

TO: ALL PROVIDERS

FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A

DATE: AUGUST 8, 2005

**SUBJECT: COMPREHENSIVE ERROR RATE TESTING (CERT)
DOCUMENTATION ISSUES**

The Comprehensive Error Rate Testing program (CERT) was implemented to allow the Centers for Medicare & Medicaid Services (CMS) to monitor claims payment accuracy. Each month, a sample of claims is examined by AdvanceMed (the CERT contractor) to determine if claims were paid in accordance with Medicare guidelines. Thus far, the most common CERT errors are related to documentation.

CERT Documentation Issues

Claim denials after CERT review may reflect insufficient documentation, or errors within that documentation. *Insufficient documentation* can take many forms, including but not limited to:

- The date of service is not documented.
- The appropriate person providing the service is not identified (i.e., missing names, signatures, credentials).
- The service rendered is not adequately document/described.
- The chief complaint for the visit is not documented.
- The primary diagnosis is not documented in the medical records.
- A copy of the physician's referral, initial evaluation, or plan of treatment for therapy services is not submitted.
- Physical therapy flow sheets with units of time are not submitted with copies of physical therapy progress notes.
- The results of the laboratory service, the physician's order, or the beneficiary's medical condition that justifies the need for a laboratory service is not submitted.
- Minimum Data Set (MDS) Patient Assessments are missing for Skilled Nursing Facility (SNF) claims.

Some of the most common *documentation errors* include:

- The key components of the service provided are not adequately documented to meet the definition of the HCPCS code billed.

- The medical record does not support that the services rendered were medically reasonable and necessary for the diagnosis and/or treatment of the patient's presenting condition.
- The documentation includes conflicting information (i.e., the diagnosis on the claim is not consistent with the diagnosis in the medical record, documentation in the history is not consistent with the examination, the date of service on the claim is not the same as the date documented in the medical record).

Below are some tips to avoid documentation errors and subsequent overpayment requests:

1. Respond to the documentation request from AdvanceMed. Should you receive a letter from AdvanceMed asking for your records pertaining to a claim(s), please respond promptly and provide all the information requested in the letter. Even though the claim may have already been paid, failure to respond to the documentation request will result in denial of the claim and a request for an overpayment refund to Medicare.

2. Maintain complete and accurate records. Documentation is one of the most important factors for medically reviewed claims. Determining that a service was provided and was medically necessary is dependent on the information received from the provider. The medical records must support the services and level of care provided with sufficient documentation.

CareFirst's goal is to help providers get their claims processed in an accurate and timely manner. Remembering these documentation tips will help prevent claim errors and claim denials. CareFirst recommends that providers keep a copy of the records they send to the CERT contractor, along with confirmation that they were sent (i.e., fax confirmation sheets or priority tracking numbers). It is also a good idea to have a clinician check the records before they are sent to ensure all pertinent records have been included.

CERT Medical Record Submission

To assist AdvanceMed in acquiring timely submission of medical records, CMS has asked the Affiliated Contractors, such as CareFirst, to contact those providers identified as having missing or tardy information. If you do not respond to AdvanceMed's request for records, or if the medical records are incomplete or insufficient, our CERT Coordinator will contact you to see that the records are submitted and incomplete cases are resolved. CareFirst will monitor those providers identified as showing a pattern of non-response or insufficient record submission.

CERT Error Rate

The Comprehensive Error Rate Testing (CERT) Program has provided error rate calculations based on accuracy of claim payment decisions. The error rates for CareFirst have steadily improved; however, much effort is needed to maintain this pattern of improvement.

CareFirst performs an analysis of the CERT data used to produce the reported error rate in an effort to identify strategies for error reduction. Based on these findings, CareFirst provides on-going communications with providers regarding ways to improve the error rate. In the Fiscal Year 2003, the failure of providers to respond to requests for medical records was the significant problem. For the Fiscal Year 2004, insufficient documentation of services has been the major issue. As outlined above, all documentation that substantiates billing for a service must be submitted.

In December 2004, Affiliated Contractors were provided with access to a web site posting claims for which the CERT contractor has requested medical records from a provider to support payment. CareFirst noted that approximately 40% of our providers did not have adequate address or telephone information on file. This information is gathered from the physical address and telephone number available on the Fiscal Intermediary Shared System (FISS). This information is pulled by CERT for their use in contacting providers. It is important for providers to make sure that their main provider address and telephone number is correct as submitted on the provider enrollment form (CMS 855). If providers find that this information is not correct, they should contact the Provider Enrollment Department for assistance. For direction in calling Provider Enrollment, contact Medicare Customer Service at 1-800-633-4227.

This intermediary periodically publishes articles on CERT errors identified for coding issues and for the billing of non-covered or unallowable services. Recent articles have informed of the inappropriate billing of unlisted HCPCS codes and the billing of multiple units on non-timed HCPCS codes. All CERT articles are intended for use as educational tools and they should serve as a prompt for an internal analysis of billing within each facility.

Thank you for your cooperation. We look forward to working closely with you on achieving the CERT program objectives.

If you have any questions you can contact our Provider Service line at 1-866-488-0545.

If you have questions regarding the CERT program or need to contact the CERT contractor, contact the AdvanceMed management team at (804) 264-1778 or (804) 264-3268 (fax).

The address of the CERT contractor is:

AdvanceMed
CERT Disposition Department - Distribution
1530 E. Parham Road
Richmond, Virginia 23228

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ARE AVAILABLE AT NO COST FROM OUR WEBSITE AT www.marylandmedicare.com.