CERT: National Findings, Proper Medical Record Keeping and Medicare Recoupment Prevention

Presented by:
Becky Gunderson Director of Medical Review
Rachel Guy-Webber CERT Team Leader

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Agenda

• CERT overview
• CERT requests
• Submission of Documentation
• National findings & preventative advice

Prelude

• The CFO Act of 1990 requires all federal agencies have annual financial audit
• Executive Orders from last three Presidents required to calculate payments made correctly under the law
• www.paymentaccuracy.gov
• MAC contracts with CMS require that we lower the payment error rate
CERT Overview

What is CERT?

• First improper payment measured in 1996 by HHS OIG
• CMS began producing the Medicare FFS improper payment rate in 2003
• Measure accuracy of the Medicare Fee-for-Service program
• Determines if Medicare claims are compliant with coverage, coding and billing rules
How CERT Works

• Randomly select processed claims
• Medical records are requested by the CERT Documentation Contractor
  – Livanta
• Medical records are reviewed for compliance by independent medical review contractor (CERT Review Contractor)
  – AdvanceMed

What Providers Need to Do

• Promptly respond to requested information
  – Within 75 days of the initial request
• Non-responders receive an error
  – Billed charges are denied
  – Payments are adjusted/recouped
• SSA 1833
  – Prohibits Medicare payment when documentation is lacking
Modes of Submission

- Fax (preferred method)
- Mail
- CD
  - Acceptable image formats are TIF and PDF
  - Encrypt and/or password protect CD
    - Include note indicating contact person for password

Updating Provider Address

https://www.certprovider.com
Medical Request Cooperation

• Cooperation is essential for medical record requests between:
  – Physicians’ offices
  – Labs
  – Hospitals
  – Skilled Nursing Facilities (SNF)
  – DME suppliers
• All entities must work together to obtain records for patients
• HIPAA - not a violation

CERT Review Decision

• Overpayments, underpayments and adjustments not impacting reimbursement are processed by MAC
• Error found: claim(s) will be recouped by your MAC
• Recoupments/adjustments found on remittance advice
Appealing a CERT Denial

• Appeal must be filed within 120 days of finalized claim
  – Submit appeal to MAC (normal process)
• No dollar amount is too small to appeal
• You can make a difference with the contractor and national error rate

Calculate Improper Payment Rate

• Statistical Contractor
• Sample size allows for extrapolated rates
  – National
  – Contractor
  – Service
• Uses statistical weighting
• Not a fraud rate
## National Findings

### CERT Improper Payment Rates

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2014 Report</th>
<th>2015 Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improper Payment Rate</td>
<td>Improper Payment Rate</td>
</tr>
<tr>
<td></td>
<td>(In Billions)</td>
<td>(In Billions)</td>
</tr>
<tr>
<td>Part A (Total)</td>
<td>11.4%</td>
<td>11.0%</td>
</tr>
<tr>
<td></td>
<td>$29.6</td>
<td>$28.7</td>
</tr>
<tr>
<td>Part A (Excluding Hospital IPPS)</td>
<td>13.1%</td>
<td>14.7%</td>
</tr>
<tr>
<td></td>
<td>$19.2</td>
<td>$21.7</td>
</tr>
<tr>
<td>Part A (Hospital IPPS)</td>
<td>9.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td></td>
<td>$10.4</td>
<td>$7.0</td>
</tr>
<tr>
<td>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</td>
<td>53.1%</td>
<td>39.9%</td>
</tr>
<tr>
<td></td>
<td>$5.1</td>
<td>$3.2</td>
</tr>
<tr>
<td>Part B</td>
<td>12.1%</td>
<td>12.7%</td>
</tr>
<tr>
<td></td>
<td>$11.0</td>
<td>$11.5</td>
</tr>
<tr>
<td>Overall</td>
<td>12.7%</td>
<td>12.1%</td>
</tr>
<tr>
<td></td>
<td>$45.8</td>
<td>$43.3</td>
</tr>
</tbody>
</table>
Top 15 DME CERT Strata

