MAC for Jurisdiction H during our audit period, because Novitas was one of the three MACs with the highest total amount paid to providers for the services that we identified as the most commonly billed.[4]

OBJECTIVE

Our objective was to determine whether Novitas made payments to providers in Jurisdiction H for selected Part B services provided to patients residing in nursing homes that met Medicare requirements and guidance.

BACKGROUND

Medicare Program and the Role of Medicare Administrative Contractors

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Part B provides supplementary medical insurance for medical and other health services, including E/M, psychotherapy, podiatry, and wound care services.

[1] There are 7 MACs in 12 geographic areas (jurisdictions) that process Part B medical claims.

[2] E/M services are performed by physicians and other health care professionals to assess and manage patients' health.

[3] This was the most recent data available at the start of our audit.

[4] Jurisdiction H covers providers in Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas.

CMS contracts with MACs to process and pay Part B claims. MACs help CMS detect and prevent improper payments and promote Medicare compliance within their jurisdictions. MACs' responsibilities include educating providers on Medicare requirements and billing procedures, applying system edits to claims to determine whether claims are complete and reimbursable, and performing medical reviews of claims to determine whether services provided to patients are medically necessary.[5]

Medical reviews include prepayment and post-payment reviews, which consist of collecting information for a selection of claims and reviewing patient medical records to ensure that Medicare pays only for services that meet all Medicare coverage, documentation, coding, and medical necessity requirements. MACs use the results of prepayment reviews to help ensure they make proper Medicare payments. MACs use the results of post-payment reviews to recover any improper payments for claims that were already paid. MACs perform prepayment and post-payment reviews that target problem areas identified by analyzing claim data.

Medical reviews that focus on specific providers are conducted as part of CMS's Targeted Probe and Educate (TPE) program; we refer to these reviews as "TPE reviews." TPE reviews typically evaluate 20 to 40 claims and supporting medical records per provider for an item or a service, and MACs provide individualized education to providers that are noncompliant.[6] MACs analyze available data to identify for TPE reviews those providers (1) that have historically high claim-denial rates, (2) that have billing practices that vary from their peers, or (3) for whom evidence suggests that there is a potential risk to the Medicare trust fund.

The MACs also develop local coverage determinations (LCDs) for their individual jurisdictions. LCDs are determinations by a MAC on whether a particular item or service is reasonable and necessary and therefore covered by Medicare within the specific MAC jurisdiction.[7]

[5] An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, acts on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

[6] The TPE program's process typically includes up to three rounds of prepayment or post-payment probe reviews, each of which may be followed by one-on-one education until the provider becomes compliant (CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.5).

[7] The Social Security Act (the Act) § 1869(f)(2)(B).

Medicare Coverage and Billing Requirements for Services Provided to Patients Residing in Nursing Homes

Part B covers many medical and other health services such as physicians' services, diagnostic tests, psychological therapy, and durable medical equipment provided to patients residing in nursing homes.[8]

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Social Security Act (the Act) § 1862(a)(1)(A) and 42 CFR § 411.15(k)(1)). In addition, Medicare payments must not be made to a provider for a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e) and 42 CFR § 424.5(a)(6)).

To receive Medicare payment for E/M, psychotherapy, podiatry, and wound care services, the provider submits a claim to the MAC responsible for its jurisdiction using the appropriate Current Procedural Terminology (CPT®)[9, 10] codes and Healthcare Common Procedure Coding System (HCPCS) codes to bill for those services.[11, 12] When billing for covered services, providers must also comply with billing requirements specified in the LCDs for their jurisdiction.

[8] The Act §§ 1832(a)(1) and 1861(s).

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[11] CPT codes are five-digit numeric or alphanumeric codes that are used for reporting and billing medical services and procedures for performance measurement.

[12] 45 CFR §§ 162.1000 and 162.1002.

Medicare Coverage and Billing Requirements for Evaluation and Management Services for Nursing Facility Care

A provider performs an E/M service to assess and manage a patient's health. The codes providers use to bill E/M services are organized into various categories and levels. The codes distinguish between new and established patients, and, in general, the more complex the visit, the higher the level of code a provider may bill within the appropriate category. To determine the appropriate code, providers must consider key components when documenting an E/M service, such as patient history, examination, and level of medical decision-making. [13, 14] It is not medically necessary or appropriate to bill a higher level code when a lower level code is warranted, and the documentation should support the level of service reported.[15]

Initial Nursing Facility Visit

The initial nursing facility visit is the initial comprehensive assessment visit during which the provider completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the patient (LCD L35068).[16, 17] According to the AMA *CPT Professional Code Book*, CPT codes 99304 through 99306 are for initial nursing facility care for patients residing in a nursing facility.[18] These codes are billed daily for nursing facility care, for the evaluation and management of a patient. The codes refer to different levels of medical decision making complexity (low to high), and all three key components are required to support the services billed to Medicare. Table 1 on the next page details AMA's guidance for these codes for our audit period.

[13] American Medical Association CPT Codebook, *Evaluation and Management Services Guidelines*.

[14] CMS, *1997 Documentation Guidelines for Evaluation and Management Services*.

[15] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, Ch. 12, § 30.6.1.

[16] While this language was removed from the LCD as of July 25, 2019, it can also be found in the Claims Processing Manual, Ch. 12 § 30.6.13.A.

[17] This LCD is retired but was effective during our audit period.

