DISCLAIMER

• This resource is not a legal document. This presentation was prepared as a tool to assist providers.
• This presentation was current at the time it was created.
• Although every effort has been made to assure accurate information, responsibility for correct claim submission lies with the provider of the services.
• Reproduction of this material for profit is prohibited
AGENDA

- Medicare Contracting
- Comprehensive Error Rate Testing
- Office of Inspector General
- Recovery Auditor
- Subjects for review
  - Wide spread service specific
  - Provider specific review
- Updates/Innovations
- Website and General Information
Medicare Contracting

- MAC (Medicare Administrative Contractor)
- DMEMAC (Durable Medical Equip MAC)
- HH&H (Home Health and Hospice)
- CERT (Comprehensive Error Rate Testing)
- RA (Recovery Auditors)
- ZPIC (Zone Program Integrity Contractor)
- QIC (Qualified Independent Contractor)
- QIO (Quality Improvement Organization)
MAC A/B Jurisdiction Map

JF Noridian
JE Noridian
J5 WPS
J6 NGS
J8 WPS
J11 Palmetto
J15 Novitas
J15 CGS
J11 Palmetto
JN FCSO
JJ Cahaba
JK NGS
Quality Improvement Organizations

- BFCC-QIO
- Beneficiary and Family Centered Care
  - Beneficiary and Family Centered Care
  - Kepro
    - www.keproqio.com
- QIN-QIO
- Quality Innovation Network
  - Alliant-Georgia Medical Care Foundation (GA, NC)
    - www.alliantquality.org
  - atom Alliance (AL, IN, KY, MS, TN) 3340 Players Club Parkway, Suite 300 Memphis, TN 3812 800-528-2655
    - http://atomalliance.org
Comprehensive Error Rate Testing Program

- Established by CMS to monitor the accuracy of claim payment in the Medicare Fee-For-Service program
- Sampling methodology, randomly selected claims based on services with the highest historical improper payments
- Communication with the provider all has CMS letterhead (contractors are invisible)
- Preferred method of record exchange is fax (mail is secondary)
  - Include bar coded cover sheet or Claim ID (CID) number on submitted documentation
- Reimbursement recouped by the MAC
- Same appeal rights as Medicare
Comprehensive Error Rate Testing Program

- CERT Documentation Contractor
  - [https://www.certprovider.com](https://www.certprovider.com)
  - Fax or mail documentation
- CERT Review Contractor
  - Determines error rate for the MAC
  - Same appeal rights as under Medicare
- CERT Statistical Contractor
- CERT Report Website Contractor
  - Maintains [https://www.cms.hhs.gov/cert](https://www.cms.hhs.gov/cert)
Comprehensive Error Rate Testing Program

November 2016 Forecasting Report For MAC Jurisdiction J

1. Summary

The CERT statistical contractor calculates contractors’ projected 2016 national improper payment amounts and rates on a quarterly basis, based upon claims completely reviewed. This report includes reviewed claims data from the sampling period July 2014 through June 2015, as of May 11, 2016.

Table 1.1: Showing Error Rate for 2016 by “Claims Type”

<table>
<thead>
<tr>
<th>Claims Type</th>
<th>Paid Claims Error Rate (for reviewed claims)</th>
<th>95% Confidence Interval</th>
<th>Number of sampled claims (Completely Reviewed)</th>
<th>Error Rate (partial imputation)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall JJ</td>
<td>12.7%</td>
<td>10.0% - 15.4%</td>
<td>2,749</td>
<td>12.7%</td>
</tr>
<tr>
<td>Part B</td>
<td>11.0%</td>
<td>5.9% - 16.1%</td>
<td>1,305</td>
<td>11.0%</td>
</tr>
<tr>
<td>Overall Part A</td>
<td>13.4%</td>
<td>10.6% - 16.3%</td>
<td>1,444</td>
<td>13.4%</td>
</tr>
<tr>
<td>Part A(excl Inpatient Hospital PPS)</td>
<td>20.8%</td>
<td>15.8% - 25.8%</td>
<td>513</td>
<td>20.8%</td>
</tr>
<tr>
<td>Part A(Inpatient Hospital PPS)</td>
<td>3.3%</td>
<td>2.4% - 4.1%</td>
<td>931</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

*For the pool of incomplete reviewed claims, the errors for claims waiting feedback or documentation are imputed with historical error rate based on the assigned error category. The claims that have not been reviewed are not included.
## PART B Top 10 – By Type of Service

