Comprehensive Error Rate Testing (CERT)

Help Prevent Pathology and Laboratory Errors

Cahaba Government Benefit Administrators®, LLC Provider Outreach and Education

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Comprehensive Error Rate Testing (CERT)

The CERT Program

Measures improper payments in the Medicare fee-for-service (FFS) program and is designed to comply with the Improper Payments Elimination and Recovery Act of 2012 (IPERA).

CERT contractors manage the program

- The CERT Documentation Contractor
  - Request and receive provider medical record documentation
  - Providers have 75 days to submit requested records

- The CERT Review Contractor
  - Review selected claims and associated medical records
Significant CERT Errors Identified

CERT Errors for Pathology and Laboratory Services

- Insufficient documentation
  - Medical necessity not documented
  - No provider signature(s)
  - No physician order(s)
  - No documentation of intent
- Incorrect Coding
Medical Record Documentation

- Providers are encouraged to document accurately in the medical record and bill laboratory services correctly.

- If a physician’s order for a diagnostic test is not included in the medical record, the physician must document the intent to order the laboratory service.

- Documentation must support the medical necessity for the services performed.

CERT Article: Significant Increase in Pathology and Laboratory Service Errors (November 2014)
Documentation of Intent

Change Request (CR) 6698: Signature Requirements for Medical Review Purposes

- EXCEPTION 2:
  - Orders for clinical diagnostic tests are not required to be signed, however
    - Documentation of intent to order laboratory service is required
    - Medical necessity must be documented (e.g., progress notes)
    - Document the specific test ordered
    - Sign documentation

A note stating “Ordering Lab” is not sufficient

Pub. 100 - 08 Program Integrity Manual (PIM)
Pub. 100 - 02 Benefit Policy Manual - Chapter 15, §80.6.1
42 CFR 410
Code of Federal Regulations (CFR) § 410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions

(a) Ordering diagnostic tests

All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem.

42 Code of Federal Regulation 410.32(d)
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/410_32.pdf
(2) Documentation and recordkeeping requirements

(i) Ordering the service: The physician or (qualified nonphysician practitioner, as defined in paragraph (a)(3) of this section), who orders the service must maintain documentation of medical necessity in the beneficiary’s medical record.

(ii) Submitting the claim: The entity submitting the claim must maintain the following documentation:

(A) The documentation that it receives from the ordering physician or nonphysician practitioner.

(B) The documentation that the information that it submitted with the claim accurately reflects the information it received from the ordering physician or nonphysician practitioner.
(3) Claims review

(i) Documentation requirements

Upon request by CMS, the entity submitting the claim must provide the following information:

(A) Documentation of the order for the service billed (including information sufficient to enable CMS to identify and contact the ordering physician or nonphysician practitioner).

(B) Documentation showing accurate processing of the order and submission of the claim.

(C) Diagnostic or other medical information supplied to the laboratory by the ordering physician or nonphysician practitioner, including any ICD–9–CM code or narrative description supplied.
Medical Record Documentation

Code of Federal Regulations (CFR) § 410.32 - Conditions

(iii) Medical Necessity

The entity submitting the claim may request additional diagnostic and other medical information to document that the services it bills are reasonable and necessary. If the entity requests additional documentation, it must request material relevant to the medical necessity of the specific test(s), taking into consideration current rules and regulations on patient confidentiality.

PIM Manual section; chapter 3, section 3.2.33

- Third-party Additional Documentation Request
  - Provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested.
National Coverage Determinations (NCDs)

- **NCD Coding Policy Manual and Change Report - October 2014**
  - National coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B

- **Documentation examples**
  - **Blood Glucose - Documentation Requirements (Page 86)**
    The ordering physician must include evidence in the patient’s clinical record that an evaluation of history and physical preceded the ordering of glucose testing and that manifestations of abnormal glucose levels were present to warrant the testing.

  - **Thyroid Function tests - Documentation Requirements (Page 97)**
    When thyroid function tests are billed at a greater frequency than the norm (two per year), the ordering physician’s documentation must support the medical necessity of this frequency.

General Information: Documentation Requirements

All "Indications" must be clearly documented in the patient’s medical record and made available to Medicare upon request.

Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/treating physician must indicate the medical necessity for performing a qualitative drug test. All tests must be ordered by the treating provider, and all drugs/drug classes to be tested must be indicated in the order.

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard or digital copy documentation of the lab results, along with copies of the ordering/referring physician’s order for the qualitative drug test. The physician must include the clinical indication/medical necessity in the order for the qualitative drug test.

Documentation must support CMS 'signature requirements' as described in the Medicare Program Integrity Manual (Pub. 100-08), Chapter 3.
Submitting Documentation

- Respond timely to CERT medical record request
- Submit appropriate documentation including, but not limited to:
  - Physician orders
  - Progress note(s) to match the DOS billed
  - Clear documentation of intent
  - Lab results/reports
  - Diagnostic tests/reports
- Sign records with a legible identifier for services provided/ordered
- CERT will accept late documentation
- Appeal unfavorable decisions
  - Additional supporting appeal documentation to Cahaba GBA
Resources

Review CERT examples of laboratory errors and compliance guidelines in the following references:

- **Part B Monthly CERT Findings** (scroll down the page; click on a specific month; review the article and click on the word “summary”; scroll the EXCEL spreadsheet to view CERT error rationale for laboratory HCPCS codes)

- **Medicare Signature Requirements - Educational Resources for Health Care Professionals**

- **Pub. 100-04 Medicare Claims Processing Manual; Chapter 16 - Laboratory Services**

CMS Home Page: http://www.cms.gov/

Comprehensive Error Rate Testing (CERT): www.cms.gov/CERT/

CMS Clinical Lab Center (view NCDs, Policies, Regulations, etc.):
http://www.cms.gov/Center/Provider-Type/Clinical-Labs-Center.html

Cahaba GBA Home Page: http://www.cahabagba.com/

Local Coverage Determinations (LCDs) are located at:
Provider Contact Center

Alabama, Georgia and Tennessee

1-877-567-7271