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IMPROPER PAYMENTS FOR EVALUATION AND MANAGEMENT SERVICES COST MEDICARE BILLIONS IN 2010

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EXECUTIVE SUMMARY: IMPROPER PAYMENTS FOR EVALUATION AND MANAGEMENT SERVICES COST MEDICARE BILLIONS IN 2010
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WHY WE DID THIS STUDY

Evaluation and management (E/M) services are visits performed by physicians and nonphysician practitioners to assess and manage a beneficiary's health. Medicare paid $32.3 billion for E/M services in 2010, representing nearly 30 percent of Part B payments that year. In 2012, the Office of Inspector General (OIG) reported that physicians increased their billing of higher level codes, which yield higher payment amounts, for E/M services in all visit types from 2001 to 2010. The Centers for Medicare & Medicaid Services (CMS) found that E/M services are 50 percent more likely to be paid for in error than other Part B services; most improper payments result from errors in coding and from insufficient documentation.

HOW WE DID THIS STUDY

We conducted a medical record review of a random sample of Part B claims for E/M services from 2010, stratifying claims from physicians who consistently billed higher level codes for E/M services (i.e., "high-coding" physicians) and claims from other physicians. Certified professional coders determined whether the E/M service documented in the medical record for each sampled claim was correctly coded and/or sufficiently documented.

WHAT WE FOUND

In total, Medicare inappropriately paid $6.7 billion for claims for E/M services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. We found that 42 percent of claims for E/M services in 2010 were incorrectly coded, which included both upcoding and downcoding (i.e., billing at levels higher and lower than warranted, respectively), and 19 percent were lacking documentation. Additionally, we found that claims from high-coding physicians were more likely to be incorrectly coded or insufficiently documented than claims from other physicians.

WHAT WE RECOMMEND

We recommend that CMS (1) educate physicians on coding and documentation requirements for E/M services, (2) continue to encourage contractors to review E/M services billed for by high-coding physicians, and (3) follow up on claims for E/M services that were paid for in error. CMS concurred with our first recommendation, did not concur with our second recommendation, and partially concurred with our third recommendation

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OBJECTIVE

To determine the extent to which evaluation and management (E/M) services in 2010 were incorrectly coded and/or lacking documentation.

BACKGROUND

E/M services are visits covered under Medicare Part B and performed by physicians and nonphysician practitioners (hereinafter, collectively referred to as physicians) to assess and manage a beneficiary's health.[1] Medicare paid $32.3 billion for E/M services in 2010, representing nearly 30 percent of Part B payments that year.[2, 3] E/M services are divided into broad categories that reflect the type of service, the place of service, and the patient's status. These broad categories of E/M services are known as visit types. Most visit types are further divided into three to five levels, which reflect the complexity of a visit and correspond to Current Procedural Terminology (CPT) codes for billing purposes.[4, 5] Higher level codes within a visit type correspond to increased complexity of the E/M service and higher payment rates.[6]

In 2012, OIG reported that from 2001 to 2010, physicians increased their billing of higher level codes for E/M services in all visit types.[7] Additionally, OIG identified 1,669 physicians who consistently billed for the two highest level codes for E/M services in 2010. Moreover, the

[1] Nonphysician practitioners are health care providers (e.g., nurse practitioners, clinical nurse specialists, and physician assistants) who practice either in collaboration with a physician or under the supervision of a physician.

[2] Office of Inspector General (OIG) analysis of the 2010 National Claims History Part B file.

[3] Medicare-allowed amounts are 100 percent of the payment made to a provider (e.g., a physician) by both Medicare and the beneficiary. Medicare pays 80 percent of allowed charges, and the beneficiary is responsible for the remaining 20 percent.

[4] Certain visit types do not have complexity levels. These visit types are hospital observation discharge services (99217), standby services (99360), and other E/M services (99499).

[5] **The five character codes and descriptions included in this study are obtained from Current Procedural Terminology (CPT®), copyright 2009 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this study should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

[6] Payment rates for E/M services are set forth by the Medicare physician fee schedule. Section 1848(a)(1) of the Social Security Act established this fee schedule as the basis for Medicare reimbursement for all physician services, including E/M services, beginning in January 1992.

[7] OIG, *Coding Trends of Medicare Evaluation and Management Services* (OEI-04-10-00180), May 2012.

Centers for Medicare & Medicaid Services (CMS) has reviewed the appropriateness of claims for E/M services through the Comprehensive Error Rate Testing (CERT) program.[8] In its 2011 CERT report, CMS found that E/M services made up a large proportion of Part B improper payments and were 50 percent more likely to be paid for in error than other Part B services.[9] Most of these improper payments for E/M services were due to incorrect coding and insufficient documentation.

Coding of E/M Services

E/M services must be medically reasonable and necessary, in addition to meeting the individual requirements of the CPT code that is used on the claim.[10, 11] According to CMS, "[I]t would not be medically necessary or appropriate to bill [for] a higher level of [E/M] service when a lower level of service is warranted."[12] Physicians are responsible for ensuring that the claims they submit to Medicare accurately reflect the E/M services provided and the billing levels corresponding to those services.[13]

As defined by CPT, the level of an E/M service is determined by seven components: patient history, physical examination, medical decisionmaking, counseling, coordination of care, the nature of the patient's presenting problem(s), and time. The first three components are key in determining the correct code for the E/M service:

- *Extent of patient history*. Physicians use their clinical judgment and the nature of the patient's presenting problem(s) to determine the depth of history needed to complete the service. A patient history can be classified into one of four types, ranging from problem focused to comprehensive.
- *Extent of physical examination*. Physicians use their clinical judgment and the presenting medical problem(s) to determine the type of examination needed. There are four types of physical examinations, ranging from problem focused to comprehensive.
- *Complexity of medical decisionmaking*. The complexity of medical decisionmaking hinges on the number of possible diagnoses or the

[8] As a result of the Improper Payments Information Act (IPIA) of 2002, CMS established the CERT program to randomly sample and review claims submitted to Medicare.
[9] CMS, *Medicare Fee-for-Services 2011 Improper Payments Report*, October 2012, pp. 32–33. Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf on October 21, 2013.
[10] CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 12, § 30.6.1.A.
[11] Social Security Act § 1862(a)(1)(A).
[12] CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 12, § 30.6.1.A.
[13] CMS, *Evaluation and Management Services Guide*, December 2010, p. 4.

number of options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and other information that physicians must obtain, review, and analyze; and the risk of significant complications, morbidity, and/or mortality. There are four types of medical decisionmaking, ranging from straightforward to high complexity.

For visits that consist predominantly of counseling or coordination of care, time—rather than the three factors listed above—is the key factor in determining the correct code for the E/M services.[14] See Appendix A for more detail on the components used to determine the level of an E/M service.

Documentation of E/M Services

Physicians' documentation must support the medical necessity and appropriateness, as well as the level, of the E/M service.[15, 16] Clear and concise medical record documentation is required in order for physicians to receive accurate and timely payment for furnished services.[17] In the medical record, physicians should document the care a patient received and pertinent facts, findings, and observations about the patient's health history.[18] The medical record should also be complete and legible and include the date and legible identity of the physician who furnished the service. Further, Medicare requires that services provided be authenticated by the author of the medical record, with either a handwritten or electronic signature.[19] If the signature in the medical record is illegible or missing, CMS asks the physician to "attest" to his/her signature.[20] If the physician does not provide this attestation statement, CMS then considers the claim to be insufficiently documented.

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[14] If the level of an E/M service is based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the medical record should describe the counseling and/or activities to coordinate care. CMS, *Evaluation and Management Services Guide*, December 2010, pp. 21 and 25.

[15] For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary's medical record and confirm that Medicare coverage criteria have been met. CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 3, § 3.3.2.1. See also Social Security Act § 1156(a).

[16] The Social Security Act states that Medicare will not pay for services, including E/M services, unless the provider has furnished information necessary to support the claim. Social Security Act § 1833(e).

[17] CMS, *Evaluation and Management Services Guide*, December 2010, p. 3.

[18] Ibid. pp. 3–4.

[19] Stamped signatures are not acceptable. CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 3, § 3.3.2.4.

[20] Ibid.

