WPS Medicare Part B - Quarterly CERT Error Findings Report

~ INDIANA ~

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed April 2014 through June 2014 for Indiana providers. The findings below are reported based on the type of error assessed by the CERT Contractor (e.g., insufficient documentation, incorrect coding, etc.).

Insufficient Documentation - 80% of total errors

Reasons for Errors:

- Missing the physician order or clinical documentation of intent of ordering the billed Phenobarbital, quantitation of drug times 3 units, methadone, drug confirmation times 3 units, and column chromatography/mass spectrometry (CPT 80184, 80299, 83840, 80102, 82544). Missing signed and dated clinical documentation to support medical necessity for the billed labs. Also missing Phenobarbital, quantitation of drug times 3 units, methadone, drug confirmation times 3 units, and column chromatography/mass spectrometry lab results. Requested additional documentation from the listed ordering and billing provider and received no response.
- Billed lab test drug confirmation (1), benzodiazepines (1), urinalysis; qualitative or semi-quantitative, except immunoassays (1), chromatography, quantitative, column (EG, GAS LIQUID OR HPLC) (1), column chromatography/mass spectrometry, ; qualitative, single stationary and mobile phase (1), column chromatography/mass spectrometry; quantitative, single stationary and mobile phase (1) and drug screen, qualitative; multiple drug classes by high complexity test method (CPT 80102, 80154, 81005, 82491, 82541, 82542, G0431). Missing treating physician clinical records that support the need/reason/medical necessity for lab testing. Submitted physician order and lab results and multiple group therapy notes.
- Billed drug confirmation, each procedure, and urinalysis; qualitative or semi-quantitative, except immunoassays, methadone (80102, 81005, 83840, G0431). Missing the physician order or clinical documentation of intent to for ordering the tests and missing clinical documentation to support medical necessity of tests. Missing clinical documentation that supports medical necessity in a beneficiary who is "compliant with her medication" and "has no evidence of diversion or aberrant behavior" per office progress notes. This is the 4th time this drug screen was done in a compliant beneficiary in last nine months. Requested additional documentation from the ordering provider and received no response.
- Missing the ordering provider signed and dated clinical documentation to support medical necessity for the billed labs (CPT 82550, 80061, 84443, 85025, 83036, 80053). Submitted documentation included E-requisition and lab reports. Requested additional documentation from the ordering provider and received no response.
- Missing the physician order or clinical documentation of intent of ordering the billed lipid panel (CPT 80061). Submitted documentation includes results and a co-signed Lab requisition.

