Warning: Minor errors can mean big takebacks for AWV claims

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Compliance

A health system was forced to return more than $11 million to Medicare based on botched annual wellness visit (AWV) claims. You stand a better chance of avoiding this kind of disaster if you button down your internal compliance protocols, and you can limit the damage by negotiating strong indemnification in your billing services contract.

The U.S. Department of Justice announced on Feb. 7 that Penn State Health (PSH), a multi-hospital health system in central Pennsylvania, would pay $11.7 million "to resolve allegations of civil liability for submitting claims to Medicare for Annual Wellness Visit (AWV) services that violated Medicare rules and regulations."

PSH discovered the problematic claims, dated between December 2015 and November 2022, and "disclosed the matter to the United States Attorney's Office" for the Central District of Pennsylvania, the DOJ release indicates. Self-disclosure is a well-known method of reducing potential liability when a Medicare provider discovers it has unwittingly received overpayments (*PBN 11/19/07*).

As there is no legal action associated with the case, there is no publicly available information explaining what went wrong with PSH's AWV claims. The health system has acknowledged in a statement only a "discrepancy with regard to documentation requirements for Medicare Annual Wellness Visits."

Have a protocol

While there's no exact indication of what caused PSH's problem, it's clear internal compliance programs for medical practices can keep claims and documentation errors from snowballing into major headaches such as theirs.

Mary Aperance, an associate in the health services practice group at Rivkin Radler in Albany, N.Y., says "routine internal audits should be conducted to hone in on documentation or billing errors that can range from isolated instances to more systemic ones that could ultimately lead to a voluntary self-disclosure."

In fact, OIG has identified AWVs as a major target of its own audits, which means that internal audits gain in importance; you're better off catching whatever mis-takes your staff is making first (*PBN 6/13/22*).

Just because the AWV is familiar and looks simple doesn't mean your providers can't get off-track and start regularly missing steps that, without internal audits, would go undetected until hundreds or even thousands of improper claims have been filed. For example, the proper use of modifier **25** (Significant, separately identifiable E/M service) is also well-known, but that didn't prevent a Maryland oncology and hematology practice from having to pay $850K to settle with prosecutors last year for a string of allegedly improper uses (*PBN 10/2/23*).

And it only takes a single missed service to skew a claim. "Oftentimes, the payer denies payment for services provided because a provider's underlying documentation satisfies all but one requirement to bill a particular CPT code," Aperance says, adding that she's seen psychological service claims "denied for not including an 'individualized treatment plan' as a standalone document despite the fact that the underlying clinical notes contained all of the elements of an individualized treatment plan."

On the odd chance you don't already have one, there are plenty of source materials from CMS and its contractors that you can follow for AWV protocol. Medicare administrative contractor Novitas, for example, lays out a detailed AWV checklist at its website (*see resources, below*).

Note: Novitas makes a point of distinguishing between requirements for initial AWVs (**G0438**) and subsequent AWVs (**G0439**), a distinction worth noting, as the Medicare denial rate for subsequent AWVs has been over 20% for years (*PBN 1/22/24*).

Outside billers a possible shield

If you've outsourced your billing, that can provide an added layer of protection from overpayment issues due to error — if you've written it into your contract.

External billing services, which might be provided by a management services organization (MSO), can't be held responsible for your own mistakes. But if it's their malfeasance that's the reason for your bad claims, you can demand the billers cover the resulting expense Ñ provided you've drafted your agreement properly.

"The relationship should be governed by an agreement that details the specific services to be provided by the MSO, and often includes a provision indemnifying the medical practice against liabilities incurred as a result of the MSO's intentional or negligent acts," Aperance says. "This can help to protect the medical practice if, as an example, an overpayment is owed to a payer as a result of negligent billing errors by the MSO."

Resources

• U.S. Department of Justice, "Penn State Health Agrees To Pay More Than Eleven Million Dollars Following Its Voluntary Disclosure Of Improper Billings Related To Medicare Annual Wellness Visit Services," Feb. 7, 2024: *www.justice.gov/usao-mdpa/pr/penn-state-health-agrees-pay-more-eleven-million-dollars-following-its-voluntary*
• Novitas, "Annual Wellness Visit (AWV) documentation checklist," modified Nov. 16, 2022: *www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00219104*