The documentation in the medical record must also support the type of each key component used to determine the appropriate level of E/M service. CMS has issued guidelines for physicians to use when determining and documenting the appropriate level of an E/M service. These guidelines outline what documentation is necessary to include in the medical record to support the level of an E/M service. There are two versions of the documentation guidelines, one from 1995 and one from 1997.[21, 22] There are differences between these two versions, the most substantial being in the section regarding physical examinations.[23] Physicians can use either version of the documentation guidelines, but not a combination of the two, to determine the appropriate level for an E/M service.[24] However, to document E/M services provided on or after September 2013, physicians may use the *1997 Documentation Guidelines* for an extended history of present illness along with other elements from the *1995 Documentation Guidelines*.[25]

Related OIG Work

This study is part of a larger body of work about E/M services. The first study in this series found that from 2001 to 2010, physicians increased their billing of higher level codes for E/M services in all visit types.[26] Additionally, 1,669 physicians consistently billed for the two highest level codes for E/M services in 2010. The second study looked at the adoption of electronic health record (EHR) technology, finding that 57 percent of physicians who provided E/M services in 2010 used an EHR system at their primary practice locations in 2011.[27]

In 2006, OIG reported that 75 percent of consultations—which are one type of E/M service—did not meet Medicare coverage requirements in

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[21] The full names of these publications are the *1995 Documentation Guidelines for Evaluation and Management Services* and the *1997 Documentation Guidelines for Evaluation and Management Services*. They can be found online at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf and http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf, respectively.

[22] Hereinafter, we refer to these two versions of documentation guidelines as the *1995 Documentation Guidelines* and the *1997 Documentation Guidelines*.

[23] CMS, *Evaluation and Management Services Guide*, December 2010, p. 13.

[24] Ibid., pp. 1 and 13.

[25] CMS, *FAQ on 1995 & 1997 Documentation Guidelines for Evaluation & Management Services*, September 2013. Accessed at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/EM-FAQ-1995-1997.pdf on January 10, 2014.

[26] OIG, *Coding Trends of Medicare Evaluation and Management Services* (OEI-04-10-00180), May 2012.

[27] OIG, *Use of Electronic Health Record Systems in 2011 Among Medicare Physicians Providing Evaluation and Management Services* (OEI-04-10-00184), June 2012.

2001, resulting in $1.1 billion in improper payments.[28] OIG also found that consultations billed for at the highest level were miscoded 95 percent of the time. In 2010, CMS discontinued paying for CPT codes for consultations.[29]

METHODOLOGY

We based this study on a medical record review of a random sample of Part B claims for E/M services from 2010.

Selection of Sample for Medical Review

Using CMS's National Claims History File, we identified all Part B claims for E/M services with a service date in 2010 and a Medicare payment amount greater than zero.[30] We limited our analysis to E/M services that corresponded to visit types with three to five complexity levels.[31] We also limited our analysis to physicians who had claims for 100 or more E/M services in 2010.[32] Therefore, our sampling frame consisted of 369,629,103 claims for E/M services and represented $32.3 billion in Medicare payments.

We grouped claims into two strata defined by physicians' coding of E/M services.

- Stratum 1 consisted of 828,646 claims from physicians we categorized as "high-coding physicians." To identify high-coding physicians, we (1) identified physicians whose average code level was in the top 1 percent of their primary specialty; and (2) from that subset of physicians, identified those that billed for the two highest level codes for E/M services at least 95 percent of the time.
- Stratum 2 consisted of 368,800,457 claims for E/M services from physicians we categorized as "other physicians." These physicians did not meet the criteria used to identify high-coding physicians.

[28] OIG, *Consultations in Medicare: Coding and Reimbursement* (OEI-09-02-00030), March 2006.

[29] 74 Fed. Reg. 61738, 61768–69 (Nov. 25, 2009).

[30] Typically, a set of services is billed for on one Part B claim; each service is listed as a separate line item on that claim. For the purposes of this report, we refer to claim line items as claims.

[31] The sampling frame includes claims with CPT codes 99201–99205, 99211–99215, 99218–99223, 99231–99236, 99241–99245, 99251–99255, 99281–99285, 99304–99310, 99324–99328, 99334–99337, 99341–99346, and 99347–99350.

[32] Claims submitted by physicians with fewer than 100 E/M services represented less than 2 percent of Medicare payments in 2010 and 30 percent of all physicians who billed for E/M services.

We then selected a stratified simple random sample of 673 claims (309 from stratum 1 and 364 from stratum 2). See Tables B-1 and B-2 in Appendix B for further details on this study's sample selection.

Medical Record Review

We used a contractor to collect and review for completeness the medical records for each sampled claim. The contractor mailed up to three requests to obtain the medical records and telephoned nonresponding physicians to ensure they had received the requests. The final request was sent by certified mail, which requires a signature.

We did not receive medical records for 55 claims:

- We classified 39 of these claims as undocumented errors, either because the physician received our request but did not respond to it or because the documentation that the physician sent did not contain any information relevant to our sampled claim.
- We classified the remaining 16 claims as nonrespondents because we did not receive responses and were unable to confirm that the physicians had received our requests.[33] Three of these claims were associated with physicians whose national provider identifiers had been deactivated.

Overall, we received the medical records for, or classified as errors, 657 of the 673 sampled claims, for a weighted response rate of 98.6 percent.[34] The response rate for stratum 1 was 96.4 percent,[35] and the response rate for stratum 2 was 98.6 percent.[36] Hereinafter, projections to our population and strata are based on these response rates. Table 1 shows the number of sampled claims, respondent claims, and response rate by stratum and overall.

[33] We will refer a list of nonresponding physicians to CMS.

[34] Overall results are projectable to 98.6 percent of the population of Medicare claims for E/M services in 2010, representing $31.5 billion of $32.3 billion.

[35] Results for stratum 1 are projectable to 96.4 percent of Medicare claims for E/M services billed for by high-coding physicians, representing $104 million of $108 million.

[36] Results for stratum 2 are projectable to 98.6 percent of Medicare claims for E/M services billed for by other physicians, representing $31.4 billion of $32.2 billion.

Table 1: Sampled Claims and Response Rate by Stratum, 2010

Stratum	Description	Number of Sampled Claims	Number of Respondent Claims	Response Rate
1	Claims for E/M services billed for by high-coding physicians	309	298	96.4%
2	Claims for E/M services billed for by other physicians	364	359	98.6%
Total		**673**	**657**	**98.6%**

Source: OIG analysis of 2010 Part B claims for outpatient E/M services, 2013.

We also contracted with three certified professional coders (hereinafter, referred to as reviewers), each of whom had experience reviewing claims for E/M services. In addition, we contracted with a registered nurse to assist with determinations on whether documentation supported medical necessity. The reviewers independently reviewed a set of records and consulted with the nurse as needed. The reviewers completed a standardized data-collection instrument that was based on Medicare coverage and documentation requirements for E/M services and applied relevant local coverage determinations, as appropriate.[37] Applying both the *1995* and *1997 Documentation Guidelines*, reviewers determined the appropriate level for an E/M service using whichever version of the documentation guidelines resulted in the most advantageous code for the physician. We developed the instrument in collaboration with the reviewers and tested it on a separate sample of claims.[38]

The reviewers conducted the medical review between October 2012 and May 2013. The reviewers determined whether the E/M service documented in the medical record for each sampled claim was correctly coded and/or sufficiently documented.

- Reviewers classified sampled claims for E/M services as incorrectly coded if the medical record supported a lower or higher level code (i.e., "miscoded") or if there were other coding errors, such as

[37] Medicare claims processing contractors develop their own coverage guidelines (i.e., local coverage determinations) regarding medical necessity, if no national coverage determination exists. Section 522 of the Benefits Improvement and Protection Act of 2000 defines a local coverage determination as a decision by a Medicare claims processing contractor whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with section 1862(a)(1)(A) of the Social Security Act (e.g., a determination as to whether the service or item is reasonable and necessary).