### Table 2.1 Top 10 Type of Service - Sorted by Projected Improper Payment

<table>
<thead>
<tr>
<th>PART B Type of Service</th>
<th>Projected Error Rate</th>
<th>Projected Improper Payment</th>
<th>Number of Claims Sampled</th>
<th>95% Confidence Interval</th>
<th>Proportion of Overall Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall JJ Part B</td>
<td>11.0%</td>
<td>$708,372,282</td>
<td>1,305</td>
<td>5.9% - 16.1%</td>
<td></td>
</tr>
<tr>
<td>Lab tests - other (non-Medicare fee schedule)</td>
<td>46.0%</td>
<td>$125,087,678</td>
<td>285</td>
<td>33.5% - 58.5%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Hospital visit - subsequent</td>
<td>22.0%</td>
<td>$62,331,561</td>
<td>129</td>
<td>15.9% - 28.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Hospital visit - initial</td>
<td>37.1%</td>
<td>$55,557,397</td>
<td>73</td>
<td>29.2% - 44.9%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Office visits - established</td>
<td>5.9%</td>
<td>$47,512,825</td>
<td>98</td>
<td>2.9% - 8.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Minor procedures - other (Medicare fee schedule)</td>
<td>31.3%</td>
<td>$46,709,098</td>
<td>80</td>
<td>18.5% - 44.0%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Minor procedures - musculoskeletal</td>
<td>57.8%</td>
<td>$36,564,075</td>
<td>13</td>
<td>13.7% - 101.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Hospital visit - critical care</td>
<td>45.9%</td>
<td>$34,633,994</td>
<td>26</td>
<td>33.8% - 58.0%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Office visits - new</td>
<td>24.7%</td>
<td>$33,458,685</td>
<td>34</td>
<td>14.6% - 34.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Nursing home visit</td>
<td>37.5%</td>
<td>$28,059,395</td>
<td>28</td>
<td>25.4% - 49.6%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>7.7%</td>
<td>$23,673,338</td>
<td>66</td>
<td>0.3% - 15.1%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
Comprehensive Error Rate Testing Program

Laboratory Errors

- 79% a valid physician order was not submitted
- 15% a valid ICD-9 code alone does not justify
- 2% no ordering practitioner signature or illegible identifier
- 2% lab results alone submitted
- 1% documentation submitted does not adequately describe the service defined by the CPT/HCPCS code
- 1% not medically necessary
## Comprehensive Error Rate Testing Program

### E&M Errors

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Medical Necessity</th>
<th>Insufficient Document</th>
<th>No Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Initial</td>
<td>79%</td>
<td>18%</td>
<td>3%</td>
</tr>
<tr>
<td>Hospital Subs</td>
<td>70%</td>
<td>30%</td>
<td>0%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>67%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Office New</td>
<td>86%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>Office Estab</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Why Does CERT Matter?

• CMS requires that we recoup the payments
  • You did the work and deserve to be reimbursed
• We use it as an indicator of vulnerabilities
• CMS evaluates MACs based on CERT performance
  • Contract awards influenced by CERT rates
  • CERT rates play a role in Award Fees
Comprehensive Error Rate Testing Program
Laboratory Errors Solutions

• Require an order
• Require signature or attestation
• Drop down boxes
• Assign a point person in your organization to receive and respond to Additional Documentation Requests
  • Identify that person to CERT
  • https://www.certprovider.com
• We will work with you to educate physicians and SNFs about providing documentation
Comprehensive Error Rate Testing Program
E&M Errors Solutions

- Assign an individual to be your CERT contact person
  - Communicate with your billing company
  - Hospitalists communicate with the hospital medical records
  - Set up a process where your records are sent
- Return the records to the CERT Documentation Contractor in a timely fashion
- Ensure medical record documentation is complete, accurate and supports the level E&M code billed
  - Train your coders
  - Do not reward up-coding
  - Physician coders?
- Clear legible signatures
- Validate that the claim contains the correct ICD-10 and CPT codes
For Providers Submitting Documentation via CD

• Providers should send the password to: CERTMAIL@livanta.com with the subject of the e-mail to include the CID number

• There is no need for the provider to encrypt the e-mail

• Following this procedure will ensure that there is no delay in processing the documentation
CERT

The Comprehensive Error Rate Testing (CERT) program was initiated by CMS to achieve the agency’s mission to emphasize accountability, pay claims appropriately, and to provide a renewed focus on the customer. The program produces national, contractor-specific, and service-specific paid claim error rates, as well as a provider compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The provider compliance error rate is a measure of the extent to which providers are submitting claims correctly.

The program has independent medical reviewers periodically reviewing representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system. The independent reviewers medically review claims that are paid; by contrast, claims that are denied are validated to ensure that the decision was appropriate.