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Table 1: AMA Guidance on Complexity Levels for Initial Nursing Facility Care

Complexity	CPT Code	CPT Code Description	All Components Required To Support Billed Services		
			Clinical History[19]	Physical Examination[20]	Medical Decision Making[21]
Low ↓ High	99304	Initial Nursing Facility Care of Low Severity	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward or Low Complexity
	99305	Initial Nursing Facility Care of Moderate Severity	Comprehensive	Comprehensive	Moderate Complexity
	99306	Initial Nursing Facility Care of High Severity	Comprehensive	Comprehensive	High Complexity

Subsequent Nursing Facility Care

Subsequent nursing facility care must be reasonable and medically necessary to meet the medical needs of the patient.[22] According to the AMA *CPT Professional Code Book*, CPT codes 99307 through 99310 are for nursing facility care subsequent to initial admission for patients residing in a nursing facility.[23] These codes are billed daily for nursing facility care, for the evaluation and management of a patient. The codes refer to different levels of medical

[19] The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). Detailed clinical history is a chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problem. Comprehensive clinical history is chief complaint; extended history of present illness; review of systems that directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

[20] The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). Detailed physical examination is an extended examination of the affected body area(s) and other symptomatic or related organ system(s). Comprehensive physical examination is a general multisystem examination or a complete examination of a single organ system.

[21] Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by: (1) the number of possible diagnoses and/or the number of management options that must be considered; (2) the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; (3) the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

[22] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, Ch. 12, § 30.6.13.B.

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decision making complexity (low to high), and two of three key components are required to support the services billed to Medicare. Table 2 details AMA's guidance for these codes for our audit period.

Table 2: AMA Guidance on Complexity Levels for Subsequent Nursing Facility Care

Complexity	CPT Code	Description of Patient	Two of Three Components Required To Support Billed Services		
			Clinical History	Physical Examination	Medical Decision Making
Low ↓ High	99307	Stable/Recovering or Improving	Problem Focused	Problem Focused	Straightforward Complexity
	99308	Responding Inadequately to Therapy or Minor Complication	Expanded Problem Focused	Expanded Problem Focused	Low Complexity
	99309	Significant Complication or Significant New Problem	Detailed	Detailed	Moderate Complexity
	99310	Unstable or Significant New Problem Requiring Immediate Physician Attention	Comprehensive	Comprehensive	High Complexity

In addition, Novitas's LCD states that frequent visits may be unreasonable, particularly if the patient is medically stable. However, the LCD recognizes that there are instances where more frequent visits may be appropriate (LCD 35068). Furthermore, an E/M service is separately reportable on the same day of service as another procedure under limited circumstances.[24] Medicare may make a separate payment for an E/M service if it is significant and separately identifiable, and the provider uses modifier 25.[25, 26] Appending modifier 25 to a CPT code on a claim allows the claim to bypass automated system edits in a MAC's claim processing system that are designed to prevent improper payment for services that should not be billed on the same day.[27]

[24] *National Correct Coding Initiative Policy Manual* (NCCI Manual), chapter I, § D.

[25] NCCI Manual, chapter I, §§ D and E(b).

[26] A modifier is a two-character code reported with a HCPCS or CPT code and is used to give Medicare additional information needed to process a claim (NCCI Manual, chapter I, § E).

[27] NCCI Manual, chapter I, § E.

Medicare Coverage and Billing Requirements for Psychotherapy Services

Psychotherapy is treatment for mental illness and behavioral disturbances. Part B covers mental health services, such as psychotherapy, provided by qualified professionals (e.g., physicians, psychiatrists, clinical psychologists, clinical social workers, physician assistants, and nurse practitioners).[28] A provider establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development (LCD L35101).

For patients suffering from dementia, the type and degree of dementia must be considered in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should support that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment (LCD L35101).

Providers bill Part B for psychotherapy services using one of six psychotherapy CPT codes based on the actual time spent on psychotherapy and whether the service was provided alone or in conjunction with an E/M service.[29] Each code has an associated time range, and providers should choose the code closest to the actual time spent with the patient.[30] For example, CPT codes 90832 and 90833 (both described as 30 minutes, with the next code 90834 being 45 minutes) are billed for 16 to 37 minutes of psychotherapy. (Medicare does not cover psychotherapy services lasting less than 16 minutes.) Figure 1 on the next page shows the psychotherapy CPT codes and their descriptions.[31]

[28] The Act §§ 1832(a)(1) and 1861(s); 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

[29] *CPT copyright 2018 and 2019 American Medical Association. All rights reserved*.

[30] American Medical Association*, Psychiatry Services Guidelines*.

[31] Our audit did not include any services for CPT codes 90836 or 90838.

Figure 1: Psychotherapy CPT Codes and Descriptions

CPT Code	Description
90832	Psychotherapy (30 min)
90833	Psychotherapy (30 min + E/M)
90834	Psychotherapy (45 min)
90836	Psychotherapy (45 min + E/M)
90837	Psychotherapy (60 min)
90838	Psychotherapy (60 min + E/M)

Medicare Coverage and Billing Requirements for Podiatry Services

Mycotic nail debridement (nail debridement) is a podiatry service covered by Part B that involves the removal of a diseased toenail bed or viable nail plate.[32] Nail debridement is a temporary reduction in the length and thickness of an abnormal nail plate. Documentation for nail debridement services must include a current nursing facility order, dated and signed with the physician's signature (LCD 35013). Providers bill Part B for nail debridement services using CPT code 11720 for one to five nails treated and 11721 for six or more nails treated.[33]

Medicare Coverage and Billing Requirements for Wound Care Services

Surgical debridement is a wound care procedure to treat wounds that are refractory to healing or have complicated healing cycles either because of the nature of the wound itself or because of complicating metabolic and/or physiological factors.[34]

Part B coverage for surgical debridement on a continuing basis, for a given wound in a given patient, is contingent upon evidence documented in the patient's medical record that the wound is improving in response to the wound care being provided (LCD 35125).