[38] We conducted a preliminary review of 10 claims for E/M services to test the instrument and to ensure consistency among the reviewers. These 10 claims were not included in our sample.

documentation supporting a code for a non-E/M service (i.e., "wrong code") or if the medical record indicated unbundling.[39]

- Reviewers classified sampled claims for E/M services as insufficiently documented if the medical record (1) did not contain pertinent information to support the service provided (e.g., the patient's name and status, overall condition and diagnosis, and the extent of services performed), (2) did not support the medical necessity of the service provided, and/or (3) was illegible.[40] Reviewers also identified sampled claims for E/M services for which the physicians' signatures were illegible, missing, or unacceptable (e.g., typed name with no initials or signature). CMS provides physicians with an opportunity to attest to a signature when it is illegible or missing. Because we did not request signature attestations from physicians, claims for E/M services with only signature issues were not considered to be in error.[41]

Our contractor and reviewers also collected information on whether the medical record for the sampled claim was (1) paper or electronic (i.e., medical record type) and (2) formatted using the *1995* or *1997 Documentation Guidelines* (i.e., medical record format). See Tables B-3 and B-4 in Appendix B for further details on this study's subgrouping.

Analysis

We analyzed the information from the medical record review to determine the percentage of claims for E/M services in 2010 that were incorrectly coded and/or lacking documentation overall, by stratum, and by subgroup. For miscoded claims, we compared the original code from the sampled

[39] "Unbundling" is the practice of inappropriately reporting each component of a service or procedure instead of reporting the single comprehensive code. CMS does not allow additional payments for separate E/M services performed by a physician on the same day as a procedure, unless the E/M service is significant, is separately identifiable, and is above and beyond the usual preoperative and postoperative care associated with the procedure, indicated by modifier 25 on the claim. We considered claims to be in error if modifier 25 was listed on the claim and the medical record did not support that the E/M service was significant, was separately identifiable, and was above and beyond the usual preoperative and postoperative care associated with the procedure.

[40] We did not request documentation needed to determine whether guidelines were met for "incident to" and "split/shared" billing and resident/teaching physician arrangements. As a result, we did not consider these claims to be in error if certain documentation was missing. However, we did consider these claims to be in error if the errors were discernible. For example, an office visit with a new patient cannot be performed "incident to"; it would be considered an error if auxiliary personnel or a nonphysician practitioner was documented in the medical record as having provided the service and it was then billed for by the physician. CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 15, § 60.1.B. See also First Coast Service Options, Inc., *Billing physician assistant services 'incident to' a doctor FAQ*. Accessed at http://medicare.fcso.com/FAQs/Answers/157191.asp on December 18, 2013.

[41] Thirteen percent of claims for E/M services in 2010 had illegible, missing, or unacceptable signatures and no other errors.

claim with the correct code. When the correct code was lower than the code originally billed for, we considered the claim to be upcoded. Conversely, when the correct code was higher than that originally billed for, we considered the claim to be downcoded.[42] We determined whether differences in error rates were statistically significant between strata and subgroups.[43] For the subgroups of medical record type and format, differences for all error rates were not statistically significant at the 95-percent confidence level.[44]

We also calculated the projected amount that Medicare inappropriately paid in 2010 for claims for E/M services that were incorrectly coded and/or lacking documentation overall and by stratum. For miscoded claims (including those with an insufficient-documentation error), we considered as inappropriate the net *difference* between the amount that was paid and the amount that should have been paid. For all other errors, we considered the entire Medicare payment amount from the sampled claim to be inappropriate.

The CERT Program and This Evaluation

This evaluation is not designed to reproduce or review the findings reported through the CERT program. CMS reported on E/M services through its CERT program in 2011 and 2012. Further, our review and the results reported through the CERT program should not be directly compared because the goals and methodologies of each review are different. The goal of the CERT program is to measure the performance of CMS's contractors by calculating a paid-claims error rate, while the objective for this OIG study was to determine specifically whether E/M services billed to Medicare in 2010 were incorrectly coded and/or lacking documentation overall, by stratum, and by subgroup. Our evaluation thus provides greater depth of information specific to E/M services than the CERT program offers. Additionally, CMS bases error rates on dollars and number of services, whereas our review bases the error rate on the number

[42] Reviewers identified eight claims for E/M services for which the medical record supported a code for a different visit type than that originally billed by the physician. We considered these claims to be miscoded. If the payment rate for the correct code was lower than the payment rate for the code originally billed, we considered the claim to be upcoded. Similarly, we considered the claim to be downcoded if the payment rate for the correct code was higher than the payment rate for the code originally billed by the physician.

[43] We used an independent group t-test to determine whether differences in error rates between strata were statistically significant. We used a Rao-Scott chi-square test to determine whether differences in error rates between subgroups were statistically significant.

[44] See Appendix F for sample sizes, point estimates, confidence intervals, and results of statistical tests.

of claims. For more information on the CERT program and how it relates to this evaluation, see Appendix C.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Fifty-five percent of claims for E/M services were incorrectly coded and/or lacking documentation in 2010, resulting in $6.7 billion in improper Medicare payments

According to our medical record review, 55 percent of claims for E/M services in 2010 were incorrectly coded and/or lacking documentation. Medicare inappropriately paid $6.7 billion for these claims, representing 21 percent of Medicare payments for E/M services in 2010. In particular, 26 percent were upcoded and 15 percent were downcoded. Additionally, nearly 7 percent of claims for E/M services in 2010 were both incorrectly coded and insufficiently documented. Table 2 shows the percentage of erroneous claims for E/M services and payments in error. See Appendix D for point estimates and confidence intervals.

Table 2: Percentage of and Medicare Payments for Claims for E/M Services in Error, 2010

Type of Error	Percentage of Claims for E/M Services	Medicare Payments (in Billions)
Incorrectly Coded	42.4%	$3.3
-Miscoded	40.4%	$2.8
- Upcoded	26.0%	$4.6
- Downcoded	14.5%	($1.8)
- Other Coding Error (e.g., Wrong Code, Unbundling)	2.0%	$0.5*
Lacking Documentation	19.0%	$4.6
- Insufficiently Documented	12.0%	$2.6
- Undocumented	7.0%	$2.0
Overall Gross**	61.3%	$7.9
Overlapping	(6.7%)	($1.1)
Overall Net**	**54.6%**	**$6.7**

*The 95-percent confidence interval for this point estimate was $80,378,029 to $829,370,881. Because few sampled claims for E/M services in 2010 fell into the category of "other coding error," the confidence interval for this estimate was wide.
**The column sum of certain percentages and dollar figures does not equal the overall gross or net totals because of rounding.
Source: OIG analysis of 2010 E/M medical records, 2014.

Most (79 percent of) miscoded claims were upcoded or downcoded by *one* level; however, 17 percent and 4 percent of claims were upcoded and downcoded, respectively, by two levels. A small percentage (0.8 percent) of claims were upcoded by three levels, and an even smaller percentage (0.004 percent) were upcoded by four levels. No claims in our sample were downcoded by three or four levels.

Twenty-six percent of claims for E/M services were upcoded

Twenty-six percent of claims for E/M services were upcoded in 2010. That is, a lower level code would have been more appropriate for the E/M service documented in the medical record than the code billed for by the physician. For example, for one claim in our sample, the physician billed for code 99215 (the highest level code for the visit type "established patient office/outpatient visit"); however, the medical record supported a lower level code, 99213.[45] For this visit type, at least two of the three key components must be documented in order to bill for a specific level of E/M service. For 99215 to have been appropriate, the medical record should have contained documentation to support at least two of the following: a comprehensive patient history, a comprehensive examination, and medical decisionmaking of high complexity.[46] For this sampled claim, the medical record contained documentation that supported only an expanded problem-focused examination and medical decisionmaking of moderate complexity.[47]

Fifteen percent of claims for E/M services were downcoded

Fifteen percent of claims for E/M services were downcoded in 2010. That is, a higher level code would have been more appropriate for the E/M service documented in the medical record than the code billed for by the physician. For example, for one claim in our sample, the physician billed for code 99213 (the middle-level code for the visit type "established patient office/outpatient visit"); however, the medical record supported a higher level code (99214).[48] The documentation in the medical record for this sampled claim supported a comprehensive patient history, a detailed examination, and medical decisionmaking of moderate complexity. For 99213 to have been appropriate, the medical record should have contained documentation to support at least two of the following: an expanded problem-focused patient history, an expanded problem-focused examination, and medical decisionmaking of low complexity.[49]

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[45] See footnote 5 for the AMA copyright notice.

[46] Ibid.

[47] No patient history was documented in the medical record for this sampled claim. However, this claim was not considered insufficiently documented for this missing patient history, because the other two key components were sufficiently documented and at least two of the three key components must be documented in order to bill for a specific level of E/M service for this visit type.