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1390</td>
<td>Oxygen concentrator</td>
</tr>
<tr>
<td>A4253</td>
<td>Blood glucose/teagent strips</td>
</tr>
<tr>
<td>K0823</td>
<td>PWC gp 2 std cap chair</td>
</tr>
<tr>
<td>E0260</td>
<td>Hosp bed semi-elec w/ matt</td>
</tr>
<tr>
<td>J7507</td>
<td>Tacrolimus oral per 1 MG</td>
</tr>
<tr>
<td>A4259</td>
<td>Lancets per box</td>
</tr>
<tr>
<td>J7626</td>
<td>Budesonide non-comp unit</td>
</tr>
<tr>
<td>E0601</td>
<td>Cont airway pressure device</td>
</tr>
<tr>
<td>E0431</td>
<td>Portable gaseous O2</td>
</tr>
<tr>
<td>B4015</td>
<td>Enteral feed supp pump per d</td>
</tr>
<tr>
<td>A7034</td>
<td>Nasal application device</td>
</tr>
<tr>
<td>A7030</td>
<td>CPAP full face mask</td>
</tr>
<tr>
<td>B4154</td>
<td>EF spec metabolic assessment</td>
</tr>
<tr>
<td>A5500</td>
<td>Diab shoe for density insert</td>
</tr>
<tr>
<td>Q0513</td>
<td>Disp fee inhal drugs/30 days</td>
</tr>
</tbody>
</table>

DMEPOS Errors

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2014 Report</th>
<th>2015 Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improper Payment Rate</td>
<td>Improper Payment Amount</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>53.1%</td>
<td>5.1B</td>
</tr>
</tbody>
</table>

• Insufficient documentation
  – 2014: 92.4%; 2015: 83% of DMEPOS errors
  – DMEPOS supplier unable to obtain medical records
  – Medical records lacked required elements
  – Missing physician signature
Insufficient Documentation

• Oxygen
  – Missing treating physician’s clinical records to support condition
  – Missing information confirming on-going clinical need within 12 months of service date
  – Missing signed and dated order from treating physician
    • Any change in the order requires new order

• CPAP
  – Missing treating physician’s detailed written order specific to supplies
    • Mask interface, replacements, etc. must be individually detailed
    • Requires replacement frequency

Medical Records

• Contemporaneous medical record must contain
  – Beneficiary was evaluated and/or treated for a condition supporting the DME ordered
  – Note: Detailed Physician Order/CMN is not considered part of the medical record
### Order Reminders

- May be completed by someone other than physician
  - Treating physician must review, sign and date

- Acceptable orders
  - Fax
  - Photocopy
  - Electronic
  - Original pen and ink

- Certificate of Medical Necessity (CMN) can serve as the order if sufficiently detailed

### Common Errors – Part A Services

As of the November 2015 Report
### Part A Top 15 CERT DRG Strata

<table>
<thead>
<tr>
<th>Code</th>
<th>DRG Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>885</td>
<td>Psychoses</td>
</tr>
<tr>
<td>470</td>
<td>Major joint replacement or reattachment of lower extremity w/o mcc</td>
</tr>
<tr>
<td>945</td>
<td>Rehabilitation w cc/mcc</td>
</tr>
<tr>
<td>942</td>
<td>Esophagitis, gastroint &amp; misc digest disorders w/o mcc</td>
</tr>
<tr>
<td>227</td>
<td>Cardiac defibrillator implant w/o cardiac cath w/o mcc</td>
</tr>
<tr>
<td>004</td>
<td>Teach w/mv 96+ hrs or psch exc face, mouth &amp; neck w/o maj o.r.</td>
</tr>
<tr>
<td>247</td>
<td>Perc cardiovas proc w drug-eluting stent w/o mcc</td>
</tr>
<tr>
<td>244</td>
<td>Permanent cardiac pacemaker implant w/o cc/mcc</td>
</tr>
<tr>
<td>243</td>
<td>Permanent cardiac pacemaker implant w cc</td>
</tr>
<tr>
<td>313</td>
<td>Chest pain</td>
</tr>
<tr>
<td>682</td>
<td>Renal failure w mcc</td>
</tr>
<tr>
<td>292</td>
<td>Heart failure &amp; shock w cc</td>
</tr>
<tr>
<td>552</td>
<td>Medical back problems w/o mcc</td>
</tr>
<tr>
<td>287</td>
<td>Circulatory disorders except amy, w card cath w/o mcc</td>
</tr>
<tr>
<td>946</td>
<td>Rehabilitation w/o cc/mcc</td>
</tr>
</tbody>
</table>