- Billed column chromatography/mass spectrometry, creatinine; other source, desipramine, doxepin, imipramine, and meprobamate (CPT 82570, 80160, 80166, 80174, 82542, 83805). Missing signed and dated clinical documentation to support medical necessity for the billed labs and physician order/ intent of ordering the tests. Received laboratory reports and unsigned visit note.
- Billed for travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge (P9604). Missing documentation of the mileage traveled. Documentation submitted includes an unsigned requisition form, and lab test results. Also received a travel requisition form showing 217 miles per patient which is not completely filled out by lab staff.
- Billed radiologic examination, chest, 2 views, frontal and lateral (CPT 71020). Missing the physician order or clinical documentation of intent of ordering the x-ray and clinical documentation to support medical necessity. Received chest x-ray report only. Requested additional documentation from the billing provider and received duplicate documentation.
- Billed manual therapy, therapeutic exercises, and therapy activities (CPT 97110-GO, 97140-GO, 97530-59-GO). Missing: 1) Treating physician's signed and dated certification of the Plan of Care; 2) Attestation statement from the therapist who performed OT on billed date; Submitted documentation included illegible signed treatment flow sheet and unsigned daily notes. Requested additional documentation from the billing provider and received signature log from the ordering provider, order missing long term goals to be consider a POC, and occupational initial evaluation with signature from the therapist only. The plan of care must contain, at minimum: Diagnoses; Long term treatment goals; and Type, amount, duration and frequency of therapy services. The plan must be reviewed, dated and signed by a physician/NPP to complete the certification requirements in 42 CFR 410.61(e).
- Billed for chiropractic manipulative treatment (CMT); spinal, 3-4 regions (CPT 98941-AT) for date of service in August 2013. Missing: 1) clinical documentation supporting the date of the initial visit which shows symptoms causing patient to seek treatment; mechanism of trauma; quality and character of symptoms/problem; onset, duration, intensity, frequency, location and radiation of symptoms; aggravating or relieving factors; and prior interventions, treatments, medications, secondary complaints, and date of initial treatment; 2) the treatment plan showing recommended level of care; specific treatment goals; and objective measures to evaluate treatment effectiveness. Documentation submitted includes several NP notes and chiropractic progress notes dated May through August. Documentation submitted is insufficient.
- Billed chiropractic manipulation, CPT 98941-AT. Missing: 1) signed and dated initial evaluation with P.A.R.T Exam; 2) Signed and dated initial and subsequent treatment plans related to billed chiropractic services, and 3)All subsequent treatment notes prior to billed DOS. Submitted documentation included visit note dated billed date only. Without a treatment plan and documentation of areas of subluxation there is insufficient documentation submitted to support the billed service.
- Billed CPT 96523, irrigation of implanted venous access device for drug delivery systems. Missing: 1) Attestation statement of the person who performed billed service. Submitted documentation includes several office visit notes that support beneficiary is receiving Chemotherapy and unsigned flow sheet and attestation statement from the billing provider. Requested additional documentation from the billing provider and received beneficiary data form with insurance information, etc.

- Billed normal saline solution, per 250cc, 5 units of service (J7050). Missing physician's order for the normal saline as billed. Missing clinical documentation to support the infusion of normal saline was for other than to facilitate the infusion or injection or for incidental hydration. Submitted documentation included therapy note that saline was used to administer the pre-medications and chemotherapy that has been initialed by the nurse and signed by the treating physician.
- Billed for a hemodialysis procedure with single evaluation by a physician or other qualified health care professional (CPT 90935) and subsequent hospital care (CPT 99232). Missing the hospital progress note and the hemodialysis examination procedure note. Submitted includes multiple progress notes from other providers and a note from billing provider stating they billed wrong hospital, but with the correct charges, and submitted 2 days of hospital notes.
- Billed CPT 90791. Missing licensed clinical social worker's documentation to support psychiatric diagnostic evaluation. Submission includes statement that a thorough search of the files failed to reveal any record of this patient, discharge instructions and ED progress note.
- Billed anesthesia service (00810-QZ). Missing: 1) Billing provider signed and dated pre-anesthesia evaluation and 2) Billing provider signed and dated post-anesthesia evaluation. Submitted documentation includes colonoscopy report, anesthesia record and pre- and post-anesthesia orders. Requested additional documentation and received no response from the billing provider.
- Billed CPT 95117 - Professional Services for Allergen Immunotherapy for date of service in August 2013. Missing physician's updated treatment plan and dosage regimen applicable to the billed DOS and medical record/documentation such as Medical history and examination (including allergy testing) upon which the need for the treatment is based per LCD requirement. Also missing valid signature or attestation statement for the office visit note. Received from follow-up request includes authenticated OV note with nurse's note stating "currently on immunotherapy, frequency of immunotherapy 1 x 7 days, patient reached maintenance dose on July 10th. Insufficient documentation to support the billed service.
- Billed CPT 99211 (office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician, usually, the presenting problem(s) are minimal, typically, 5 minutes are spent performing or supervising these services). Missing a signature attestation statement for the unsigned office visit note. After follow-up request, received a duplicate office visit with signature added.
- Billed CPT 99232. Missing the billing provider signed and dated subsequent progress note. Submitted documentation includes several hospital inpatient notes. Requested additional documentation from the billing provider and received duplicate documentation.

