CERT: Documentation of Clinical Diagnostic Tests

May 29, 2014

Cahaba Government Benefit Administrators®, LLC
Provider Outreach and Education
Disclaimer

This resource is not a legal document. The presentation was prepared as a tool to assist providers and was current at the time of creation. Responsibility for correct claims submission lies with the provider of services. Reproduction of this material for profit is prohibited; providers are encouraged to share this education with staff.

CPT® copyright 2014 and AMA trademark
All Rights Reserved
Topics

- Comprehensive Error Rate Testing (CERT)
- Documentation of Clinical Diagnostic Services
  - Pathology & Laboratory Services
- The Medical Review Program
- Coverage Determinations
- Resources
Comprehensive Error Rate Testing

CERT: Measures Improper Payments

Documentation Contractor: Request Records 75 Days to Submit

Review Contractor: Review Claims/Records
CERT Errors: Pathology and Laboratory

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

- Incorrect Coding
CERT A/B MAC Outreach & Education

CERT Task Force Education

- MAC and provider partnership
- Reduce CERT errors
- National “hot topics”
  - Compliance scenarios

CERT A/B MAC Outreach & Education


Disclaimer: Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Contractor Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.
<table>
<thead>
<tr>
<th>Type</th>
<th>Codes</th>
<th>Errors and Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology and Laboratory Services</td>
<td>CPT 85025</td>
<td>Service Incorrectly Coded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree per CPT codebook 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pub 100-2 Chapter 15 Â§80.6.1 Orders/Following Orders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 CFR 410.32(a) Physician's order/intent</td>
</tr>
</tbody>
</table>

**Rationale**

Missing:
Order for CBC with automated differential.

CERT Received:
a) Progress note indicating plan was for CBC secondary to elevated WBCs, and

b) Lab results for CBC with differential.

Documentation supports recoding to 85027 (CBC without differential).
<table>
<thead>
<tr>
<th>Type</th>
<th>Codes</th>
<th>Errors and Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology and Laboratory Services</td>
<td>CPT 80154</td>
<td><strong>Insufficient Documentation</strong></td>
</tr>
<tr>
<td></td>
<td>82055</td>
<td></td>
</tr>
<tr>
<td></td>
<td>82145</td>
<td><strong>Disagree per SSA 1833(e)</strong></td>
</tr>
<tr>
<td></td>
<td>82205</td>
<td><strong>42 CFR Â§ 410.32(a) Physician’s Orders</strong></td>
</tr>
<tr>
<td></td>
<td>82520</td>
<td><strong>42 CFR Â§ 410.32 (d)(2)(i) Medical necessity</strong></td>
</tr>
<tr>
<td></td>
<td>82542</td>
<td><strong>PUB 100-2, Chapter 15 Â§ 80.6.1 Requirements for</strong></td>
</tr>
<tr>
<td></td>
<td>82570</td>
<td><strong>Ordering and Following Orders for Diagnostic Tests</strong></td>
</tr>
<tr>
<td></td>
<td>83840</td>
<td></td>
</tr>
<tr>
<td></td>
<td>83925</td>
<td><strong>PUB 100-8 Chapter 3 Â§ 3.6.2.2 Reasonable and</strong></td>
</tr>
<tr>
<td></td>
<td>83986</td>
<td><strong>Necessary Criteria</strong></td>
</tr>
<tr>
<td></td>
<td>84311</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale**

Missing the treating **physician's specific order** for or clinical documentation supporting **intent to order** each of the billed laboratory tests.

Billed for creatinine; amphetamine or methamphetamine; barbiturates; benzodiazepines; cocaine or metabolite; alcohol; methadone; column chromatography/mass spectrometry; opiates (3 UOS); spectrophotometry; and ph, body fluid.
<table>
<thead>
<tr>
<th>Type</th>
<th>Codes</th>
<th>Errors and Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology and Laboratory Services</td>
<td>CPT 83883</td>
<td><strong>Insufficient Documentation</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree per SSA 1833(e)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 CFR Â§ 410.32(a) Ordering diagnostic test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 CFR Â§ 410.32 (d)(2)(i) Medical necessity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PUB 100-2 Chapter 15 Â§ 80.6 Diagnostic test Clinical laboratory services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 CFR 482.24(c)(1) Condition of participation: medical record services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PUB 100-8 Chapter 3 Â§ 3.3.2.4.D Signature Requirements</td>
</tr>
</tbody>
</table>