Providers bill Part B for surgical debridement services using one of six CPT codes depending on the depth of the tissue removed and the surface area of the wound.[35] Figure 2 on the next page shows the wound care CPT codes and their descriptions.

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[32] Nail debridement was the only type of podiatry service included in our audit.

[33] *CPT copyright 2018 and 2019 American Medical Association. All rights reserved*.

[34] Surgical debridement was the only type of wound care service included in our audit.

[35] *CPT copyright 2018 and 2019 American Medical Association. All rights reserved*.

Figure 2: Wound Care CPT Codes and Descriptions

CPT Code	Description
11042	Debridement of subcutaneous tissue (first 20 sq cm)
11043	Debridement of muscle and/or fascia (first 20 sq cm)
11044	Debridement of bone (first 20 sq cm)
11045	Debridement of subcutaneous tissue (each add'l 20 sq cm)
11046	Debridement of muscle and/or fascia (each add'l 20 sq cm)
11047	Debridement of bone (each add'l 20 sq cm)

Note: Fascia is a thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $53.7 million in Part B payments Novitas made to providers in Jurisdiction H for the selected services during our audit period. We selected a stratified random sample of 150 patient-months (60 for E/M, 60 for psychotherapy, and 30 for podiatry and wound care services), totaling $41,944.[36] A patient-month (which we refer to as a "sample item" throughout this report) included all payments for each service type provided to a patient in a calendar month. For example, all payments for psychotherapy services provided to a patient in January 2019 were grouped as one sample item to better determine whether medical necessity, coding, documentation, and the frequency of the services billed met Medicare requirements and guidance.

We requested supporting documentation from both the providers who billed for the selected services associated with the sample items and the nursing homes where the patients resided. We provided those records to an independent medical review contractor, who then determined whether the selected services met Medicare requirements and guidance.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[36] The 30 podiatry and wound care service sample items consisted of 18 podiatry services and 15 wound care services. Three sample items included both podiatry and wound care services provided to the patient in the same calendar month.

Appendix A describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates. Appendix D contains Federal requirements and Novitas's LCDs related to the selected services.

FINDINGS

Novitas paid providers in Jurisdiction H for selected Part B services provided to patients residing in nursing homes that did not meet Medicare requirements and guidance. Of the 150 sample items, 59 met the requirements and guidance; however, 91 sample items did not meet the requirements and guidance, resulting in improper payments totaling $14,322.[37, 38, 39] Specifically, 42 E/M, 35 psychotherapy and 14 podiatry sample items did not meet the requirements and guidance. All 15 sample items that included wound care services met Medicare requirements and guidance.

Table 3 shows the total number of noncompliant sample items and improper payment amounts for the selected services.

Table 3: Noncompliant Sample Items and Improper Payment Amounts

Service Type	Number of Sample Items Reviewed	Number of Noncompliant Sample Items	Improper Payment Amount
E/M	60	42	$5,264
Psychotherapy	60	35	8,625
Podiatry	18	14	433
Wound Care	15	0	0
Total	**153[40]**	**91**	**$14,322**

For the 91 noncompliant sample items, the medical review contractor determined that the services were: not reasonable and medically necessary (49 sample items); insufficiently documented, or documentation was not provided (31 sample items); incorrectly coded

[37] We did not review four sample items and treated them as non-errors because we determined that the billing providers were no longer in business after we had selected our sample.

[38] For each noncompliant sample item, we determined the improper payment for the noncompliant sample claims by calculating the difference between the amount paid for the services and the amount that should have been paid based on the independent medical review determinations. Only the amounts paid for the services that did not meet Medicare requirements were unallowable.

[39] Two sample items did not meet Medicare documentation and billing guidance but did not have any associated improper payments because they did not reflect noncompliance with Medicare requirements.

[40] The three sample items that included both podiatry and wound care services provided to the patient in the same calendar month were counted in each service type.

(13 sample items); or not separately payable under Part B (9 sample items).[41] Table 4 shows the number of noncompliant sample items by type of noncompliance for the selected services.

Table 4: Noncompliant Sample Items by Type of Noncompliance

Service Type	Not Reasonable and Medically Necessary	Insufficiently Documented, or No Documentation Provided	Incorrectly Coded	Not Separately Payable Under Part B
E/M	24	10	13	6
Psychotherapy	25	7	0	3
Podiatry	0	14	0	0
Wound Care	0	0	0	0
Total	**49**	**31**	**13**	**9**

During our audit period, Novitas's oversight of provider billing and provider education was not sufficient to ensure that the providers fully understood Medicare coding and documentation requirements (e.g., medical necessity) for the selected services.

On the basis of our sample results, we estimated that Novitas improperly paid approximately $19.5 million for the selected services that did not meet Medicare requirements and guidance.[42]

EVALUATION AND MANAGEMENT SERVICES DID NOT MEET MEDICARE REQUIREMENTS

For 42 of the 60 E/M sample items, Novitas improperly paid providers for E/M services that were not reasonable and medically necessary (24 sample items), insufficiently documented or documentation was not provided (10 sample items), incorrectly coded (13 sample items), or not separately payable under Part B (6 sample items):[43]

[41] The total number of noncompliant sample items is greater than 91 because 11 sample items had more than 1 type of noncompliance.