[48] See footnote 5 for the AMA copyright notice.

[49] Ibid.

Two percent of claims for E/M services had other coding errors

Two percent of claims for E/M service in 2010 had coding errors other than upcoding or downcoding. These errors included wrong codes (i.e., when the documentation in the medical record supported codes for non-E/M services)—and unbundling (i.e., the practice of inappropriately reporting each component of a service or procedure instead of reporting the single, comprehensive code). For example, one claim in our sample contained documentation that supported a procedure but not a significant, separately identifiable E/M service. In another example, the medical record for a claim in our sample stated that the beneficiary had received an injection; the record did not contain any documentation to support the E/M service for which the physician had billed.

Twelve percent of claims for E/M services were insufficiently documented

The documentation in the medical record must support the medical necessity and appropriateness, as well as the level, of the E/M service. Twelve percent of claims for E/M services were insufficiently documented in 2010. The documentation in the medical record must also support the type of each key—and, if applicable, contributory—component used to determine the appropriate level of E/M service. For example, the level of the E/M service for one insufficiently documented claim in our sample was based on counseling and/or coordination of care; however, only the length of time of the encounter was documented in the medical record. The medical record contained no description of the counseling and/or activities to coordinate care, as required by Medicare.

Seven percent of claims for E/M services were undocumented

Physicians must provide documentation upon request to support claims for Medicare services. Seven percent of claims for E/M services were undocumented in 2010. For these undocumented claims, either the physician received our request but did not respond to it or the documentation that the physician sent did not contain any information relevant to our sampled claim.

Claims for E/M services billed for by high-coding physicians were more likely to be incorrectly coded or insufficiently documented than those billed for by other physicians

High-coding physicians are defined as (1) physicians whose average code level was in the top 1 percent of their specialty; and (2) from that subset of physicians, those that billed for the two highest level codes for E/M services at least 95 percent of the time.

Claims for E/M services billed for by high-coding physicians were more likely to be incorrectly coded than those billed for by other physicians.

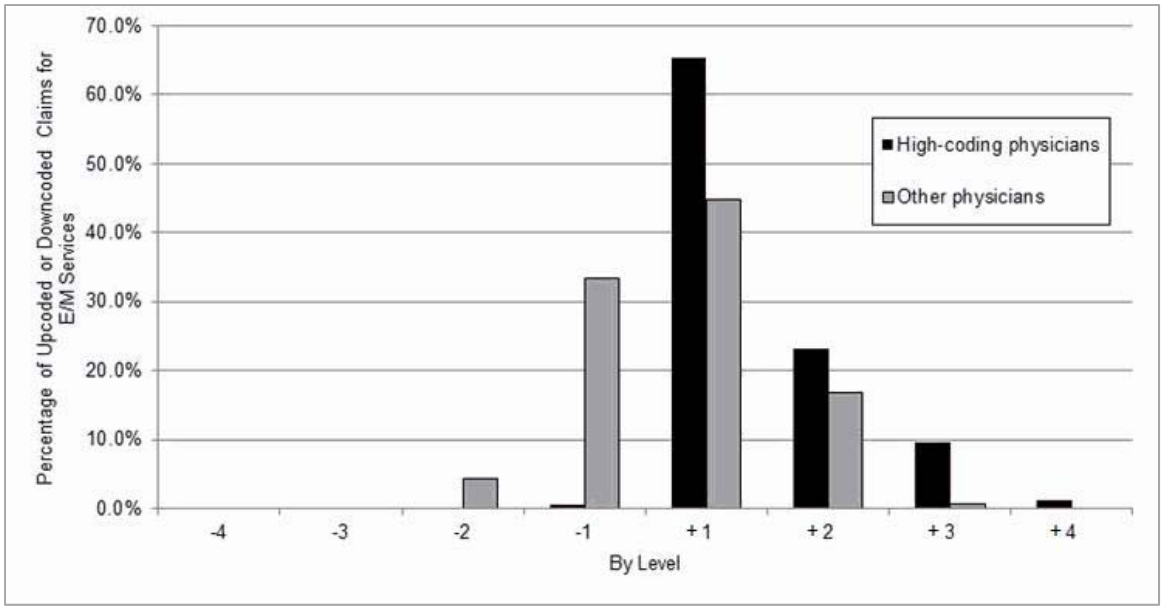
- Fifty-six percent of claims for E/M services billed for by high-coding physicians in 2010 were incorrectly coded. Medicare inappropriately paid $26 million for these claims, representing 25 percent of total Medicare payments for E/M services billed for by high-coding physicians in 2010. Medicare inappropriately paid an average of $15,594 per high-coding physician in 2010 for incorrectly coded claims for E/M services.[50] Ninety-nine percent of miscoded claims for E/M services billed for by high-coding physicians in 2010 were upcoded, while less than 1 percent were downcoded.
- Forty-two percent of claims for E/M services billed for by other physicians were incorrectly coded. Medicare inappropriately paid $3.2 billion for these claims, representing 10 percent of total Medicare payments for E/M services billed for by other physicians in 2010. Medicare inappropriately paid an average of $7,348 per other physician in 2010 for incorrectly coded claims for E/M services.[51] Sixty-four percent of miscoded claims for E/M services billed for by other physicians in 2010 were upcoded, while 36 percent were downcoded.

Figure 1 shows the percentage of upcoded claims, shown as positive, and downcoded claims, shown as negative, for E/M services by stratum and level. See Appendix E for point estimates, confidence intervals, and results of statistical tests.

[50] To determine the average amount Medicare inappropriately paid for incorrectly coded claims for E/M services per high-coding physician, we divided $26 million by the total number of physicians in stratum 1 (i.e., 1,669).

[51] To determine the average amount Medicare inappropriately paid for incorrectly coded claims for E/M services per other physician, we divided $3.2 billion by the total number of physicians in stratum 2 (i.e., 440,321).

Figure 1: Percentage of Upcoded and Downcoded Claims for E/M Services by Stratum and Level, 2010



Source: OIG analysis of 2010 E/M medical records, 2014.

Additionally, claims for E/M services billed for by high-coding physicians were more likely to be insufficiently documented than those billed for by other physicians. Twenty percent of claims for E/M services billed for by high-coding physicians were insufficiently documented, compared to 12 percent of those billed for by other physicians. The difference in error rates for undocumented claims by stratum was not statistically significant at the 95-percent confidence level. See Table E-3 in Appendix E.

CONCLUSION AND RECOMMENDATIONS

In 2010, Medicare paid $32.3 billion for E/M services. In 2012, OIG reported that from 2001 to 2010, physicians increased their billing of higher level codes for E/M services in all visit types. CMS also found through its CERT program that E/M services are 50 percent more likely to be paid for in error than other Part B services; most improper payments result from errors in coding and from insufficient documentation.

In total, Medicare inappropriately paid $6.7 billion for claims for E/M services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. Our medical record review found that 42 percent of claims for E/M services in 2010 were incorrectly coded, which included both upcoding and downcoding, and 19 percent of claims for E/M services were lacking documentation. Additionally, we found that claims from high-coding physicians were more likely to be incorrectly coded or insufficiently documented than claims from other physicians.

Collectively, our findings highlight errors associated with E/M services that must be addressed to properly safeguard Medicare. Even though Medicare payment rates for individual E/M services are small (about $100 on average), 370 million E/M services were billed for by physicians in 2010 and accounted for nearly 30 percent ($32.3 billion of $110 billion) of Part B payments that year. Given the substantial spending on E/M services and the prevalence of error, CMS must use all of the tools at its disposal to more effectively identify and eliminate improper payments associated with E/M services.

We recommend that CMS:

Educate physicians on coding and documentation requirements for E/M services

CMS should educate physicians on coding and documentation requirements for E/M services, either directly or through its contractors. Specifically, CMS should educate physicians on the components used to determine the level of an E/M service and emphasize the documentation needed in the medical record to support that level. CMS should also review its current materials for educating physicians regarding the coding and documentation of E/M services and determine whether any revisions or updates are needed.