Incorrect Coding - 16% of total errors

Reasons for Errors:

- Billed CPT 99214 (Detailed history, detailed exam, and moderate MDM, requires 2/3 key components). Documentation supports down code to CPT 99213 with expanded problem focused history, comprehensive exam, and low complexity MDM. Submitted documentation includes a visit note indicating that the HPI reviewed per bullet points and to "see bullet points" for problem/plan but does not include these bullet points. No response from follow-up request. Coded E/M with the documentation received.

- Billed CPT 99220 requires 3 of 3 components (comprehensive history, comprehensive exam, and high complexity MDM). Documentation supports a down code from 99220 to 99218 as billed with detailed history (Limited ROS), comprehensive exam, and moderate MDM per 1995 E/M guidelines.
- Billed CPT 99223 - initial hospital care. Submitted note supports subsequent visit CPT 99233 with detailed history, comprehensive exam and moderate MDM, meeting 2 of 3 requirements of detailed history/detailed exam/high complexity MDM.
- Billed CPT 99233 requires 2 of 3 components (detailed history, detailed exam, and high complexity medical decision making). Documentation supports a down code from 99233 to 99232 as with Expanded Problem Focused History, Detailed Exam, and Moderate MDM per 1995 and 1997 E/M guidelines.
- Billed CPT 99233. Documentation supports a down code to 99232 with Expanded Problem Focused History, Expanded Problem Focused Exam, and moderate MDM per 1995 and 1997 E/M guidelines.
- Billed CPT 99233. Documentation supports a down code to 99232 with Problem Focused History (Limited HPI and No ROS), Expanded Problem Focused Exam per 1995 E/M guidelines, and Moderate MDM per 1995 E/M guidelines.
- Billed CPT 99285 requires 3 of 3 components (comprehensive history, comprehensive exam, and high complexity MDM). Documentation supports a down code from 99285 to 99284 with detailed history, comprehensive exam, and moderate MDM per 1995 E/M guidelines.
- Billed 99306 - Initial Nursing Facility Care requiring 3/3 Components; Comprehensive History and Exam and High complexity MDM. Documentation supports a down code to 99304 also requiring 3/3 Components; Detailed/Comprehensive History & Exam and Straightforward/Low MDM. Documentation is of Detailed History and Exam and Moderate MDM.

Medically Unnecessary Service or Treatment – 2% of total errors

Reasons for Errors:

- Billed laboratory test is not medically necessary for lack of the verification of the treating physician's documentation to support medical necessity; therefore the venipuncture (CPT 36415) is not reasonable and necessary.

Other Errors – 2% of total errors

Reasons for Errors:

- Billed CPT G0206 (Diagnostic mammography, producing direct digital image, unilateral, all views) with the ordering physician's NPI as the rendering provider as well. Submitted includes a letter from the billing provider stating in part that the claim was submitted in error with the ordering physician's NPI being identified as the rendering physician instead of the rendering radiologist's NPI and the claim has been submitted for correction. Of note, the claim was cancelled and resubmitted after CERT selection, and the correct performing radiologist's NPI was paid.

Based on CERT error findings for this quarter, below are educational resources that can assist in avoiding these issues in your practice.

CMS Resources

- **Provider Signature Requirements** - CMS Internet-Only Manual(IOM), Publication 100-08, Chapter 3, Section 3.3.2.4
- **Requirements for Ordering and Following Orders for Diagnostic Tests–** IOM, PUB 100-02, Chapter 15, section 80.6.1
- **Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services** – IOM, PUB 100-02, Chapter 15, section 220.1
- **Identifying the Certifying Physician** - IOM, PUB 100-04, Chapter 5, section 10.3.F
- **Payment for Anesthesiology Services** – IOM, PUB 100-04, Chapter12, section 50
- **Selection of Level of Evaluation and Management Service** - IOM , PUB 100-04, Chapter 12, section 30.6.1

WPS Medicare Resources

Local Coverage Determinations (LCDs) for:

- Allergy Testing and Allergy Immunotherapy
- Chiropractic Services
- Qualitative Drug Testing

Additional WPS Medicare web page resources:

- CERT Articles
- CERT Error Analysis
- Evaluation & Management Services (under Resources, Provider Specialties/Services)

Medicare Part B - Current Updates
September 2014

Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for compliance with Medicare rules and regulations. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

CMS Secure Net Access Portal (C-SNAP) Part B Appeals Status

Check the status of your Part B Appeals with C-SNAP. All you need is the beneficiary's name, date of service or the Internal Control Number (ICN). Status is available within 10 days after request submission. Once completed, the Decision Date and the Decision are available.