There are two contractors who administer the CERT Program on behalf of CMS. The CERT Review Contractor selects random samples of claims from each Medicare claims processing contractor for medical review. For each claim selected, the CERT Documentation Contractor (CDC) requests medical records from the physicians and non-physician providers who billed for the services, tracks record receipts, and prepares the documentation for review. Using the medical record documentation received, the contractors verify that the services were billed correctly, and that the Medicare Administrative Contractor (MAC) decisions regarding the payment and processing of the claim(s) were accurate and based on sound policy. Claims that are billed, paid, or processed incorrectly are categorized as errors.

Use the following resources to learn more about the program.

- CERT Brochure
- CERT Computer Based Training (CBT)
- Evaluation & Management Documentation Guidelines
- Frequently Asked Questions About CERT
- Insufficient Documentation Identified for Prolonged Evaluation & Management (E&M) Codes Inpatient setting, 99356-99357
- Medicare Signature Requirements – Special Edition 1419
- Help Prevent Pathology and Laboratory Errors
- Monthly Comprehensive Error Rate Testing (CERT) Findings
  - January 2016
Recent Comprehensive Error Rate Testing (CERT) Findings – 11/15 Feedback

The data in the November 2015 error feedback files is derived from claims submitted July 1, 2013 through June 30, 2014. An analysis of these files has resulted in the following findings:

Service Type Analysis

Pathology and Laboratory codes accounted for the highest projected improper payments by HCPCS code. Pathology and Laboratory services accounted for approximately 70% of the line errors. 74% of lab errors were due to insufficient documentation including a missing physician order or intent to order the billed services and missing documentation to support medical necessity for the tests. CERT denials for Pathology and Laboratory Services have accounted for the highest percentage of all lines in error.

Approximately 13% of the line errors were due to Evaluation & Management (E&M) codes. E&M Subsiquent (99231-99233), E&M Office Visits Established (99211-99215), E&M Office Visits New (99201-99205) and Hospital Initial (99221-99223) accounted for the highest percentage of all line errors in the E&M category. Errors included incorrect coding, insufficient documentation to support the services billed, span date errors and no response for documentation.

Error Categories

The November 2015 error feedback files indicate the following:

- Insufficient documentation errors contributed to approximately 87% of CERT errors which included errors for inadequate documentation and errors for documentation that failed to meet policy requirements, such as failure to submit a valid physician order for the services rendered. Lab errors accounted for the highest number of insufficient documentation errors.

- Incorrect coding contributed to approximately 9% of the errors. This included documentation for E&M codes that did not meet service level requirements and lab codes billed did not match physician orders. E&M accounted for the majority of incorrect coding errors.

- Medical necessity contributed to approximately 2% of the errors. Services billed were not rendered, services not covered, service provided by someone other than billing provider, response received/improper documentation, and span date error contributed to the remaining 2% of errors.

What Providers Can Do to Help Prevent CERT Errors

- Ensure medical record documentation is complete, accurate and supports reasonable and necessary service
OIG 2016 Work Plan

- Duplicate graduate medical education payments (direct and indirect)
- Bone marrow and stem cell transplant (dx and unbundling)
- IMRT correct billing and not billing as part of developing an IMRT plan (DL36743)
- Physician home visits (in lieu of an office or outpatient R&N)
- Use of prolonged services E&M codes (99354-99416)
- Chiropractic services (maintenance therapy)
- Outpatient physical therapy
- High-use (repeated) sleep testing (DL36745)
Recovery Auditor Activity

- No new JJ activity 2015, 2016 on website
- MOHS surgery with pathology billed by different provider
- Zoledronic acid more than one time/year
- Hyperbaric oxygen therapy excessive units
- Physician erroneously billing putting procedural modifier in the units field
- Power mobility devices
- Apligraf incorrect billing units
- Radiologists billing for medically unnecessary 3D studies
- Separate E&M mode on same day as a procedure
- ESAs & CSF c/w NCDs & LCDs

www.cotiviti.com
Probes and Reviews

• Based on identified vulnerabilities
  – Data analysis
  – CERT, OIG, RA

• Prepay review – the system MCS selects the claim when submitted by the provider if it meets the criteria for review
  – Provider Specific – 20-40 claims
  – Service Specific – 100 claims
  – Before the claim is processed

• Post-pay
  – Paid/processed claims are selected for review
Give Us Feedback

Your feedback is very important to Cahaba and the Centers for Medicare and Medicaid Services (CMS). While browsing our website, a small box may display inviting you to complete a satisfaction survey following your visit. The survey is anonymous and takes about 3-4 minutes to complete. It provides our staff with input to know which tools and pages you found useful and which ones may need improvement. We would encourage and appreciate your participation.
Current Prepayment Medical Review Log

The table below provides you with a list of the most current prepayment reviews being conducted by the Part B Medical Review Department. This is not an all inclusive list.