Continue to encourage contractors to review E/M services billed for by high-coding physicians

As part of its efforts to address recommendations made in the OIG report *Coding Trends of Medicare Evaluation and Management Services*

(OEI-04-10-00180), CMS directed its contractors to consider high-coding physicians as they prioritize their medical review strategies. Toward that end, CMS should continue to encourage its contractors to focus medical record reviews of E/M services on claims from high-coding physicians, including those identified in this review and through analysis of subsequent years of claims data. We acknowledge that CMS and its contractors must weigh the costs and benefits of reviewing claims for E/M services against doing so for more costly Part B services. However, by applying our criteria and focusing medical record review on high-coding physicians, CMS and its contractors would be more likely to identify errors and improper payments, thereby making reviews of E/M services more cost effective.

Follow up on claims for E/M services that were paid for in error

In a separate memorandum, we will refer to CMS for appropriate action the sampled claims for E/M services that were incorrectly coded and/or lacking documentation. CMS should make payment adjustments, as appropriate, to include following up on both overpayments and underpayments.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our first recommendation, did not concur with our second recommendation, and partially concurred with our third recommendation.

With regard to our first recommendation, CMS concurred and agrees that physician education and outreach are critical parts of an effective enforcement strategy. CMS will continue to issue education documents on E/M services and will collaborate with contractors to respond to questions and clarify policies when inconsistencies in billing practices arise.

With regard to our second recommendation, CMS did not concur. CMS directed a medical review contractor to review claims billed by high-coding physicians that were previously referred by OIG, and the first phase of these reviews resulted in a negative return on investment. On the basis of the results of additional reviews, CMS will reassess the effectiveness of reviewing claims billed by high-coding physicians as compared to other efforts, such as Comparative Billing Reports. We acknowledge that CMS must weigh the costs and benefits of reviewing claims for E/M services against doing so for more costly Part B services; however, we continue to believe that CMS should focus its medical review efforts on those services billed for by high-coding physicians, as these claims are more likely to be in error than claims for E/M services billed for by other physicians. We also encourage CMS to use other efforts, such as Comparative Billing Reports, that aim to reduce the high error rate associated with claims for E/M services billed for by high-coding physicians.

With regard to our third recommendation, CMS partially concurred. CMS will analyze each overpayment to determine which claims exceed its recovery threshold and can be collected consistent with its policies and procedures. For the overpayments identified in this report that will not be collected, CMS could send an educational notice to physicians that billed for these claims. These notices could describe the type of error identified, explain the reason the overpayment is not being recovered, and provide information on how to correctly bill for future E/M services. We will send information to CMS regarding the improper payments identified in this report under separate cover.

We removed a fourth recommendation listed in our draft report—for CMS to consolidate the *1995* and *1997 Documentation Guidelines for Evaluation and Management Services*—because we did not determine whether the errors we identified resulted from having two versions of

documentation guidelines. However, having two versions of documentation guidelines may be confusing for physicians and could contribute to the high error rate associated with E/M services.

We support CMS's efforts to address these issues and encourage continued progress. For the full text of CMS's comments, see Appendix G.

APPENDIX A

Components Used To Determine the Level of an Evaluation and Management Service

As defined by the Current Procedural Terminology[52] manual, the codes for E/M services, which correspond to three to five levels within a visit type, include seven basic components: patient history, physical examination, medical decisionmaking, counseling, coordination of care, the nature of the patient's presenting problem (i.e., the reason for the visit), and time. The first three components are key to determining the correct code for the E/M service, and the remaining four components are contributory.[53] The physician must use the following three key components to determine the appropriate code:

- Extent of patient history—Using their clinical judgment, physicians assess the nature of the patient's presenting problems to determine the depth of the history needed to complete the service. A patient history can be classified into one of four types:
    - problem focused (brief history of present illness or problem);
    - expanded problem focused (brief history of present illness with problem-pertinent system review);
    - detailed (extended history of present illness with pertinent past, family, and social history directly related to the presenting problem; includes review of a limited number of additional systems); and
    - comprehensive (extended history of present illness with review of body systems directly related to the patient's problems; complete past, family, and social history).

[52] **The five character codes and descriptions included in this study are obtained from Current Procedural Terminology (CPT®), copyright 2009 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this study should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

[53] Exceptions to this rule are visits that consist predominantly of counseling or coordination of care; *time* is the key factor to determining the correct code for these E/M services. If the level of an E/M service is based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the medical record should describe the counseling and/or activities to coordinate care. CMS, *Evaluation and Management Services Guide*, December 2010, pp. 21 and 25.

- Extent of physical examination—Using their clinical judgment and depending on the presenting medical problems, physicians can perform one of four types of examination:
    - problem focused (limited examination of the affected body area or organ system);
    - expanded problem focused (limited examination of affected area or systems with other symptomatic or related organ systems);
    - detailed (extended examination of affected body area and other related systems); and
    - comprehensive (a general multisystem examination or a complete examination of a single organ system).

- Complexity of the physician's medical decisionmaking—The complexity of the physician's medical decisionmaking is based on factors needed to establish a diagnosis and/or select a management option: the number of possible diagnoses or the number of options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and other information that physicians must obtain, review, and analyze; and the risk of significant complications, morbidity, and/or mortality. Four types of medical decisionmaking are recognized:
    - straightforward,
    - low complexity,
    - moderate complexity, and
    - high complexity.

  Table A-1 illustrates the key components used to determine the appropriate code for a new patient office visit. There are five levels of complexity for this office visit.

Table A-1: Key Components Used To Determine the Level and CPT Code for New Patient Office Visit

CPT Code*	Presenting Problem(s)	Key Components		
		Patient History	Examination	Medical Decisionmaking
99201	Self-limited or minor; the physician typically spends 10 minutes face-to-face with the patient and/or family	Problem focused	Problem focused	Straightforward
99202	Low to moderate severity; the physician typically spends 20 minutes face-to-face with the patient and/or family	Expanded problem focused	Expanded problem focused	Straightforward
99203	Moderate severity; the physician typically spends 30 minutes face-to-face with the patient and/or family	Detailed	Detailed	Low complexity
99204	Moderate to high severity; the physician typically spends 45 minutes face-to-face with the patient and/or family	Comprehensive	Comprehensive	Moderate complexity
99205	Moderate to high severity; the physician typically spends 60 minutes face-to-face with the patient and/or family	Comprehensive	Comprehensive	High complexity

*See footnote 52 for the AMA copyright notice.

Source: CMS, *Evaluation & Management Services Guide 2010*, December 2010.

APPENDIX B

Additional Information on Sample Selection and Subgrouping

Table B-1: Population and Sample Size of Claims for E/M Services by Stratum, 2010

Stratum	Definition	Population			Sample		
		Claims	Medicare Payments	Physicians	Claims	Medicare Payments	Physicians
1	Claims for E/M services billed for by high-coding physicians	828,646	$107,652,434	1,669	309	$40,039	259
2	Claims for E/M services billed for by other physicians	368,800,457	$32,211,029,164	440,321	364	$31,468	363
Total		**369,629,103**	**$32,318,681,598**	**441,990**	**673**	**$71,507**	**622**

Source: OIG analysis of 2010 Part B claims for E/M services, 2014.