[42] We estimated that for our audit period Novitas improperly paid providers $19,480,109.

[43] The number of noncompliant sample items totals more than 42 because 11 sample items had more than 1 type of noncompliance.

- **Services Were Not Reasonable and Medically Necessary.** Medicare requires that services be reasonable and necessary for the diagnosis or treatment of illness or injury.[44] Furthermore, no payment will be made for routine physical checkups (the Act 1862(a)(7)). In addition, frequent visits by a provider may be unreasonable, particularly if the patient is medically stable (LCD 35068).

  For 24 sample items, the independent medical review contractor determined that the E/M services were not reasonable and medically necessary. Specifically, the contractor determined that the documentation did not support an acute medical issue, any medical order changes, or follow-up needs related to a previous medical issue to warrant the frequency of visits during the patient-month, and indicated, in most cases, that the services were for routine physical checkups.

EXAMPLE

Services Not Reasonable and Medically Necessary

A 61-year-old female patient with a medical history of dementia, Parkinson's disease, hypertension, and tremor disorder was a nursing home resident for more than 6 years. Due to her recent decline in function and weakness, she was referred to a physiatry group (i.e., physical medicine and rehabilitation physicians) for evaluation and therapy. She was seen five times by the physiatry nurse practitioner during the month associated with the sample item. The independent medical review contractor determined that while the documentation supported that the initial visit was reasonable and medically necessary, the following four E/M visits did not indicate that the patient had any new issues or complaints and was able to fully participate in her therapy services. As such, those four E/M visits were routine physical checkups and not reasonable and medically necessary because the patient was stable.

[44] The Act § 1862(a)(1)(A) and 42 CFR § 411.15(k)(1).

- **Services Were Incorrectly Coded.** Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."[45] Medical records must clearly reflect the medical necessity of the service, as well as the key components (as described in Table 1 and Table 2) necessary to report the particular level of care reported (LCD 35068). The AMA *CPT Professional Codebook, Evaluation and Management Services Guidelines*, instructs providers on how to select the appropriate E/M CPT code to bill based on the level of E/M service provided.

  EXAMPLE

  Incorrectly Coded Services

  A 62-year-old male patient was seen by a physiatry nurse practitioner to follow up on the patient's progress with regaining independence with hygiene and grooming. The provider billed CPT code 99309 for two E/M visits; however, the documentation did not support that at least two of the three key components (i.e., detailed interval history and examination and medical decision-making of moderate complexity) were provided at the level required for the service billed. Because only one of the three key components (detailed physical examination) met the requirements for CPT code 99309, the provider should have billed the lower level CPT code 99308.

  For 13 sample items, the E/M services were incorrectly coded. Specifically, for 11 of the 13 sample items, the independent medical review contractor determined that (1) the documentation did not reflect that the necessary key components to report the level of service provided to the patient were supported and (2) a lower level CPT code should have been billed. For the remaining two sample items, providers incorrectly billed for an initial nursing facility care visit rather than a subsequent nursing facility care visit, or a subsequent nursing facility care visit rather than an initial nursing facility care visit.

- **Services Were Insufficiently Documented or Documentation Was Not Provided.** Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."[46] Certain key components are required to support the level of E/M service provided, including history, examination, and medical decision-making.[47]

  For 10 sample items, the independent medical review contractor determined that information in the patients' medical records did not support the services billed by the providers (3 sample items), or the providers did not submit any documentation (8 sample

[45] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

[46] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

[47] American Medical Association, *Evaluation and Management Services Guidelines*.

items).[48] Without the documentation, the independent medical review contractor could not determine whether the services met Medicare requirements. Therefore, we considered those sample items as noncompliant.

- **Services Were Not Separately Payable Under Part B.** Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."[49] Furthermore, once a patient has elected a hospice, the hospice assumes responsibility for care related to the patient's terminal illness and related conditions.[50] Thus, all services provided to a hospice patient related to any hospice diagnoses are to be performed by the hospice staff and reimbursed through the hospice benefit, not Part B. In addition, E/M services billed with modifier 25 must clearly indicate that a significant and separately identifiable E/M service was performed by the same service provider on the same day of a medical procedure or other service.[51]

  EXAMPLE

  Services Not Significant and Separately Identifiable

  An 80-year-old male patient had all toenails debrided using nail clippers and tissue nipper. The provider billed Part B for both an E/M service and the podiatry procedure. The independent medical review contractor noted that the documentation did not indicate that the E/M service was significant and separately identifiable above and beyond the minor surgery performed on the same day, and that no pertinent problems were addressed beyond the initial issue that led to the minor surgery. As such, payment for the E/M service would have been included in the payment for the podiatry procedure and not separately payable under Part B.

  For six sample items, the independent medical review contractor determined that providers inappropriately billed for E/M services that were related to the patient's hospice diagnosis and should have been reimbursed through the patient's hospice benefit (three sample items), or that the documentation did not support that a significant or separately identifiable E/M service was provided (three sample items).

[48] The number of sample items totals more than 10 because 1 sample item included services that were insufficiently documented, and documentation was not provided.

[49] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

[50] The Act § 1861(dd); 42 CFR §§ 418.20, 418.22, and 418.24.

[51] American Medical Association, *Evaluation and Management Services Guidelines* and NCCI Manual, chapter I, § E(b).

