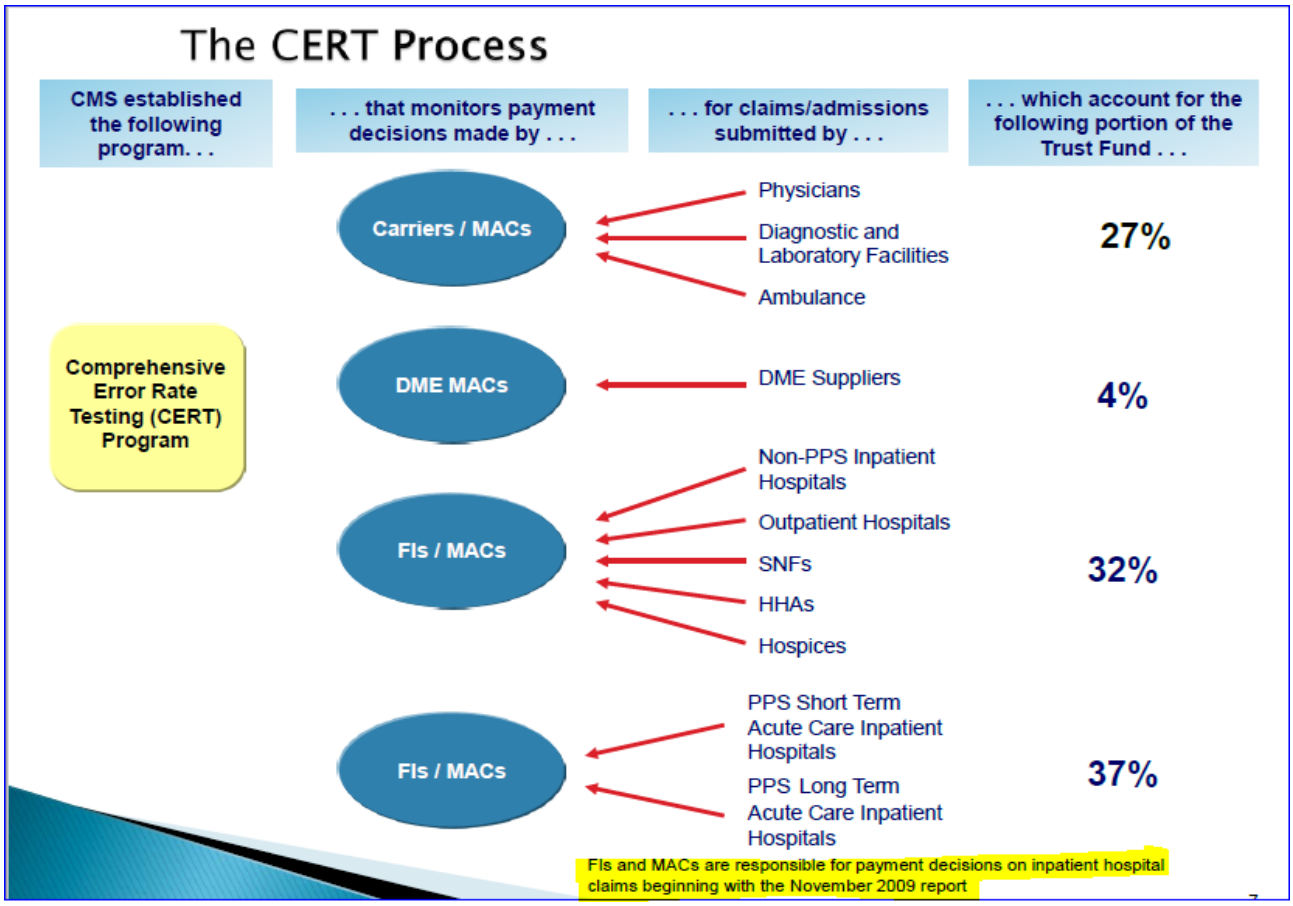
CODING, DOCUMENTATION AND CERT REPORTS – THE SLIPPERY SLOPE FOR CDI SPECIALISTS

Who knew that when Jack & Jill when up the hill to fetch a pail of water, they would have to ensure that in order to keep the level of water the same on the way back down, they would need to both ***support*** the pail. Many of you in this industry are also tasked with "supporting the level in the pail," or for that matter, multi-pails. We all know the challenges of being tasked daily with Clinical Documentation Improvement (CDI) audits and that a primary focus of these audits is ensuring that the coding and documentation ***supports*** the level of service.