June 2016

<table>
<thead>
<tr>
<th>Review Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Service, ALS, Emergency</td>
<td>A0427</td>
</tr>
<tr>
<td>Ambulance Service, BLS, Non-Emergency</td>
<td>A0428</td>
</tr>
<tr>
<td>E &amp; M Time Studios</td>
<td>99201-99499</td>
</tr>
<tr>
<td>Emergency Department Visit; E &amp; M</td>
<td>99285</td>
</tr>
<tr>
<td>Initial Hospital Care; E&amp;M</td>
<td>99223</td>
</tr>
<tr>
<td>Office Visits; Established Patient</td>
<td>99211-99215</td>
</tr>
<tr>
<td>Subsequent Hospital Care</td>
<td>99231-99233</td>
</tr>
<tr>
<td>Subsequent Nursing Facility Care</td>
<td>99309-99310</td>
</tr>
<tr>
<td>Ultrasound Guidance for Needle Placement</td>
<td>76942</td>
</tr>
<tr>
<td>Self-Administered Injections- Phentolamine Mesylate</td>
<td>J2760</td>
</tr>
<tr>
<td>Home Visit, established patient</td>
<td>99348</td>
</tr>
<tr>
<td>Utilization of Modifier 24 with Ophthalmology E &amp; M Codes</td>
<td>99201-99215 &amp; 92002-92014</td>
</tr>
<tr>
<td>Office or other outpatient visit for the evaluation and management of an established patient: Widespread Prepay Probe</td>
<td>99214</td>
</tr>
<tr>
<td>VAPS- Percutaneous Vertebroplasty and Augmentation: Widespread Prepay Probe</td>
<td>22510-22515</td>
</tr>
<tr>
<td>Subsequent Hospital Care: Widespread Prepay Probe</td>
<td>99233</td>
</tr>
<tr>
<td>Initial Hospital Care: Widespread Prepay Probe</td>
<td>99223</td>
</tr>
</tbody>
</table>
Percutaneous Left Atrial Appendage

- February 2016, NCD 20.34
- Covers left atrial appendage closure through Coverage with Evidence Development for FDA approved device in certain clinical circumstances
- For non FDA approved device patients must be enrolled in a qualifying FDA approved randomized controlled trial
- LCD 35889 modified to be consistent with the NCD
Observation E&M

• Primary provider directing the observation care
• Initial observation care  99218-99220
• Subsequent observation care 99224-99226
• Observation care discharge  99217
• Observation or inpatient care/admit & discharge on same DOS
  99234-99236

• Consultants Office or other outpatient visits
• New patient  99201-99205
• Established patient  99211-99215
Unused Drugs or Biologicals

• MLN MM5923 Updated 2013
• MACs may require use of modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded
• Change Request 9603
• Effective January 3, 2017 these claims shall be submitted with the JW modifier.
• New MLN will be released
Signature Requirements

- CR 9225, Implementation 8/25/2015
- The contractor shall consider evidence in a signature log, attestation statement or other documentation submitted to determine the identity of the author of a medical record entry if the signature is illegible
  - MUST BE SIGNED
  - Signature log (typed names and signatures) or attestation statement (include name, DOS, credentials) MUST accompany the documentation
  - Testing may not have signature-If medical documentation by the treating practitioner is in the medical record and that record is authenticated
  - Illegible signature or initials and practitioner name printed
    - Below the signature
    - In the letterhead or addressograph
    - If multiple printed practitioners one must be circled or highlighted
Signature Requirements

• CR 9332, Implementation October 1, 2105
• Contractor shall accept confirmation of amendments or delayed entries to paper records that are initialed and dated, if the medical record contains evidence associating the provider’s initials with their name
Chronic Care Management

- CPT 99490 20 minute unit of clinical staff time directed by a health care professional per month
  - Multiple chronic conditions expected to last at least 12 months
  - Physician directed
  - Initiated with a comprehensive E&M, annual wellness or initial preventive physical exam visit
  - Comprehensive care plan established, implemented, revised or monitored
  - Obtain consent from the beneficiary
  - Must be able to document the services and time (certified EHR tech.)
  - 24/7 access to management services
  - Facility and provider may bill separately