### Top Errors Affecting Part A

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2014 Report</th>
<th>2015 Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>10.7%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Inpatient Prospective Payment System (IPPS)</td>
<td>12.2%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) Inpatient</td>
<td>7.0%</td>
<td>10.4%</td>
</tr>
</tbody>
</table>
Common ESRD Error Findings

- Lack of physician order for dialysis; lab tests; medications
- Missing signature(s) on medication records and treatment notes
- Incorrect number syringes billed in reflection of medication administered

Tips to Avoid ESRD Findings

- Lab tests need to have a physician order
- Medical documentation must be authenticated to ensure physician involvement in the treatment plan
- Ensure units are coded based on the coding guidelines illustrated in Coding Books.
Common IPPS Error Findings

• Services Could have been Provided on an Outpatient Basis
  – Missing documentation to support necessity of inpatient admission
    • Can include:
      – H&P
      – Physician signature
      – Orders for admission

• Procedure codes
  – Particularly approach for spinal procedures: anterior vs. posterior

• Diagnosis Codes
  – Reason for admission when complication after procedure leads to admission

Tips to Avoid IPPS Findings

• Clear Documentation
  – Document, document, document
  – Patient Condition
  – Symptoms

• Providers must follow the Medicare regulations associated with inpatient stays

• Physician certification statement
DRG 242-244 Errors

Permanent Cardiac Pacemakers
• Single and Dual Chamber
• NCD 20.8.3
  – Procedure not Necessary thus Inpatient Admission not Necessary
  – Procedure not Necessary but Inpatient Admission Supported
    • Procedure codes removed
    • DRG change

DRG 242-244 Tips

• Clear Documentation
  – Indication for Dual or Single Chamber
• Documentation
  – H&P
  – List of medications
  – Diagnostic reports
  – Surgical report
  – Hospital documentation
  – Pertinent outpatient facility documentation
    • Please note: this is not an all inclusive list
DRG 242-244 Resources

- NCD 20.8.3

DRG 490-491 Errors

- Spinal procedures except fusion
  - Procedure not medically reasonable
  - Inpatient admission not medically necessary
    - Services provided without complication; could have been provided as outpatient
  - Documentation lacks:
    - Conservative measures
    - Imaging reports to support need for procedure
    - Effect(s) of fracture/pain on patient
DRG 490-491 Errors

- Incorrect Coding
  - Principal diagnosis
    • Example: Replacing diagnosis code 721.3 (lumbosacral spondylosis) with 998.12 (hematoma complicating a procedure)
  - Procedure code
    • Example: Replacing procedure code 02.12 (Other Repair of Cerebral Meninges) with code 03.59 (Other Repair and Plastic Operations on Spinal Cord Structures)

DRG 490-491 Tips

- Collaboration with outpatient facility
  - Obtain:
    • Treatment history
    • Conservative treatment measures
    • Imaging reports
    • Documentation of effects of pain/fracture
DRG 470 and Other Joint Replacement Errors

- Major joint replacement
- Procedure not medically reasonable
- Lack of documentation supporting:
  - Conservative measures
  - Effect of pain on activities of daily living
    - Increased pain with activity? Weight bearing?
    - Pain with range of motion? Effect on gait?