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature "Help Center."

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please call Medicare Customer Service at

Iowa, Kansas, Missouri, and Nebraska	Indiana and Michigan
(866) 518-3285	(866) 234-7331

C-SNAP User Manual is now available on the C-SNAP Home page at: http://medicareinfo.com

Change to CMS Secure Net Access Portal (C-SNAP) Reopening feature early September 2014

In early September 2014, the current Clerical Error Reopen (CER) submission in C-SNAP via the "Appeals" pages will be changed. This enhancement will enable a provider to enter revised claim information that will be transmitted to the MCS through C-SNAP. The new CER feature will allow you to change some specific claim information on a denied claim and receive immediate notification that the claim adjustment has been accepted into MCS. For more information see the article Change to CMS Secure Net Access Portal (C-SNAP) Reopening Feature Early September 2014 found on the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska

http://www.wpsmedicare.com/j5macpartb/departments/appeals/_files/change-csnap-reopening-feature.pdf

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/appeals/_files/change-csnap-reopening-feature.pdf

Coming to the CMS Secure Net Access Portal (C-SNAP) in Early September 2014

In early September 2014, Overpayment Claim Adjustments (OCA) - Medicare Part B providers will have an automated process to submit Medicare Secondary Payer (MSP) and non-MSP overpayment adjustments via C-SNAP. Additional information can be found at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/payment-recovery/_files/csnap-oca.pdf

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/payment-recovery/_files/csnap-oca.pdf

ICD-10 Compliance Date is October 1, 2015

Providers are required to continue to use ICD-9-CM through September 30, 2015. As additional information becomes available from CMS, we will publish that information in the weekly eNews. Sign up for WPS Medicare eNews at:
http://visitor.r20.constantcontact.com/manage/optin/ea?v=001B5adRlY4IqajYzHtZeaOuQ%3D%3D

You can find ICD-10 information on the ICD-10 page of the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/claims/icd-10/
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/claims/icd-10/

Sign up for Medicare Learning Network

CMS national provider educational products, named The Medicare Learning Network® (MLN), share up-to-date educational information and accompany the release of new or revised Medicare program policies. Available educational tools include National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment. WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page
http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/cert/
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/cert/

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Submit your Medicare Enrollment Application using Internet-based PECOS, the fastest, easiest way to enroll in the Medicare program or update your Medicare program enrollment record.

You can access Internet-based PECOS at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

The CMS publication (ICN 903767), titled ***"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations"*** helps you use internet-based PECOS. You can download it here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf

The CMS publication (ICN 903764), titled ***"The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners"*** helps you use internet-based PECOS. You can download it here: http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf

Revalidation of Medicare Provider Enrollment Information

The Affordable Care Act requires providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011, are not impacted.

Wait to submit revalidation until after your Medicare Administrative Contractor asks you to do so. Revalidation notices will be sent out on or before March 2015.

A MLN Matters article on the revalidation process is found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf

Customer Satisfaction Survey

WPS Medicare strives to continue to improve our website to meet our providers' needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products informing Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, CMS has implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

eNews

WPS Medicare publishes our eNews Listserv three times a week. Monday's eNews contains the most current and vital information Medicare providers need to know including policy updates, current Medicare information, and changes as they happen. Wednesday second eNews contains educational opportunities and Thursday's the third eNews is a publication of a CMS Listserv. To sign up, visit the WPS Medicare website and select "eNews" in the upper right corner. We encourage everyone at provider offices to subscribe, as there are no restrictions on how many individuals can subscribe.