Table B-2: Sampled Claims for E/M Services by Visit Type and CPT Code, 2010

Visit Type	CPT Code*	Complexity Level	Number of Sampled Claims for E/M Services	Percentage of Sampled Claims for E/M Services
New Patient Office/ Outpatient Visit	99201	Low	1	0.2%
	99202	Medium-Low	2	0.3%
	99203	Medium	4	0.6%
	99204	Medium-High	20	3.0%
	99205	High	21	3.1%
Established Patient Office/Outpatient Visit	99211	Low	6	0.9%
	99212	Medium-Low	17	2.5%
	99213	Medium	95	14.1%
	99214	Medium-High	177	26.3%
	99215	High	127	18.9%
Initial Observation Care	99218	Low	0	0.0%
	99219	Medium	1	0.2%
	99220	High	0	0.0%
Initial Inpatient Hospital Care	99221	Low	2	0.3%
	99222	Medium	4	0.6%
	99223	High	13	1.9%
Subsequent Inpatient Hospital Care	99231	Low	13	1.9%
	99232	Medium	48	7.1%
	99233	High	25	3.7%
Emergency Department Visit	99281	Low	0	0.0%
	99282	Medium-Low	0	0.0%
	99283	Medium	7	1.0%
	99284	Medium-High	14	2.1%
	99285	High	38	5.7%
Initial Nursing Facility Care	99304	Low	0	0.0%
	99305	Medium	2	0.3%
	99306	High	1	0.2%
Subsequent Nursing Facility Care	99307	Low	7	1.0%
	99308	Medium-Low	10	1.5%
	99309	Medium-High	4	0.6%
	99310	High	3	0.5%

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Table B-2 (Continued): Sampled Claims for E/M Services by Visit Type and CPT Code, 2010

Visit Type	CPT Code*	Complexity Level	Number of Sampled Claims for E/M Services	Percentage of Sampled Claims for E/M Services
New Patient Domiciliary/Rest Home Visit	99324	Low	0	0.0%
	99325	Medium-Low	0	0.0%
	99326	Medium	0	0.0%
	99327	Medium-High	0	0.0%
	99328	High	0	0.0%
Established Domiciliary/Rest Home Visit	99334	Low	0	0.0%
	99335	Medium-Low	1	0.2%
	99336	Medium-High	0	0.0%
	99337	High	2	0.3%
New Patient Home Visit	99341	Low	0	0.0%
	99342	Medium-Low	0	0.0%
	99343	Medium	0	0.0%
	99344	Medium-High	0	0.0%
	99345	High	0	0.0%
Established Patient Home Visit	99347	Low	0	0.0%
	99348	Medium-Low	0	0.0%
	99349	Medium-High	2	0.3%
	99350	High	6	0.9%
Total			**673**	**100.0%****

***The five character codes and descriptions included in this study are obtained from Current Procedural Terminology (CPT®), copyright 2009 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this study should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

**Column does not sum to 100 percent because of rounding.

Source: OIG analysis of 2010 Part B claims for E/M services, 2014.

Table B-3: Subgroup of Claims for E/M Services by Medical Record Type, 2010

Subgroup	Definition	Subset		
		Claims	Medicare Payments	Physicians
1	Claims for E/M services documented in paper medical records	411	$44,534	377
2	Claims for E/M services documented in electronic medical records	207	$21,448	199
Total		**618**	**$65,982**	**572***

*Column sum exceeds total because some physicians had multiple claims in our sample.
Source: OIG analysis of 2010 Part B claims for E/M services, 2014.

Table B-4: Subgroup of Claims for E/M Services by Medical Record Format, 2010

Subgroup	Definition	Claims		
		Claims	Medicare Payments	Physicians
1	Claims for E/M services formatted with *1995 Documentation Guidelines for Evaluation and Management Services*	400	$40,928	382
2	Claims for E/M services formatted with *1997 Documentation Guidelines for Evaluation and Management Services*	131	$16,069	123
3	Claims for E/M services for which the format of the medical record was unable to be determined	87	$8,985	81
Total		**618**	**$65,982**	**572***

*Column sum exceeds total because some physicians had multiple claims in our sample.
Source: OIG analysis of 2010 Part B claims for E/M services, 2014.

APPENDIX C

The Comprehensive Error Rate Testing Program and This Evaluation

OIG has performed, and continues to perform, work examining E/M services. In addition, CMS, as part of its CERT program, measures errors in E/M services. The goal of the CERT program is to measure the performance of CMS's contractors by calculating a paid-claims error rate. CMS bases the rate on the dollar paid after the contractor makes its payment decision on a claim. The paid-claims error rate is a percentage of dollars that contractors erroneously allowed to be paid. In addition to calculating the paid-claims error rate, CMS calculates a provider-compliance error rate and a services-processed error rate.

On the other hand, OIG's objective in this evaluation was to estimate a national paid-claims error rate for E/M services, as well as to compare error rates by stratum and subgroup. This OIG study was not designed to reproduce, or to review, the CERT paid-claims error rate.

Because the goals of our review and the CERT program differ, the respective methodologies used to calculate the error rates differ. Our review included the following factors, differentiating it from CMS's CERT program:

- a stratified sample by physicians' coding of E/M services and
- subgrouping by medical record type (i.e., the medical record for the sampled claim was paper or electronic) and by medical record format (i.e., the medical record for the sampled claim was formatted using the *1995* or *1997 Documentation Guidelines for Evaluation and Management Services*).

In addition, there are differences in how the CERT program and OIG report the calculated error rates. As mentioned previously, CMS calculates three different error rates. For the paid-claims error rate and provider-compliance error rate, CMS bases the rate on dollar amounts. For the services-processed error rate, CMS bases the error rate on the number of services. Our review bases the error rate on the number of claims. In addition to calculating the overall fee-for-service error rate, CMS calculates error rates for individual contractors. Our review calculates error rates for the strata and subgroups and projects the error rate nationally, as well as dollars associated with claims paid in error.

Although the respective goals and methodologies of our review and the CERT program differ, the error categories in each review are similar.

CMS groups claims identified as containing improper payments through its CERT program into five categories: no documentation, insufficient documentation, medical necessity, incorrect coding, and "other" (e.g., duplicate payment error, noncovered or unallowable service). Similarly, our review groups claims for E/M services into three categories: no documentation, insufficient documentation, and incorrect coding. Our review did not determine whether E/M services were medically necessary in 2010. We also did not have an "other" category because we did not determine whether E/M services were duplicative, noncovered, or unallowable.

APPENDIX D

Sample Sizes, Point Estimates, and Confidence Intervals of Claims for Evaluation and Management Services

Table D-1: Sample Sizes, Point Estimates, and Confidence Intervals of Incorrectly Coded, Insufficiently Documented, and/or Undocumented Claims for E/M Services, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Gross percentage of incorrectly coded, insufficiently documented, and/or undocumented claims for E/M services	657	61.3%	55.0%–67.6%
Gross Medicare payments for incorrectly coded, insufficiently documented, and/or undocumented claims for E/M services*	657	$7,869,264,031	$6,095,196,627–$9,643,331,435
Percentage of claims for E/M services with multiple (i.e., overlapping) errors	657	6.7%	4.1%–9.3%
Medicare payments for claims for E/M services with overlapping errors	657	$1,119,607,546	$557,880,415–$1,681,334,677
Net percentage of incorrectly coded, insufficiently documented, and/or undocumented claims for E/M services	657	54.6%	49.4%–59.7%
Net Medicare payments for incorrectly coded, insufficiently documented, and/or undocumented claims for E/M services*	657	$6,749,656,485	$5,222,278,129–$8,277,034,841
Percentage of Medicare payments for incorrectly coded, insufficiently documented, and/or undocumented claims for E/M services of total Medicare payments for E/M services in 2010	657	21.4%	17.0%–25.8%

*To calculate the payments for claims for E/M services that were miscoded, we subtracted the payment amount for the correct code from the payment amount for the code on the claim.
Source: OIG analysis of 2010 E/M medical records, 2014.

Table D-2: Sample Sizes, Point Estimates, and Confidence Intervals of Incorrectly Coded Claims for E/M Services, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of incorrectly coded claims for E/M services	657	42.4%	37.4%–47.6%
Medicare payments for incorrectly coded claims for E/M services*	657	$3,261,643,225	$2,065,237,356–$4,458,049,093
Percentage of Medicare payments for incorrectly coded claims for E/M services of total Medicare payments for E/M services	657	10.3%	6.8%–13.9%
Percentage of miscoded claims for E/M services	657	40.4%	35.5%–45.6%
Medicare payments for miscoded claims for E/M services*	657	$2,806,768,770	$1,658,804,226–$3,954,733,313
Percentage of miscoded claims for E/M services for which the physician used both the *1995* and *1997 Documentation Guidelines***	301	3.4%	1.4%–8.0%
Percentage of upcoded claims for E/M services	657	26.0%	21.7%–30.7%
Percentage of miscoded claims for E/M services that were upcoded by 1 level	293	45.3%	37.2%–53.7%
Percentage of miscoded claims for E/M services that were upcoded by 2 levels	293	16.8%	11.4%–24.0%
Percentage of miscoded claims for E/M services that were upcoded by 3 levels	293	0.8%	0.1%–4.8%
Percentage of miscoded claims for E/M services that were upcoded by 4 levels	293	0.004%	0.001%–5.0%
Medicare payments for upcoded claims for E/M services	657	$4,569,195,340	$3,617,700,452–$5,520,690,228
Percentage of downcoded claims for E/M services	657	14.5%	11.2%–18.5%
Percentage of miscoded claims for E/M services that were downcoded by 1 level	293	33.5%	26.1%–41.8%
Percentage of miscoded claims for E/M services that were downcoded by 2 levels	293	3.6%	1.5%–8.5%
Percentage of miscoded claims for E/M services that were downcoded by 3 levels	293	0.0%	0.0%–5.0%