Joint Replacement Tips

- Reasonable and necessary
- “Conservative treatment attempted and failed” notation alone is not sufficient
- Document patient historical and clinical findings
- Collaborate with outpatient facilities
- Pre-operative imaging findings
Joint Replacement Tips:

- Document continued symptoms after conservative measures
- Document reason for the joint replacement
  - Osteoarthritis
  - Acute femoral fracture
  - Nonunion/Mal-union articular fracture
  - Other

Joint Replacement Resources

- MLN Matters SE1236 for Knee or Hip Joint Replacements
Inpatient Rehabilitation Facility (IRF) Documentation Errors

- Documentation Insufficient or Missing:
  - Patient Assessment Instrument (PAI)
  - Pre-admission Screening
  - Post-admission Evaluation
  - Interdisciplinary Team Meeting Notes/Attendees
  - Plan of Care
  - Admission Orders
  - PT and OT Evaluations

IRF Tips

- Pre-admission screening
  - Licensed or certified clinician w/in 48 hrs
  - Conveyed to rehab physician prior to admit
  - Must include specific elements
  - Finding and results of pre-admission screening
  - Support services are reasonable and necessary
IRF Tips

• Post-Admission Physician Evaluation
  – Completed w/in 24hrs following admit
  – Support admission was reasonable and necessary

• Plan of Care
  – Completed w/in 4 days of admit
  – Include specific elements

IRF Tips

• Admission Orders
  – Generated at time of admission

• IRF Patient Assessment Instrument (PAI)
  – Electronic or paper
  – Data collected at admission and discharge
  – Correspond with information in medical record
  – More info can be found: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html
IRF Tips

• Interdisciplinary Team Conference
  – All required attendees must be present
  – Must be held at least once per week

• Therapy Treatments and Evaluations
  – Must begin 36 hrs from midnight on day of admission
  – Evaluation constitutes beginning of therapy services

IRF Resources

• Internet Only Manual (IOM), 100-02 Chapter 1, Section 110, *Inpatient Rehabilitation Facility Services*

• Medicare Learning Network (MLN), *Inpatient Rehabilitation Therapy Services: Complying with Documentation Requirements*
Inpatient Psychiatric Facility (IPF)
Documentation Errors

• Missing
  – Certification
  – Recertification
• Medical record doesn’t indicate need for intensive treatment and daily active services

IPF Tips

• Certify at the time of admission
• Recertification provided as of 12th day
• Subsequent recertification at least every 30 days; utilization review committee may determine greater frequency
IPF Tips

- Medical Record Must Contain:
  - Certification and/or recertification of treatment; signed and dated by physician
  - Reasonable expectation of improvement and/or performed as diagnostic study
  - Individual treatment plan (when applicable)
  - Social service records
  - Physician order
  - Diagnostic lab results

IPF Resources

- Medicare General Information, Eligibility and Entitlement Manual, Publication 100-01 Chapter 4 Section 10.9
Skilled Nursing Facility (SNF) Errors

- Certifications/recertifications not submitted
- Delayed certifications without reason for delay
- No qualifying hospital stay (3-day stay)
- Documentation did not support RUG level billed
- Units of service billed incorrectly

SNF Resources

- Regulations and Guidance
- MLN Matters SE1428
## Part B Top 15 CERT Strata

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99223</td>
<td>Initial hospital care</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit ext</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent hospital care</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital care</td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit ext</td>
</tr>
<tr>
<td>99291</td>
<td>Critical care first hour</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic exercises</td>
</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit ext</td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>99222</td>
<td>Initial hospital care</td>
</tr>
<tr>
<td>98941</td>
<td>Chiropract many 3-4 regions</td>
</tr>
<tr>
<td>99285</td>
<td>Emergency dept visit</td>
</tr>
<tr>
<td>99205</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>84443</td>
<td>Assay thyroid stim hormone</td>
</tr>
<tr>
<td>A0428</td>
<td>Mx</td>
</tr>
</tbody>
</table>
Top Errors Affecting Part B