Every November, the Department of Health and Human Services (HHS) makes public, its annual Improper Payment Rates for the prior year. Contained within this is the Comprehensive Error Rate Testing (CERT) program. The list also contains the Annual CMS Fee-for-Service (FFS) Improper Payments Report. The CERT reports are designed to monitor claim payment accuracy of the CMS FFS program, in order to protect the integrity of the Medicare Trust Fund. The CERT report identifies types of errors and assesses error rates at both national and regional levels in all types of healthcare settings in the U.S. The CERT report drills down into the errors and can home in on specific provider types or services and also allows CMS to evaluate the performance of Medicare Administrative Contractors (MACs), such as CGS, Noridian, FCSO, and others around the country.

FIRST THINGS FIRST - THE CERT PROCESS – COURTESY OF CMS



Where does the industry stand with respect to overall levels of care in the vast majority of services provided? How can we tell if our trips up and down the CDI hill are paying off? Well, CERT (image below), is one of several great tools that CMS publishes on their website (link below) that everyone can access. The CERT reports show us what CMS has found trending in overpayments to the healthcare industry, year to year and in what areas they are commonly occurring. This is a great forecast of future audit areas and can help you focus CDI efforts within your practice/entity.

Let's look at the 2018 CERT Report by Specialty in the graphic below:

2018 CMS CERT REPORT

Table D1: Top 20 Service Types with Highest Improper Payments: Part B

Part B Services (BETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Other drugs	$1,092,458,318	9.1%	(0.1%) - 18.4%	0.0%	65.8%	0.0%	1.1%	33.2%	3.4%
Office visits - established	$1,050,386,680	7.1%	6.0% - 8.2%	5.7%	24.5%	2.0%	66.4%	1.5%	3.3%
Lab tests - other (non-Medicare fee schedule)	$981,823,792	29.8%	25.7% - 33.9%	0.6%	93.7%	4.7%	0.0%	1.0%	3.0%
Hospital visit - subsequent	$767,051,514	14.2%	12.4% - 16.0%	10.4%	41.3%	0.0%	48.4%	0.0%	2.4%
Hospital visit - initial	$688,320,885	24.6%	22.6% - 26.7%	3.3%	30.3%	0.0%	66.4%	0.0%	2.1%
Ambulance	$599,536,134	13.4%	10.2% - 16.6%	0.0%	68.9%	23.8%	5.4%	1.9%	1.9%
Minor procedures - other (Medicare fee schedule)	$587,274,834	15.0%	11.9% - 18.1%	1.9%	91.6%	2.4%	3.7%	0.4%	1.8%
Minor procedures - musculoskeletal	$392,674,133	29.1%	15.9% - 42.3%	0.0%	86.7%	13.3%	0.0%	0.0%	1.2%
Nursing home visit	$355,453,205	18.2%	14.5% - 21.8%	11.5%	32.1%	0.0%	47.5%	8.9%	1.1%
Office visits - new	$344,549,782	12.7%	10.5% - 14.9%	0.0%	10.9%	0.0%	86.0%	3.1%	1.1%
Specialist - other	$294,693,195	27.2%	17.8% - 36.6%	3.5%	94.1%	0.4%	2.0%	0.0%	0.9%
Specialist - psychiatry	$293,503,840	26.3%	18.3% - 34.3%	2.5%	90.3%	0.0%	0.8%	6.3%	0.9%
Chiropractic	$260,878,720	41.0%	34.5% - 47.5%	0.0%	88.3%	7.7%	4.0%	0.0%	0.8%
Other tests - other	$246,371,070	13.4%	7.5% - 19.3%	5.9%	91.1%	0.3%	2.7%	0.0%	0.8%
Emergency room visit	$238,537,192	11.3%	9.4% - 13.3%	0.0%	5.8%	0.0%	94.2%	0.0%	0.7%
Hospital visit - critical care	$197,877,373	19.7%	15.0% - 24.3%	5.4%	39.8%	0.0%	54.6%	0.2%	0.6%
Ambulatory procedures - other	$142,495,895	17.9%	9.2% - 26.6%	1.1%	98.8%	0.0%	0.0%	0.1%	0.4%
Advanced imaging - CAT/CT/CTA: other	$133,362,254	12.9%	5.3% - 20.5%	0.0%	96.5%	0.0%	0.0%	3.5%	0.4%
Oncology - radiation therapy	$112,699,466	10.3%	(2.2%) - 22.7%	0.0%	100.0%	0.0%	0.0%	0.0%	0.3%
Eye procedure - cataract removal/lens insertion	$111,630,382	6.6%	1.0% - 12.2%	0.0%	96.8%	0.0%	0.1%	3.1%	0.3%
All Type of Services (Incl. Codes Not Listed)	**$10,472,333,004**	**10.7%**	**9.3% - 12.0%**	**3.4%**	**65.2%**	**3.1%**	**23.6%**	**4.7%**	**32.5%**