Transitional Care Management

- To transition the beneficiary from an inpatient environment to the community
- Begins with a qualified discharge from a facility
- 30 day period begins on the day of discharge and continues for the next 29 days
- Interactive contact within 2 business days from the D/C
- Face to face visit must occur with in 7 (CPT 99496) or 14 (CPT 99495) days
- DOS the date of the face to face
- May be provided by telecommunication
- Includes many non-face-to-face services
- May report other R&N E&M services during the period

Advanced Care Planning

- 1/1/2016 Advanced Care Planning (99497, 99498)
  - Face-to-face service including the explanation and discussion of advance directives
  - When reasonable & necessary for the diagnosis or treatment of injury or illness
  - Can be billed –
    - On same day as E/M
    - During period covered by TCM, CCM, or global surgery
- May be an element of the Annual Wellness Visit
  - deductible and coinsurance will be waived
  - Must be billed with modifier 33 (preventive services)
- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf)
CMS Open Payments

- Required by the Patient Protection and Affordable Care Act
- Disclose financial relationships for doctors and hospitals
  - Explanation of the data
  - Required reporting by manufacturers and group purchasing organizations
- [www.cms.gov/openpayments](http://www.cms.gov/openpayments)
Comprehensive Care for Joint Replacement Model

- Effective January 1, 2016
- Lower extremity joint replacement
- Coordinated, patient-centered care
- All related part A and B care for 90 days after discharge
- Participant hospitals are the initiators and bear quality and episode payment accountability
- Depending on quality and cost performance can be reward or repayment
Oncology Care Model

- Chemotherapy episode of care
- 24/7 clinician with access to medical records
- ONC certified EHR
- Care plan with the 13 components in the Institute of Medicine Care Management Plan
- Medicare FFS claims followed for 6 months
- $160 per month paid to participant
- Benchmark calculated based on diagnosis
- If performance is less than the benchmark would lead to a bonus
- Quality measures play a role
Accountable Health Communities Model

- Funding to test ways to address the health-related social needs of Medicare and Medicaid beneficiaries
  - Food insecurity
  - Inadequate or unstable housing
  - Utility needs
  - Interpersonal violence
  - Transportation
- Funding not to meet these needs but to find ways to use community services to address them
- Concept is by addressing these would decrease medical utilization and cost
- Requested letter of intent (2/8/2016)
Accountable Health Communities Mode

- Fact Sheet

- AHCM Homepage
  - https://innovation.cms.gov/initiatives/ahcm/
Million Hearts Cardiovascular Disease Risk Reduction Model

- Reopened applications ended April 15, 2016
- Predictive modeling approach to generate personalized risk calculation and stratification using the ACC/AHA ASCVD 10-yr cohort risk calculator
- Evidence based risk modification using shared decision making between beneficiaries and care teams to reduce ASCVD risk scores
- Use of prevention and population health management strategies based on needs identified during risk stratification of the beneficiaries
- Randomized-controlled trial providing targeted incentives for providers (360 intervention practices, 360 control practices)
- Study practices reimbursed based on reduction in predicted cardiac risk. Controls paid $20./beneficiary for each reporting cycle
Comprehensive Primary Care Plus

• Based on Comprehensive Primary Care initiative running Oct. 2012-Dec 2016
• Regionally based multi-payer payment reform and care delivery transformation
• CMS will work with commercial insurance plans and Medicaid agencies to provide financial support necessary for practices to make fundamental changes in their care delivery.
• Key Primary Care Functions: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement and (5) planned care and population health
• Payer proposals to partner with CMS in 20 regions
• Practices apply to participate (July 15-Sept. 1, 2016)
Transforming Clinical Practice Initiative Support and Alignment Networks 2.0

• Leverage primary and specialist care transformation work and learning to catalyze the adoption of Alternative Payment Models on a large scale.

• Designed to support clinician practices through nationwide, collaborative and peer-based learning networks that facilitate practice transformation

• Goals:
  • Reducing total cost of care
  • Improving the quality of care delivered
  • Rapidly transitioning practices through the phases of transformation in preparation for participation in and alignment with Alternative Payment Models and Advanced Alternative Payment Models

• Letter of intent by July 1, 2016 to transformation@cms.hhs.gov
Other CMS Projects

- Precertification
  - Chiropractic visits (top 15%, >12 visits/episode of treatment)
- Power assist devices
- Elective ambulance transportation
- Hyperbaric oxygen therapy
Websites and General Information

- [www.cms.hhs.gov](http://www.cms.hhs.gov)
  - CERT
  - RAs
  - QIC
- [www.cahabagba.com](http://www.cahabagba.com)
Part B Expo Medical Review

• QUESTIONS?