PSYCHOTHERAPY SERVICES DID NOT MEET MEDICARE REQUIREMENTS

For 35 of the 60 psychotherapy sample items, Novitas improperly paid providers for psychotherapy services that were: not reasonable and medically necessary (25 sample items); insufficiently documented (7 sample items), or not separately payable under Part B (3 sample items).

- **Services Were Not Reasonable and Medically Necessary.** Medicare requires that services be reasonable and necessary for the diagnosis or treatment of illness or injury.[52] The type, frequency, and duration of services must be medically necessary for a patient's condition under accepted practice standards. There must also be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning or a maintenance of level of function where decline would otherwise be expected, and the patient must have the capacity to actively participate in the therapy services prescribed (LCD 35101).[53]

  EXAMPLE

  Services Not Reasonable and Medically Necessary

  A provider billed Part B for three psychotherapy sessions for a 95-year-old patient with underlying dementia. The independent medical review contractor determined that although the patient had been receiving therapy services since July 2017, the documentation reviewed for July 2019 did not support that the patient was cognitively intact to the degree that she could engage in a meaningful verbal interaction with the therapist or maintain any learned coping skills from session to session. The independent medical reviewer also noted that there was no documentation to support functional improvement or maintenance as a result of the therapies provided. As such, these services were not supported as reasonable and medically necessary.

  For 25 sample items, the independent medical review contractor determined that the documentation did not support the frequency of the therapies provided or indicate the patients' progress towards or completion of any goals and the ability to participate meaningfully in those therapies.

- **Services Were Insufficiently Documented.** Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."[54] The medical record must indicate in

[52] The Act § 1862(a)(1)(A) and 42 CFR § 411.15(k)(1).

[53] For patients with a dementia diagnosis, the documentation should support that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

[54] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

legible form the time spent in the psychotherapy encounter and the therapeutic maneuvers such as behavior modification, supportive interactions, and interpretation of unconscious motivation that were applied to produce therapeutic change or stabilization (LCD 35101).

For seven sample items, the independent medical review contractor determined that there was no documentation to support that individual psychotherapy with face-to-face therapeutic interaction between the patient and therapist was provided, but rather that a clinical treatment plan review was performed (six sample items),[55] or that the provider did not include the start and stop times for the billed psychotherapy session to support the number of minutes that the patient was seen (one sample item).

- **Services Not Separately Payable Under Part B.** Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."[56] Furthermore, once a patient has elected a hospice, the hospice assumes responsibility for care related to the patient's terminal illness and related conditions.[57]

  For three sample items, the independent medical review contractor determined that providers inappropriately billed for psychotherapy services that were related to the patient's hospice diagnosis and should have been reimbursed through the patient's hospice benefit.

PODIATRY SERVICES DID NOT MEET MEDICARE REQUIREMENTS

For 14 of the 18 sample items that included podiatry services, Novitas improperly paid providers for podiatry services that were insufficiently documented (13 sample items) or had no documentation (1 sample item).

Services Were Insufficiently Documented or Documentation Was Not Provided. Documentation for nail debridement services for patients residing in nursing homes must include a current nursing facility order (dated and signed with the date of the physician's signature) for nail debridement services issued by the patient's physician (LCD 35013). Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."[58]

[55] A clinical treatment plan review is a periodic evaluation of a patient's ongoing treatment to ensure its continued appropriateness, effectiveness, and alignment with the patient's goals and needs.

[56] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

[57] The Act § 1861(dd); 42 CFR §§ 418.20, 418.22, and 418.24.

[58] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

For 14 sample items, the podiatry services were insufficiently documented or documentation was not provided. Specifically, for 13 sample items, the independent medical review contractor determined that the documentation did not include a nursing facility order that met documentation requirements (12 sample items) or did not include the physician's signature (1 sample item) for nail debridement services. For the remaining sample item, the provider did not submit any documentation to support the service billed. Without the documentation, the independent medical review contractor could not determine whether the services met Medicare requirements. Therefore, we considered the sample item as noncompliant.

NOVITAS'S OVERSIGHT OF PROVIDER BILLING AND EDUCATION WAS NOT SUFFICIENT TO PREVENT IMPROPER PAYMENTS

During our audit period, Novitas's oversight of provider billing and education was not sufficient to ensure that the providers fully understood Medicare coding and documentation requirements for the selected services. Novitas explained that it performs monthly data-driven analyses for all codes billed to Medicare and prioritizes the findings and selects the top priority issues for further review. For the CPT codes included in our audit, Novitas stated that it conducted clinical reviews for the majority of those codes and found the same types of noncompliance identified in our audit. Additionally, Novitas noted that while it conducts medical reviews for psychotherapy services at the provider level, it can only pursue the most egregious providers due to resource constraints.

Furthermore, Novitas stated that nursing homes have always been an area of medical review interest because E/M services have historically had a high error rate, and the opportunity for fraud and billing errors is high for psychotherapy services. Novitas provides continuous provider education (e.g., webinars, one-on-one training, website materials, documentation review checklists) to assist providers with correct billing practices. Novitas explained that because there are so many E/M codes, it is difficult to educate providers on each code and when it should be used. However, to better assist providers, Novitas's website includes an E/M Interactive Score Sheet to help identify the appropriate level of E/M service performed.[59]

Because of our substantial findings (i.e., 91 of the 150 sample items did not comply with Medicare requirements and guidance) and Novitas's concerns about provider billing of the selected services, we believe that additional oversight and annual provider education would improve compliance with Medicare requirements and guidance.