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf

What did Jack and Jill fetch for 2018? Did they support the pail? Let's look at the data from the above CERT report. You will notice there are a few standout categories, Established Patient Visits and New Patient Visits, which will be our focus in this article:

- **ESTABLISHED PATIENT VISITS**
  - *OVER $1 BILLION DOLLARS IN PROJECTED IMPROPER PAYMENTS*
  - *IMPROPER PAYMENT RATE AT 7.1%*
  - *INCORRECT CODING AT 66.4% - LEADS THE HIGHEST ERROR RATE IN THIS CATEGORY*
  - *INSUFFICIENT DOCUMENTATION IS SECOND, WITH 24.5% ERROR RATE*

- **NEW PATIENT VISITS**
  - *OVER $344 MILLION IN PROJECTED IMPROPER PAYMENTS*
  - *IMPROPER PAYMENT RATE AT 12.7%*
  - *INCORRECT CODING AT 86.0% - LEADS THE HIGHEST ERROR RATE IN THIS CATEGORY*
  - *INSUFFICIENT DOCUMENTATION IS SECOND, WITH 10.9% ERROR RATE*

It's not always about Medical Necessity, or is it? From the above statistics, it would seem that the primary error types in 2018 for Established Patient Visits and New Patient Visits are Coding and Insufficient Documentation. Medical

Necessity was barely in the running in either of these categories. So does that mean we don't have to be concerned about it anymore? No, that would be incorrect. Medical Necessity will always be required to support any service, but if the Coding and Documentation are incorrect/insufficient, it makes tracking Medical Necessity more difficult.

With Established Visits having a Coding Error rate of almost 67% and New Patient Visits leading with 86% in Coding Errors, that means Jack and Jill went up and down the wrong hill. Combine those statistics with Insufficient Documentation at 24.5% for Established Patients and almost 11% for New Patients and then the whole trip back down the hill is basically a wash; they were challenged with supporting the respective pails, as the documentation wasn't sufficient to demonstrate Medical necessity.

We know what Coding Errors are, but what about Insufficient Documentation errors? CERT reviewers determine that a claim has insufficient documentation errors when the supporting documentation does not allow the reviewer to fully ascertain if some or all of the potentially allowed services were provided as billed, were medically necessary, or were provided at all). A CERT reviewer might also put a claim under this Error Category if a particular component of the required documentation is determined to be missing. Specific examples of such components include:

- *A Provider Signature on an Order*
- *Unauthenticated medical records (for example, no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer,*
- *an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures)*
- *Any form that needs to be completed*
- *Incomplete progress notes (e.g., unsigned, undated, or insufficient detail)*
- *No documentation of intent to order services and procedures (e.g., incomplete, missing signed order, or progress note does not describe intent for services to be provided)*

What can happen if my practice gets a request for medical records (ADR – Additional Documentation Request), as a result of a CERT audit? If your practice receives a request from an auditing entity (whether it's CERT, a Recovery Audit Contractor, a Unified Program Integrity Contractor, or a Medicare contractor), the Billing Provider/Entity is ultimately the responsible party. The Billing Provider/Entity must provide all requested supporting documentation from any/all referring provider offices (including provider orders, office notes that support medical necessity, etc.) or inpatient entities (including admission and progress notes).