continued on next page

Table D-2 (Continued): Sample Sizes, Point Estimates, and Confidence Intervals of Incorrectly Coded Claims for E/M Services, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of miscoded claims for E/M services that were downcoded by 4 levels	293	0.0%	0.0%–5.0%
Medicare payments for downcoded claims for E/M services	657	($1,762,426,570)	($2,254,640,000)–($1,270,210,000)
Percentage of miscoded claims for E/M services that were upcoded or downcoded by 1 level	293	78.8%	71.2%–84.8%
Percentage of claims for E/M services with other coding errors (e.g., wrong code, unbundling)	657	2.0%	0.9%–4.0%
Medicare payments for claims for E/M services with other coding errors	657	$454,874,455	$80,378,029–$829,370,881
Percentage of claims for E/M services for which the correct code was unable to be determined	657	2.5%	1.3%–4.8%

*To calculate the payments for claims for E/M services that were miscoded, we subtracted the payment amount for the correct code from the payment amount for the code on the claim.
**At the time of our review, physicians could use either version of the documentation guidelines, but not a combination of the two, when determining the appropriate level for an E/M service. For these claims, physicians used the *1997 Documentation Guidelines* for an extended history of present illness along with elements from the *1995 Documentation Guidelines*.
Source: OIG analysis of 2010 E/M medical records, 2014.

Table D-3: Sample Sizes, Point Estimates, and Confidence Intervals of Claims for E/M Services Lacking Documentation, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of claims for E/M services lacking documentation	657	19.0%	15.2%–23.3%
Medicare payments for claims for E/M services lacking documentation	657	$4,607,620,806	$3,435,418,912–$5,779,822,701
Percentage of insufficiently documented claims for E/M services	657	12.0%	9.0%–15.8%
Medicare payments for insufficiently documented claims for E/M services	657	$2,622,446,473	$1,724,480,895–$3,520,412,050
Percentage of undocumented claims for E/M services	657	7.0%	4.7%–10.1%
Medicare payments for undocumented claims for E/M services	657	$1,985,174,334	$1,162,105,045–$2,808,243,623
Percentage of claims for E/M services with illegible, missing, or unacceptable signatures	657	13.4%	10.2%–17.3%

Source: OIG analysis of 2010 E/M medical records, 2014.

APPENDIX E

Sample Sizes, Point Estimates, Confidence Intervals, and Results of Statistical Tests of Claims for Evaluation and Management Services, by Stratum

Table E-1: Sample Sizes, Point Estimates, and Confidence Intervals of Claims for E/M Services by Stratum, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of incorrectly coded claims for E/M services billed for by high-coding physicians	298	56.4%	50.7%–61.9%
Percentage of miscoded claims for E/M services that were upcoded by high-coding physicians	156	99.4%	95.6%–99.9%
Percentage of miscoded claims for E/M services that were downcoded by high-coding physicians	156	0.6%	0.1%–4.4%
Medicare payments for incorrectly coded claims for E/M services billed for by high-coding physicians	298	$26,027,127	$22,518,898–$29,535,356
Percentage of Medicare payments for incorrectly coded claims of total Medicare payments for claims for E/M services billed for by high-coding physicians	298	25.1%	21.9%–28.2%
Average inappropriate Medicare payment per high-coding physician for incorrectly coded claims for E/M services	298	$15,594	$13,492–$17,696
Percentage of claims for E/M services billed for by other physicians that were incorrectly coded	359	42.3%	37.3%–47.5%
Percentage of miscoded claims for E/M services that were upcoded by other physicians	145	64.1%	56.0%–71.5%
Percentage of miscoded claims for E/M services that were downcoded by other physicians	145	35.9%	28.5%–44.0%
Medicare-allowed amounts for claims for E/M services billed for by other physicians that were incorrectly coded	359	$3,235,616,097	$2,037,378,284–$4,433,853,911
Percentage of Medicare-allowed amounts for incorrectly coded claims of total Medicare-allowed amounts for claims for E/M services billed for by other physicians	359	10.3%	6.8%–13.8%
Average inappropriate Medicare payment per other physician for incorrectly coded claims for E/M services	359	$7,348	$4,627–$10,070
Percentage of insufficiently documented claims for E/M services billed for by high-coding physicians	298	19.5%	15.3%–24.4%
Percentage of insufficiently documented claims for E/M services billed by other physicians	359	12.0%	9.0%–15.8%
Percentage of undocumented claims for E/M services billed for by high-coding physicians*	298	4.7%	2.8%–7.8%
Percentage of undocumented claims for E/M services billed for by other physicians*	359	7.0%	4.7%–10.1%

*The difference between these error rates was not statistically significant at the 95-percent confidence level.
Source: OIG analysis of 2010 E/M medical records, 2014.

Table E-2: Sample Sizes, Point Estimates, and Confidence Intervals of Upcoded and Downcoded Claims for E/M Services by Stratum, 2010

Estimate Description			High-Coding Physicians			Other Physicians		
			Sample Size	Point Estimate	95-Percent Confidence Interval	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of miscoded claims for E/M services that were upcoded or downcoded	Upcoded	By 4 levels*	156	1.3%	0.3%–5.0%	137	0.0%	0.0%–1.0%
		By 3 levels	156	9.6%	5.9%–15.4%	137	0.7%	0.1%–5.0%
		By 2 levels*	156	23.1%	17.1%–30.3%	137	16.8%	11.4%–24.0%
		By 1 level	156	65.4%	57.6%–72.4%	137	45.3%	37.1%–53.7%
	Downcoded	By 1 level	156	0.6%	0.1%–4.4%	137	33.6%	26.2%–41.9%
		By 2 levels	156	0.0%	0.0%–1.2%	137	3.6%	1.5%–8.5%
		By 3 levels*	156	0.0%	0.0%–1.2%	137	0.0%	0.0%–1.0%
		By 4 levels*	156	0.0%	0.0%–1.2%	137	0.0%	0.0%–1.0%

*The difference between these error rates was not statistically significant at the 95-percent confidence level.
Source: OIG analysis of 2010 E/M medical records, 2014.

Table E-3: Results of Independent Group T-Tests for Claims for E/M Services by Stratum, 2010

Description	Stratum	Point Estimates	P-Value
Difference in percentage of incorrectly coded claims for E/M services, by stratum	High-Coding	56.4%	0.0003
	Other	42.3%	
Difference in percentage of miscoded claims for E/M services that were upcoded, by stratum	High-Coding	99.4%	<0.0001
	Other	64.1%	
Difference in percentage of miscoded claims for E/M services that were upcoded by 1 level, by stratum	High-Coding	65.4%	0.0005
	Other	45.3%	
Difference in percentage of miscoded claims for E/M services that were upcoded by 2 levels, by stratum	High-Coding	23.1%	0.1817
	Other	16.8%	
Difference in percentage of miscoded claims for E/M services that were upcoded by 3 levels, by stratum	High-Coding	9.6%	0.0004
	Other	0.7%	
Difference in percentage of miscoded claims for E/M services that were upcoded by 4 levels, by stratum	High-Coding	1.3%	0.1580
	Other	0.0%	
Difference in percentage of miscoded claims for E/M services that were downcoded, by stratum	High-Coding	0.6%	<0.0001
	Other	35.9%	
Difference in percentage of miscoded claims for E/M services that were downcoded by 1 level, by stratum	High-Coding	0.6%	<0.0001
	Other	33.6%	
Difference in percentage of miscoded claims for E/M services that were downcoded by 2 levels, by stratum	High-Coding	0.0%	0.0248
	Other	3.6%	
Difference in percentage of miscoded claims for E/M services that were downcoded by 3 levels, by stratum	High-Coding	0.0%	--*
	Other	0.0%	
Difference in percentage of miscoded claims for E/M services that were downcoded by 4 levels, by stratum	High-Coding	0.0%	--*
	Other	0.0%	
Difference in percentage of insufficiently documented claims for E/M services, by stratum	High-Coding	19.5%	0.0093
	Other	12.0%	
Difference in percentage of undocumented claims for E/M services, by stratum	High-Coding	4.7%	0.2139
	Other	7.0%	

*No claims in our sample were downcoded by 3 or 4 levels. As a result, these point estimates were the same and the difference between these error rates was not statistically significant.
Source: OIG analysis of 2010 E/M medical records, 2014.