[59] In May 2025, Novitas stated that the oversight deficiencies summarized in this paragraph are ongoing concerns but that the noncompliant error rates have been getting better as Novitas has identified billing patterns and focused on provider education.

RECOMMENDATIONS

- We recommend that Novitas implement additional oversight (e.g., documentation and billing guidance, medical reviews, and/or provider internal audits) to prevent improper payments associated with provider billing of E/M, psychotherapy, and podiatry services, which could have saved an estimated $19,480,109 for our audit period.

- We recommend that Novitas provide annual education to providers and their billing staff specific to the Medicare requirements and guidance for billing E/M, psychotherapy, and podiatry services.

NOVITAS'S COMMENTS

In written comments on our draft report, Novitas concurred with our recommendations and described actions it has taken or planned to take to address those recommendations. Specifically, Novitas stated that it continues to enhance oversight through data-driven reviews and targeted audit efforts, and provides ongoing, robust education to providers and billing staff on Medicare requirements, including billing for E/M, psychotherapy, and podiatry services. In addition, Novitas stated that it will continue to deliver targeted, annual education informed by identified billing and documentation risks and will explore opportunities to enhance provider awareness of documentation request processes, including potential collaboration with oversight entities to improve provider understanding and response to medical record requests.

Novitas's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered selected Part B services (i.e., E/M, psychotherapy, and podiatry and wound care) paid by Novitas to providers in Jurisdiction H for patients residing in nursing homes with dates of service during our audit period. Our sampling frame consisted of 292,794 patient-months with payments totaling $53,688,118.[60] A patient-month (which we refer to as a "sample item" throughout this report) included all payments for the same service type provided to a patient in a calendar month.

We selected a stratified random sample of 150 sample items with payments totaling $41,944. The sample included the following:

- 60 sample items for E/M services
- 60 sample items for psychotherapy services
- 30 sample items for podiatry and wound care services

We used an independent medical review contractor to review the medical record documentation to determine whether the services met Medicare requirements and guidance.

We did not perform an overall assessment of Novitas's internal control structure. Rather, we limited our review to those controls that were significant to our objective. Specifically, we reviewed Novitas's oversight mechanisms for reviewing and processing Medicare claims for the selected services, and for preventing improper payments for those services that did not meet Medicare requirements.

Our audit procedures enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the data.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and Novitas guidance

- Interviewed Novitas officials to gain an understanding of its policies and procedures to ensure that providers complied with applicable Part B requirements and guidance for the selected services

[60] Of the total payment amount, $31,968,724 was for E/M services, $14,034,242 was for psychotherapy, and $7,685,152 was for podiatry and wound care services.

- Obtained paid claim data from CMS's NCH file

- Created a sampling frame of 292,794 patient-months consisting of selected Part B services with payments totaling $53,688,118 (Appendix B)

- Selected a stratified random sample of 150 patient-months from our sampling frame, and for each sample item, requested medical record documentation from the billing providers and patients' nursing facility to support the services billed (e.g., plan of care, minimum data set, physician orders, medication administration logs, and nurse notes)

- Used an independent medical review contractor to review the billing provider and nursing facility documentation to determine whether the services met Medicare requirements and guidance

- Reviewed and summarized the independent medical review contractor's results and calculated the improper payment amount for the sample items

- Estimated the amount of the Part B payments for the selected services in the sampling frame that did not meet Medicare requirements (Appendix C)

- Discussed the results of our audit with Novitas officials

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of selected Part B services Novitas paid to providers in Jurisdiction H for patients residing in nursing homes with dates of service during our audit period. The services were grouped into 292,794 patient-months with payments totaling $53,688,118. A patient-month included all payments for each service type provided to a patient in a calendar month. We included only patient-months that had between 3 and 10 services for E/M and psychotherapy and patient-months with any number of services for podiatry and wound care where the total payment amount was at least $25.[61]

SAMPLE UNIT

The sample unit was a patient-month.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing six strata (Table 5). The strata were based on the number of services for each selected service type.

Table 5: Strata in Sampling Frame

Stratum – Description	No. of Patient-Months in Sampling Frame	Frame Dollar Value	Sample Size
1 – E/M (3−4 services)	92,265	$17,659,040	30
2 – E/M (5−10 services)	41,563	14,309,684	30
3 – Psychotherapy (3−4 services)	38,997	7,659,338	30
4 – Psychotherapy (5−10 services)	17,593	6,374,904	30
5 – Podiatry and Wound Care (all services; total payment between $25.00 and $181.41)	93,289	3,356,985	15
6 – Podiatry and Wound Care (all services; total payment at least $181.62)	9,087	4,328,167	15
Total	**292,794**	**$53,688,118**	**150**

[61] We included all patient-months meeting the criteria above for patients who did not have a Part A skilled nursing facility stay during the audit period.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted the items in each stratum by patient Health Insurance Claim Number and service month and then consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total amount of the Part B payments for the selected services in the sampling frame that did not meet Medicare requirements. We used this software to calculate the point estimate and the corresponding lower and upper limits of the two-sided, 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 6: Sample Details and Results

Stratum	No. of Patient-Months in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Noncompliant Sample Items	Value of Noncompliant Sample Items
1	92,265	$17,659,040	30	$5,734	19	$1,872
2	41,563	14,309,684	30	11,146	23	3,392
3	38,997	7,659,338	30	5,837	14	2,273
4	17,593	6,374,904	30	11,450	21	6,352
5	93,289	3,356,985	15	512	12	371
6	9,087	4,328,167	15	7,265	2	62
Total	**292,794**	**$53,688,118**	**150**	**$41,944**	**91**	**$14,322**

Table 7: Estimated Value of Payments in the Sampling Frame That Did Not Meet Medicare Requirements

(Limits Calculated for the 90-Percent Confidence Interval)

Point estimate	$19,480,109
Lower limit	16,451,343
Upper limit	22,508,876

APPENDIX D: FEDERAL REQUIREMENTS AND NOVITAS'S LOCAL COVERAGE DETERMINATIONS

FEDERAL REQUIREMENTS

Section 1833(e) of the Act and 42 CFR § 424.5(a)(6) state that no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

Section 1862(a)(1)(A) of the Act and 42 CFR § 411.15(k)(1) state that no payment may be made under Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Furthermore, section 1862(a)(7) states that no payment shall be made for routine physical checkups.