**Rationale**

Missing a **signature attestation** statement for the **unsigned office visit note** that supports medical necessity.
<table>
<thead>
<tr>
<th>Type</th>
<th>Codes</th>
<th>Errors and Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology and Laboratory Services</td>
<td>CPT 82520, 82742</td>
<td>Insufficient Documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree per SSA1833(a)(1)(a); Pub 100-2 Ch 15 §80.6.1 Orders/Following Orders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 CFR 410.32 (a) Physician’s orders/Intent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pub 100-8 Ch. 3 § 3.4.1.A Medical necessity</td>
</tr>
</tbody>
</table>

**Rationale**

Missing documentation that supports the **plan or intent to order** the Cocaine and Flurazepam and supports the need for and/or reason for ordering the diagnostic tests.
Signature Requirements

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

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author

- Hand written (legible)
- Electronic signature

- Stamp signatures are not acceptable - new exception
  - Change Request 8219 - Use of Rubber Stamp
  - The Rehabilitation Act of 1973
  - Effective June 18, 2013
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 intent to order laboratory service
  - Required medical record documentation (e.g., progress notes)
  - Must specify test ordered
  - Signed documentation

A note stating “Ordering Lab” **is not** sufficient

Pub. 100 - 08 Program Integrity Manual (PIM) Chapter
Pub.100 - 02 Benefit Policy Manual - Chapter 15, §80.6.1
42 CFR 410
Medical Record Documentation

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.
Medical Record Documentation

Code of Federal Regulations (CFR) § 410.32 - Conditions

(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.
The Medical Review Program

- Data driven
- Prevent improper payments in the Medicare FFS program
- May request medical records
  - 45 days to submit records
  - 60 days to complete review
- Determines billing compliance
- Coverage, coding, payment, and billing policies

Program Integrity Manual (PIM) Publication 100-08 - Chapter: 1 - Overview of Medical Review
Coverage Determinations

- National Coverage Determinations (NCDs)
  - National coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B
- Documentation examples - NCD Coding Policy Manual
  - 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 these 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.
Local Coverage Determinations (LCDs)

LCD ID: L33635 Pathology and Laboratory - Qualitative Drug Testing

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
  - CERT or Medical Review medical record request

- Submit appropriate documentation including, but not limited
  - Physician orders
  - Progress note(s) to match the DOS billed
  - Clear documentation of intent
  - Lab results/reports
  - Diagnostic tests/reports

- Legible identifier for services provided/ordered

- CERT will accept late documentation

- Appeal unfavorable decisions
  - Additional supporting documentation to CGBA

We'd welcome your feedback!

Thank you for visiting our website. You have been selected to participate in a brief customer satisfaction survey to let us know how we can improve your experience.

The survey is designed to measure your entire experience, please look for it at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

[Buttons: No, thanks | Yes, I'll give feedback]
References

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

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

Cahaba GBA CERT Page: Scroll to view monthly CERT summaries
http://www.cahabagba.com/part-b/education/comprehensive-error-rate-testing-cert/

Cahaba GBA article: CERT - Increased Lab Errors (Dec. 2013)

Comprehensive Error Rate Testing (CERT): Pathology and Laboratory Service Errors - Reminder (April 2014)

Complying with Medicare Signature Requirements: CERT Fact Sheet revised

Clinical Lab Center: http://www.cms.gov/Center/Provider-Type/Clinical-Labs-Center.html

http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.html

Medicare Benefit Policy Manual Chapter 15; section 80.6.1: Requirements for Ordering and Following Orders for Diagnostic Tests - Orders

Medicare Program Integrity Manual - Chapter 3; Section 3.2.3.3: Verifying Potential Errors and Taking Corrective Actions; Third-party Additional Documentation Request
Questions

Provider Contact Center
Alabama, Georgia and Tennessee
1-877-567-7271
Thanks for Your Attendance!

⭐ Register for upcoming events on our Cahaba GBA Schedule of Upcoming Events web page!

⭐ Please complete the electronic evaluation at the conclusion of the webinar.