APPENDIX F

Sample Sizes, Point Estimates, Confidence Intervals, and Results of Statistical Tests of Claims for Evaluation and Management Services, by Subgroups

Table F-1: Sample Sizes, Point Estimates, and Confidence Intervals of Claims for E/M Services by Medical Record Type, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of claims for E/M services documented in paper medical records	618	64.1%	58.8%–69.1%
Percentage of claims for E/M services documented in electronic medical records	618	35.9%	30.9%–41.2%
Percentage of incorrectly coded claims for E/M services documented in paper medical records*	411	44.0%	37.5%–50.7%
Percentage of incorrectly coded claims for E/M services documented in electronic medical records*	207	48.3%	39.5%–57.3%
Percentage of insufficiently documented claims for E/M documented in paper medical records*	411	14.5%	10.4%–19.9%
Percentage of insufficiently documented claims for E/M services documented in electronic medical records*	207	10.0%	5.8%–16.8%

*The difference between these error rates was not statistically significant at the 95-percent confidence level.
Source: OIG analysis of 2010 E/M medical records, 2014.

Table F-2: Results of Chi-Square Tests for Claims for E/M Services by Medical Record Type, 2010

Description	Medical Record Type	Point Estimates	P-Value
Difference in percentage of incorrectly coded claims, by medical record type	Paper	44.0%	0.4405
	Electronic	48.3%	
Difference in percentage of insufficiently documented claims, by medical record type	Paper	14.5%	0.2382
	Electronic	10.0%	

Source: OIG analysis of 2010 E/M medical records, 2014.

Table F-3: Sample Sizes, Point Estimates, and Confidence Intervals of Claims for E/M Services by Medical Record Format, 2010

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of claims for E/M services formatted with *1995 Documentation Guidelines for Evaluation and Management Services*	618	72.1%	67.1%-76.7%
Percentage of claims for E/M services formatted with *1997 Documentation Guidelines for Evaluation and Management Services*	618	16.5%	12.9%-20.9%
Percentage of claims for E/M services for which the format of the medical record was unable to be determined	618	11.4%	8.4%-15.3%
Percentage of incorrectly coded claims for E/M services formatted with *1995 Documentation Guidelines**	400	43.2%	37.1%-49.5%
Percentage of incorrectly coded claims for E/M services formatted with *1997 Documentation Guidelines**	131	52.7%	39.6%-65.4%
Percentage of insufficiently documented claims for E/M services formatted with *1995 Documentation Guidelines**	400	9.1%	6.1%–13.5%
Percentage of insufficiently documented claims for E/M services formatted with *1997 Documentation Guidelines**	131	5.5%	1.8%–15.6%

*The difference between these error rates was not statistically significant at the 95-percent confidence level.
Source: OIG analysis of 2010 E/M medical records, 2014.

Table F-4: Results of Chi-Square Tests for Claims for E/M Services by Medical Record Format, 2010

Description	Medical Record Format	Point Estimates	P-Value
Difference in percentage of incorrectly coded claims for E/M services, by medical record format	1995	43.2%	0.2002
	1997	52.7%	
Difference in percentage of insufficiently documented claims for E/M services, by medical record format	1995	9.1%	0.3743
	1997	5.5%	

Source: OIG analysis of 2010 E/M medical records, 2014.

APPENDIX G

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR - 8 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010 (OEI-04-10-00181)

Thank you for the opportunity to review and comment on the above subject OIG draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources that OIG used to review these important services. OIG's report identifies and addresses improper billing and payments for Part B services relating to evaluation and management (E/M) services in 2010. OIG's study reports that in 2010, Medicare inappropriately paid $6.7 billion for claims for E/M services that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. Incorrectly coded claims included both up coding (26 percent) and down coding (14.5 percent). Additionally, OIG found that high-coding physicians' claims were more likely to be incorrectly coded or insufficiently documented than other physicians' claims. We are working to further reduce these improper payments through a combination of education and medical review activities.

The OIG recommendations and CMS responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS consolidate the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services.

CMS Response

The CMS does not concur with the recommendation that we consolidate the 1995 and 1997 documentation guidelines. In December 2010, CMS issued the Evaluation and Management Guide that is designed to provide education on evaluation and management services. It includes information on medical record documentation, billing and coding considerations, as well as information on the 1995 and 1997 documentation guidelines. Additionally, we recently made available via the CMS website, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html, a "Frequently Asked Questions" document that emphasizes the ability to use the 1995 or 1997 guidelines for an extended history

of present illness along with other elements from the 1995 guidelines to document an E/M service furnished on or after September 10, 2013.

These two resources were developed in collaboration with the stakeholder community to assist providers in choosing the correct level of E/M visits to report when services are provided. These guidelines also assist CMS in determining whether services are coded correctly. Because E/M services encompass a wide range of patient and physician interactions and physician work, the availability of two approaches allows providers to choose the document guidelines that best reflect the services provided, which increases accuracy in reporting the level of service furnished.

Moreover, there is no data or other information included in this report that suggests that the inappropriate coding observed by OIG results from having two sets of guidelines. Therefore, there seems to be no basis upon which to conclude that consolidation of the 1995 and 1997 documentation guidelines would reduce the errors associated with reporting E/M services that are identified in this report. In fact, given the widespread usage and familiarity with the existing guidelines, a major modification might increase coding errors.

OIG Recommendation

The OIG recommends that CMS educate physicians on coding and documentation requirements for E/M services.

CMS Response

The CMS concurs with the recommendation and agrees that physician education and outreach are critical parts of an effective enforcement strategy. As stated in our response to recommendation one, CMS recently made available, via the CMS website, a "Frequently Asked Questions" document that emphasizes the ability to use the 1995 or 1997 guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an E/M service furnished on or after September 10, 2013. CMS will continue to issue educational documents, such as Medicare Learning Network articles. CMS also works collaboratively with contractors to respond to questions and clarify policies when inconsistencies in billing practices arise.

OIG Recommendation

The OIG recommends that CMS continue to encourage contractors to review E/M services billed by high-coding physicians.

CMS Response

The CMS does not concur with this recommendation. As stated in the response to recommendation three of OIG's report entitled, "*Coding Trends of Medicare Evaluation and Management Services*" (OEI-04-10-00180), CMS has directed a medical review contractor to review the high-coding physicians referred by OIG in two phases. Phase one consisted of 5,200

reviews of medical records for high-coding physicians and has resulted in a negative return on investment to CMS of $160,000. CMS began phase two of this review on August 2013; it consists of 13,509 claim reviews and is in the final stages of completion. Based on the results of this effort, CMS will reassess the effectiveness of reviewing claims for high-coding physicians versus other efforts such as Comparative Billing Reports.

OIG Recommendation

The OIG recommends that CMS follow up on claims for E/M services in error.

CMS Response

The CMS partially concurs with this recommendation. OIG reviewed claims that had dates of service during calendar year (CY) 2010. Based on OIG projections, the per claim overpayment amount is approximately $33. Some of the CY 2010 claims have or will soon exceed the 4-year claim reopening period as mandated by 42 CFR 405.980(b)(2). In addition, it is likely many of the payment differences on these E/M claims will not exceed CMS overpayment recovery threshold. CMS requests that OIG provide the claims data that includes, at a minimum, the provider number, claim payment amount, the correct code for each claim, the overpayment amount, Medicare contractor number, claim paid date, HICN, and claim/document control number. Upon the receipt of the overpayment data from OIG, CMS will analyze each overpayment to determine which claims exceed CMS recovery threshold and can be collected consistent with agency's policies and procedures.

The CMS thanks OIG for the work done on this issue and looks forward to working with OIG in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

Rachel Bessette served as the lead analyst for this study. Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to the report include Michelle Verges. Central office staff who provided support include Kevin Farber, Althea Hosein, Kevin Manley, and Christine Moritz.

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