Pursuant to 45 CFR § 162.1000, when conducting a transaction covered by this part, a covered entity must meet the following requirements:

(a) Medical data code sets. Use the applicable medical data code sets described in § 162.1002 as specified in the implementation specification adopted under this part that are valid at the time the health care is furnished.

Pursuant to 45 CFR § 162.1002, the Secretary adopts the following maintaining organization's code sets as the standard medical data code sets:

(a) For the period from October 16, 2002, through October 15, 2003:

(5) The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS),* as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4),* as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following:

(i) Physician services.
(ii) Physical and occupational therapy services.
(iii) Radiologic procedures.
(iv) Clinical laboratory tests.
(v) Other medical diagnostic procedures.
(vi) Hearing and vision services.
(vii) Transportation services including ambulance.

(c) For the period on and after October 1, 2015:

(1) The code sets specified in paragraphs . . . (a)(5) . . . of this section.

Pursuant to 42 CFR § 418.24 Election of hospice care.

(d) Waiver of other benefits. For the duration of an election of hospice care, an individual waives all rights to Medicare payments for the following services:

(2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services –

(i) Provided by the designated hospice:
(ii) Provided by another hospice under arrangements made by the designated hospice; and
(iii) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

The CMS *1997 Documentation Guidelines for Evaluation and Management Services* states that medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history, including past and present illnesses, examinations, tests, treatments, and outcomes.

The *CMS Medicare Claims Processing Manual,* Pub. No. 100-04, chapter 12, § 30.6.1(A)) states that documentation should support the level of E/M service reported. Additionally, § 30.6.13(A) states that the initial federally mandated visit is defined as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. Furthermore, § 30.6.13(B) states that E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient are payable under Part B.

The *2018-2019 National Correct Coding Initiative Policy Manual,* Chapter 1, §(E) states:

1) Modifiers may be appended to CPT codes only if the clinical circumstances justify the use of the modifier.

b) Modifier 25: the *CPT Manual* defines modifier 25 as a "significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service." Modifier 25 may be appended to an E/M CPT code to indicate that the

E/M service is significant and separately identifiable from other services reported on the same date of service. The E/M service may be related to the same or different diagnosis as the other procedure(s).

NOVITAS'S LOCAL COVERAGE DETERMINATIONS

L35068 - Evaluation and Management Services Provided in a Nursing Facility:

Initial Nursing Facility Care (99304, 99305, and 99306)

Initial nursing facility care includes all evaluation and management services performed by the same physician or group done in conjunction with that admission when performed on the same date as the admission or readmission. The nursing facility level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.

The initial visit is defined as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident.

Subsequent Nursing Facility Care (99307, 99308, 99309, and 99310)

Coverage for subsequent nursing facility care for evaluation of specific medical conditions will be considered reasonable and necessary if they would require the skill of a physician or non-physician practitioner (i.e., nurse practitioner, physician assistant, where permitted by State licensure) to evaluate the patient in a face-to-face contact.

In the nursing home environment, patients are in a controlled environment in which they are under close supervision and have immediate access to care from trained medical professionals. Under these circumstances, it is customary for physicians to direct nursing home personnel to perform, in the absence of the physician, many of those services that may be necessary but of a relatively minor nature. Frequent visits by the physician under these circumstances would then be unnecessary, particularly if the patient is medically stable. However, it would not be unreasonable for the attending physician to make several visits at the time of a new episode of illness or an acute exacerbation of a chronic illness.

The medical record should clearly reflect the particular circumstances requiring the increased frequency of services by documenting the following:

- patient instability or change in condition that the physician documents is significant enough to require a timely medical or mental status evaluation and/or physical examination to establish the appropriate treatment intervention and/or change in care plan;

- therapeutic issues that the physician documents require a timely follow-up evaluation to assess effectiveness of therapy or treatment - for example, recent surgical or invasive diagnostic procedures, pressure ulcer evaluation, psychotropic medication regimens, or (for the terminally ill) comfort measures;

- medical conditions including delirium, dementia, or changes in mental status manifest with behavioral symptoms that require timely evaluation; and

- nursing staff, rehabilitation staff, patient, or family requests to address a documented medical issue of concern that requires a physical (or mental status) examination.

The medical record must clearly reflect the medical necessity of the service, as well as the key components necessary to report the particular level of care reported.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to [the MAC] upon request.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The record must include the physician or non-physician practitioner responsible for and providing the care to the patient.

3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS codes should describe the service performed.

4. Documentation should detail the specific elements of the E/M service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information may be denied.