This comes from the Medicare Program Integrity Manual, Chapter 3, Section 3.2.3.3, entitled "Third-Party Additional Documentation Request."

In other words, if you're the Billing Provider, then you must comply in a timely manner **(45 days from the date of the request)**. If you do not respond within the designated timeframe or do not respond at all, you put yourself at risk for having your payments recouped and possibly further action.

What should we do in our own Practice, to avoid being Jack and Jill? There are a variety of things a CDI Specialist can do to help their Practice and Providers be better documenters, which will also help improve any coding issues. However, my number one recommendation is to conduct random chart audits of your providers on a weekly basis and compare the results against billed charges. This is the best way to take the pulse of your practice and find out if you need to have an educational in-service with providers and coders in order to keep your pail from spilling over.

Remember, finding out your practice's weaknesses is not a bad thing; we go from Breakdown to Breakthrough in our journey to Compliance.

This Weekly Auditing & Compliance Tip Was Written By:

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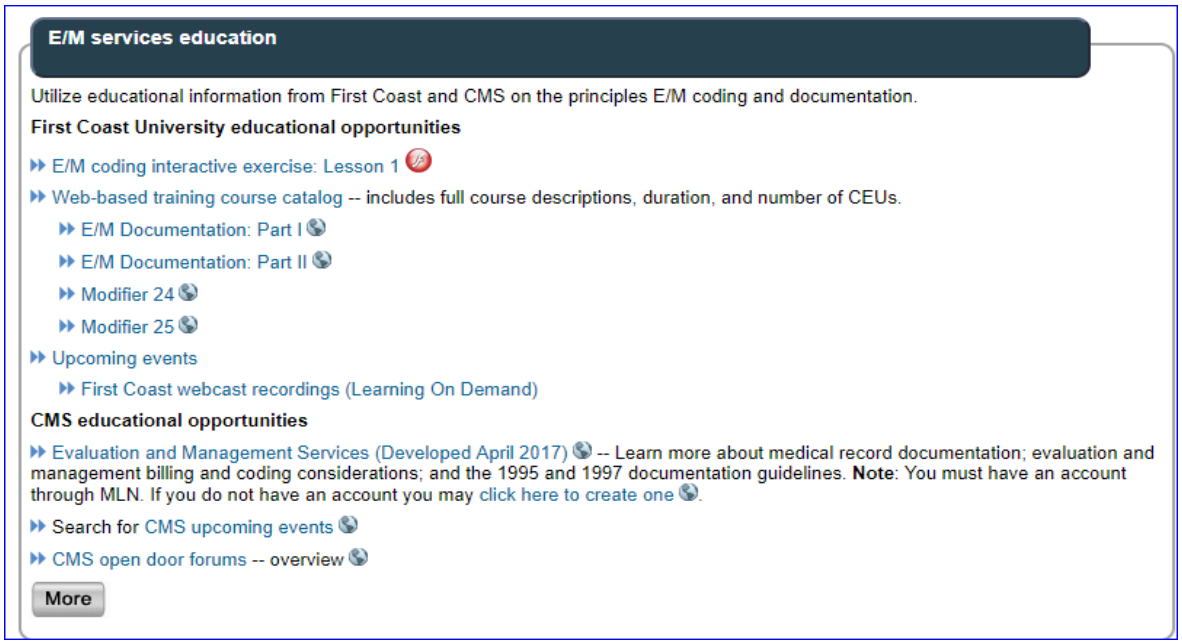
RESOURCES & TOOLS:

- CMS Comprehensive Error Rate Testing (CERT) 101 Presentation" online course **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/downloads/CERT_101.pdf**
- "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" – SE1123 **https://certprovider.admedcorp.com/**
- https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-A-B-MAC-Outreach-Education-Task-Force.html
- **https://medicare.fcso.com/Landing/233030.asp**



SOURCES:

- https://www.cgsmedicare.com/hhh/education/materials/cert.html
- https://medicare.fcso.com/Landing/233030.asp
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html