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2013 Report Improper Payment Rate</th>
<th>2014 Report Improper Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based E/M - Initial</td>
<td>28.3%</td>
<td>31.3%</td>
</tr>
<tr>
<td>Hospital Based E/M - Subsequent</td>
<td>18.2%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Critical Care E/M</td>
<td>22.9%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Chiropractor Services</td>
<td>51.7%</td>
<td>54.1%</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>6.7%</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Physician Orders (A/B) Errors

- Invalid physician order received
- Unauthenticated physician order
  - Missing signature and/or date
  - Missing credentials
  - Illegible signature w/o authentication document
    - Individual attestation
    - Facility signature log
Physician Orders (A/B) Errors

- No intent to order found
  - Progress note contains intent but is not properly authenticated
- Other critical components
  - Lab results
  - Diagnostic reports
  - How the tests results were used in the care of the beneficiary

Physician Order Tips

- Valid Signature
  - If intent is not clearly indicated in the medical record, an order must be received with a valid, legible signature and date
- Signature log for illegible signatures
- Supply attestation when needed
- Electronically Signed Order
  - Must provide CERT with facilities signature process and example
Physician Order Resources

• Refer to CR 6698 and IOM 100-08 Chapter 3, section 3.3.2.4 – Signature Requirements

E&M (A/B)

• Hospital based Evaluation and Management (E/M) Codes
  – Missing documentation – need to retrieve from hospital chart
  – Signatures missing or illegible
  – Incorrectly coded
    • Documentation did not support the necessary key components for level of E/M service
E&M

• Critical Care Evaluation and Management (E/M)
  – Missing time related elements
  – Missing or illegible signature
  – Missing documentation

Ambulance

• Ambulance Services:
  – Incorrect dates of service
  – Missing signature(s) or Illegible documentation
  – Medical necessity (could travel safely by other means)
  – Detailed documentation regarding route
  – Documenting Mileage accurately
    • Ground, under 100 miles, mileage billed to the 10th
Ambulance Tips

• Tips:
  – Thorough and accurate documentation
  – Legible records
  – ABN or bill as non-covered with GY modifier (when applicable)
  – Ensure your mileage follows the Medicare regulations
  – Educate EMTs on Medicare benefit
  – Educate local hospitals who contact Ambulance companies for services

Chiropractor

• Chiropractor Claims
  – Chiropractic treatment plan
  – Documentation insufficient to support billed service
    • Subjective improvement
    • Objective improvement
    • Changes made when patient doesn't respond
Lab Service Trends (A/B)

- Coding Errors:
  - Urinalysis w/microscopy Billed but Order is only for Urinalysis (no mention of microscopy)
  - CBC w/diff Billed; but Order Makes no Mention of the Differential
  - Lab protocols not accepted as order

Lab Service Trends

- Unbundling
- Missing laboratory results
- Venipuncture and specimen collections
Lab Service Tips

• Perform and bill only for service(s) ordered
• Submit all pertinent information to support service
  – Lab results
  – Radiology reports
  – E&M documentation

Lab Service Tips

• Work with the laboratory to obtain results not included in records
• Be sure the physician authenticates results
• Documentation should support physician involvement and knowledge of results
Therapy Trends (A/B)

• Certification and/or recertification
• Daily treatment notes not signed or present
• Medical necessity not documented sufficiently
• Missing documentation of time to support units billed
• Missing Plan of Care (POC)
• Missing physician certification of POC
• Missing therapist signatures
• Units of service incorrectly coded

Therapy Tips

• Certification required
  – Physician signature on plan of care
• Plan of care
• Clear documentation of minutes
Therapy Resources

- Medicare Benefit Policy Manual PUB 100-02, Chapter 15, Section 220, 220.1, 220.1.1, 220.1.2, 220.1.3

Summary

- Main error across DME, Part A, Part B
  - Documentation insufficient to support service billed
  - Signatures
- One provider’s documentation can affect multiple areas & claims
- Reach out to your states MAC for all you educational needs
Noridian CERT Contact Information

• DME
  – jddmecert@noridian.com
• Part A
  – CERTPartAQuestion@Noridian.com
• Part B
  – CERTQuestion@Noridian.com

Thank You for Attending

What questions do you have?