L35101 - Psychiatric Codes:

Section III: Psychotherapy Services

Psychotherapy is the treatment for mental illness and behavior disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Indications

Psychotherapy will be considered medically necessary when the patient has a psychiatric illness or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

Psychotherapy services must be comprised of clinically recognized therapies that are pertinent to the patient's illness or condition. The type, frequency and duration of services must be medically necessary for the patient's condition under accepted practice standards.

There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning, or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition, or chronic mental disorders.

The patient must have the capacity to actively participate in all therapies prescribed.

To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist.

For patients suffering from dementia, the type and degree of dementia must be considered in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should support that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

The duration of psychotherapy must be individualized for every patient. The provider of service must document in the patient's record the medical necessity for continued (prolonged) treatments.

Limitations

Psychotherapy services are not considered reasonable and necessary when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist, which allows insight-oriented, behavior-modifying or supportive therapy to be effective.

Psychotherapy services are not considered reasonable and necessary when they primarily include teaching grooming skills, monitoring activities of daily living, recreational therapy (dance, art, play) or social interaction.

General Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to [the MAC] upon request.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

4. The medical record documentation must support the medical necessity of the services as stated in this policy.

5. The total number of timed minutes must be documented in the patient's medical record.

Specific Documentation Requirements

Section III: Psychotherapy Services

1. The medical record must indicate in legible form, the time spent in the psychotherapy encounter and the therapeutic maneuvers such as behavior modification, supportive interactions and interpretation of unconscious motivation that were applied to produce therapeutic change or stabilization.

L35013 – Debridement of Mycotic Nails:

Documentation Requirements[62]

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

7. Documentation of mycotic nail debridement services to residents of nursing homes must include a current nursing facility order (dated and signed with date of signature) for mycotic nail debridement services issued by the patient's supervising physician. Such orders must meet the following requirements:

[62] We only included the sections applicable to the findings.

- The order must be dated and must have been issued by the supervising physician prior to mycotic nail debridement services being rendered.

- Telephone or verbal orders not written personally by the supervising physician must be authenticated by the dated physician's signature within a reasonable period of time following issuance of the order.

- The order must be consistent with the attending physician's overall plan of care.

- The order must be for medically necessary services to address a specific patient complaint of physical finding.

- Routinely issued or "standing" facility orders for mycotic nail debridement services that do not meet the above requirements are insufficient.

APPENDIX E: NOVITAS'S COMMENTS

NOVITAS SOLUTIONS

May 18, 2026

OFFICE OF AUDIT SERVICES, REGION VI
1100 COMMERCE STREET, ROOM 632
DALLAS, TX 75242

RE: A-06-21-04002

Novitas appreciates the opportunity to address the concerns presented by the Office of Inspector General in the report labeled *Department of Health and Human Services, Office of Inspector General (OIG) draft report Novitas Solutions, Inc., Improperly Paid Approximately $19.5 Million for Selected Medicare Part B Services Provided to Patients Residing in Nursing Homes.* It is noteworthy to mention that this report started in 2021, and the scope and timeframe of this audit was from October 1, 2018 – September 30, 2019.

The following are recommendations from OIG and Novitas' responses:
Recommendation 1:
Implement additional oversight to prevent improper payments associated with provider billing of the selected services.

Novitas Response:
Novitas is in concurrence and recognizes the importance of strengthening oversight controls to reduce the risk of improper payments associated with provider billing for the identified services. However, Novitas notes that a Public Health Emergency (PHE) began shortly after the audit period (1/31/2020–5/11/2023), which significantly limited medical review activities, including a six-month suspension of all medical reviews and a three year, three month prohibition on reviews of E/M services which accounted for 46% of the errors identified in the audit findings. Additionally, due to the age of the claims reviewed, providers were not afforded appeal rights, and a portion of the identified errors may have been overturned, reducing the projected impact.

Novitas has resumed full medical review activities post-PHE and continues to enhance oversight through data-driven reviews and targeted audit efforts. Novitas also provides ongoing, robust education to providers and billing staff on Medicare requirements, including billing for E/M, psychotherapy, and podiatry services. These efforts have contributed to measurable improvement, as reflected in a reduction in the CERT error rate from 6.22% during the audit period to 4.5% as of November 2025.

Recommendation 2:
Novitas provide annual education to providers and their billing staff specific to the Medicare requirements and guidance for billing E/M, psychotherapy, and podiatry services.
Novitas Response:

Novitas is in concurrance with the recommendation and notes that Novitas already maintains a robust and ongoing provider education program aligned with Medicare requirements. From 2017–2025, Novitas conducted over 270 in-person and virtual education events reaching approximately 39,000 providers, covering topics including E/M, psychotherapy, podiatry, wound care services, modifier usage, documentation standards, and local coverage determinations. In addition, Novitas offers comprehensive online resources, including an E/M Center with coding guidance, tools, and FAQs to support accurate billing.

Novitas will continue to deliver targeted, annual education informed by identified billing and documentation risks. Further, Novitas will explore opportunities to enhance provider awareness of documentation request processes, including potential collaboration with oversight entities to improve provider understanding and response to medical record requests. These efforts support continued improvement in billing accuracy and compliance.

In summary, Novitas remains committed to strengthening oversight and enhancing provider education to promote compliance with Medicare requirements. Through continued improvements in review processes and targeted, data-driven outreach, Novitas will sustain efforts to reduce improper payments and improve billing accuracy. These actions reflect our ongoing dedication to program integrity and continuous improvement.

Sincerely,

Deborah A Taylor

Digitally signed by Deborah A Taylor
Date: 2026.05.19 08:21:12 -04'00'

Deb Taylor
VP and COO

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