You can sign-up on the WPS Medicare website at: http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do

WPS Medicare Resources Web Page

WPS Medicare offers a wide range of resources to assist providers. We regularly develop and improve our online resources to decrease providers' costs and time spent contacting WPS Medicare. Easy Access to the following information can be found under the Resources Tab: Acronyms Lookup, CMS/External Links, Modifiers, New Providers and Provider Specialties/Services, Tips for First Time Visitors and Website Updates. Information is available 24 hours a day, 7 days a week, at a time most suitable to providers' schedules.

Visit the WPS Medicare Resource Web Page:
Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/resources/
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/resources/

Medicare Remit Easy Print (MREP)

MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view**.**

Get easy Access to MREP by visiting the WPS Medicare website below.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml
For assistance, please call (866) 518-3285 and follow the prompts for EDI assistance.

Indiana and Michigan

http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml
For assistance, please call (866) 234-7331 and follow the prompts for EDI assistance.

Medicare Incentive Programs

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. In 2014, eligible professionals may choose to participate in the following payment incentive programs.

1. Physician Quality Reporting System – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries. Find more information on the Physician Quality Reporting System program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

2. Electronic Health Records (EHR) – Medicare eligible professionals, hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology. Medicare eligible professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

CMS offers Free Mobile Applications (apps) to track payments under Open Payments

In July 2012, the Centers for Medicare & Medicaid Services (CMS) introduced two free mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that applicable manufacturers and applicable Group Purchasing Organizations (GPOs) will report under Open Payments. Created by a provision of the Affordable Care Act, Open Payments creates greater public transparency about the financial transactions among physicians, teaching hospitals, and drug and device manufacturers.

These apps are available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the Open Payments website. The mobile apps allow both industry and physician users to track payments and other transfers of value in real-time. One app is targeted specifically to physicians (***Open Payments Mobile for Physicians***) and the other one is for industry, including applicable manufacturers and applicable GPOs (***Open Payments Mobile for Industry***).

The mobile applications can be downloaded and used easily and conveniently on a mobile device. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

For more information on Open Payments and the mobile app, please see the program website at http://go.cms.gov/openpayments

For more information regarding the enhancements made to the mobile apps based upon user feedback, please use the MLN Matters article on the topic. The article can be found online at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1402.pdf.

Revised Modifications to the Medically Unlikely Edit (MUE) Program

Additional modifications are being updated in the MUE program. The updates include clarifications, general processing instructions and detailed explanations of MUE requirements and specifications. Please advise your billing staff of these changes. For more information please refer to the Medlearn Matters article MM8853 at:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8853.pdf

WPS Medicare J5 MAC - Part A

Top 10 Services - Sorted by Projected Error Rate

Rank	Inpatient MS-DRG
1	Back & Neck Proc Exc Spinal Fusion W Cc/Mcc Or Disc Device/Neurostim (490)
2	Cardiac Defibrillator Implant W/O Cardiac Cath W/O Mcc (227)
3	Perc Cardiovasc Proc W Drug-Eluting Stent W/O Mcc (247)
4	Circulatory Disorders Except Ami, W Card Cath W/O Mcc (287)
5	Perc Cardiovasc Proc W/O Coronary Artery Stent W/O Mcc (251)
6	Permanent Cardiac Pacemaker Implant W Cc (243)
7	Permanent Cardiac Pacemaker Implant W/O Cc/Mcc (244)
8	Aicd Generator Procedures (245)
9	Spinal Fusion Except Cervical W/O Mcc (460)
10	Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (392)

WPS Medicare J5 MAC - Part A

Top 10 Services - Sorted by Projected Improper Payment

Inpatient MS-DRG
Psychoses (885)
Heart Failure & Shock W Mcc (291)
Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (392)
Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc (470)
Chest Pain (313)
Chronic Obstructive Pulmonary Disease W/O Cc/Mcc (192)
Perc Cardiovasc Proc W Drug-Eluting Stent W/O Mcc (247)
Cardiac Defibrillator Implant W/O Cardiac Cath W/O Mcc (227)
Circulatory Disorders Except Ami, W Card Cath W/O Mcc (287)
Permanent Cardiac Pacemaker Implant W Cc (243)

WPS Medicare J5 MAC - Part B

Top 10 Services - Sorted by Projected Error Rate

Rank	HCPCS
1	Chiropractic manipulation (98942)
2	Chiropractic manipulation (98941)
3	Initial hospital care (99223)
4	Manual therapy (97140)
5	Hospital discharge day (99238)
6	Emergency dept visit (99285)
7	Subsequent hospital care (99233)
8	Ground mileage (A0425)
9	Routine venipuncture (36415)
10	Complete cbc w/auto diff wbc (85025)

WPS Medicare J5 MAC - Part B

Top 10 Services - Sorted by Projected Improper Payment

HCPCS
Initial hospital care (99223)
Emergency dept visit (99285)
Chiropractic manipulation (98941)
Subsequent hospital care (99233)
Ground mileage (A0425)
Office/outpatient visit est (99214)
Hospital discharge day (99238)
Subsequent hospital care (99232)
Chiropractic manipulation (98942)
Critical care first hour (99291)

WPS Medicare J8 MAC - Part A

Top 10 Services - Sorted by Projected Error Rate

Rank	Inpatient MS-DRG
1	Back & Neck Proc Exc Spinal Fusion W Cc/Mcc Or Disc Device/Neurostim (490)
2	Cardiac Defibrillator Implant W/O Cardiac Cath W/O Mcc (227)
3	Perc Cardiovasc Proc W Drug-Eluting Stent W/O Mcc (247)
4	Circulatory Disorders Except Ami, W Card Cath W/O Mcc (287)
5	Perc Cardiovasc Proc W/O Coronary Artery Stent W/O Mcc (251)
6	Permanent Cardiac Pacemaker Implant W Cc (243)
7	Permanent Cardiac Pacemaker Implant W/O Cc/Mcc (244)
8	Aicd Generator Procedures (245)
9	Spinal Fusion Except Cervical W/O Mcc (460)
10	Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (392)

WPS Medicare J8 MAC - Part A

Top 10 Services - Sorted by Projected Improper Payment

Inpatient MS-DRG
Perc Cardiovasc Proc W Drug-Eluting Stent W/O Mcc (247)
Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc (470)
Spinal Fusion Except Cervical W/O Mcc (460)
Psychoses (885)
Circulatory Disorders Except Ami, W Card Cath W/O Mcc (287)
Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (392)
Cardiac Defibrillator Implant W/O Cardiac Cath W/O Mcc (227)
Other Vascular Procedures W Cc (253)
Permanent Cardiac Pacemaker Implant W Cc (243)
Perc Cardiovasc Proc W/O Coronary Artery Stent W/O Mcc (251)

WPS Medicare J8 MAC - Part B

Top 10 Services - Sorted by Projected Error Rate

Rank	HCPCS
1	Drug screen multi drug class (G0434)
2	Assay of benzodiazepines (80154)
3	Drug confirmation (80102)
4	Drug screen multiple class (G0431)
5	Urinalysis (81005)
6	Assay of methadone (83840)
7	Assay of amphetamines (82145)
8	Blood folic acid serum (82746)
9	Chiropractic manipulation (98941)
10	Initial hospital care (99223)

WPS Medicare J8 MAC - Part B

Top 10 Services - Sorted by Projected Improper Payment

HCPCS
Initial hospital care (99223)
Office/outpatient visit est (99215)
Therapeutic exercises (97110)
Office/outpatient visit est (99214)
Subsequent hospital care (99233)
Drain/inject joint/bursa (20610)
ALS1-emergency (A0427)
Chiropractic manipulation (98941)
Subsequent hospital care (99232)
Office/outpatient visit est (99213)