

The Centers for Medicare & Medicaid Services (CMS) is tasked with preventing inappropriate Medicare payments and preserving the trust fund for the future. Much of the responsibility for this duty is defined in Title 18 of the Social Security Act, Medicare Contract Reform and other regulations enacted over the years. Review of appropriate billing is conducted by Medicare Administrative Contractors (MAC's) and other agencies contracted by CMS.

Determining whether payment is appropriate or not generally requires a review of medical record documentation. The impact on physician practices can be large, but failure to respond to requests for records will result in denials, the possibility of increased audit requests, a physician-specific review of previously paid claims, the possibility of an overpayment being assessed and more. The California Medical Association (CMA) urges physicians to respond to such requests within the time period noted in the letters you will receive if one or more of your claims are selected for review.

This guide does not cover all the audits that take place, but describes the audit activities currently taking place that may impact your practice.

Comprehensive Error Rate Testing (CERT)

The CERT Program is a federally-mandated program designed to monitor and improve accuracy of Medicare payments. This program created a way for the Centers for Medicare & Medicaid Services (CMS) to look at the paid claims error rate and provider compliance for all Medicare Administrative Contractors (MACs).

The paid claims error rate is the percentage of total dollars that MACs erroneously paid or denied for claims, and is a good indicator of how claim errors impact the Medicare trust fund. This rate is based on dollars processed after the MAC has made its payment decision on the claim and includes paid and denied claims.

The CERT contractor randomly selects claims processed by Palmetto, California's Medicare contractor, for CERT medical review. They request copies of medical records and perform a medical review of the claims selected. They determine the accuracy of claim payment, and if recoupment of monies is necessary. They then calculate the paid claim error rate and report this information to CMS.

A CERT request is mailed to physicians in a dark tan envelope and includes "Immediate Response Required" printed in red on the envelope and "Medicare Response Required" printed in black on the envelope. The envelope contains information about the CERT process, a list of information to submit and other necessary information for returning the documentation.

The number of claims requested from any MAC on an annual basis for review is limited. Since the volume of claims is very low, it is extremely important that physicians who receive requests from the CERT contractor respond with complete and legible records and documents in a timely manner. CMS uses the CERT contractor's findings to determine underlying reasons for errors in claim payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claim submissions and systems of claims processing.

How does compliance with the CERT Program benefit you?

- Ensures the appropriate reimbursement of your claims
- Prevents unnecessary denials and the need to request an appeal/redetermination
- Reflects a positive impression of the physician industry by having a low error rate
- May prevent additional medical review of the physician and their industry
- Helps support the solvency of the Medicare Program

MAC AUDITS

As the MAC for Jurisdiction 1 (which includes California), Palmetto GBA has a contractual obligation to ensure proper payment. Audits are determined by analysis of claims, referrals from the Office of the Inspector General (OIG), results of CERT and RAC audits and other sources. Each one generates a slightly different process.

Educational Audits

For the past two years Palmetto GBA has received payment error rates from the CERT Contractor that have been almost twice the national rate. A large portion of the errors are attributed to insufficient and illegible documentation and lack of or illegible signatures. In April, Palmetto mailed each enrolled provider a letter (see attachment A at the end of this guide) to highlight the critical importance of documentation. Palmetto is now taking additional steps to correct documentation errors by reviewing a small number of claims from selected providers to identify potential areas for provider education.

This target-specific educational process has been developed with approval from CMS in an effort to educate physicians and reduce the payment error rate. Physician can be selected for audit based on one or more criteria: 1) failure to respond to requests from the CERT contractor for medical records, 2) denials as a result of insufficient documentation to support the service provided, 3) missing or illegible documentation in the information submitted, or 4) missing or illegible signatures. Physicians may also be selected as a result of other required activity by the contractor.

Palmetto will notify affected physicians by letter (see attachment B at the end of this guide) that as part of a special study, a small sample of their claims will be selected for medical review. For this special study, Palmetto will request medical records for five claims. The request for medical documentation will come in the form of an additional documentation request (ADR) for a submitted claim with the identified code being studied. Failure to respond to these requests will result in non-payment of the claim.

The claims received will be reviewed, and if documentation issues are identified, the physician's practice will be contacted for an educational visit. If Palmetto is unable to connect with someone to schedule a visit, they may make an unannounced site visit to the office to establish a date for an educational meeting. Failure to participate in this education may result in 100 percent pre- and post-payment audit of claims. The outcome of this process is to educate physicians as to the necessary corrections to their records to help reduce the payment error rate.

Medical Review Progressive Corrective Action Process

All MACs are required as part of their contract to identify potential problem areas and implement processes that will resolve issues. Steps taken in this process include data analysis, medical review of claims and education of providers on the requirements for payment under the Medicare program.

Data analysis is the first step in the process. It includes reviewing claim submissions locally, regionally and nationally for atypical patterns/trends that may indicate a potential problem (i.e., more than two standard deviations from the norm). Data analysis may be performed based on general surveillance or referrals for specific complaints. These referrals may be initiated from provider or beneficiary sources, fraud alerts, CMS reports, other contractors and /or other government and non-governmental agencies. Once a determination is made that medical review is necessary, a probe review is performed to validate that a problem exists. There are two types of probe reviews: service specific and provider specific.

Palmetto has conducted multiple service-specific probes, including chest x-rays, allergy and E&M specific codes for selected specialties. When a particular claim contains a procedure code under review, an ADR is sent to the physician requesting records. Some of these service-specific probes may generate an unusually large number of requests for records within a short period of time. Palmetto tries to limit the number of record requests from any one provider to approximately 40 individual

claims that meet the review criteria. If your practice receives more than that, please contact CMA for assistance.

Once analysis of the records is completed, the results of the service-specific probe are published on the Palmetto website. The results will determine if additional action is necessary, such as a local coverage determination, or they may identify physicians who will be subjected to additional review based on their documentation.

A physician-specific probe review usually results in a request for medical records for 20 to 40 claim samples. The sample of claims selected will be based on the nature of the review (e.g., specific service or various services billed by the selected provider). Palmetto will notify the provider in writing at the beginning of the review and periodically until the conclusion of the review process.

Documentation Submission Tips

To ensure that your documentation supports the service provided and billed for, Palmetto has published numerous articles and tips (see Resources section). Letters mailed to physicians to let them know they were selected for review also contain resources to which physicians may refer. Here are some tips that are specific to all records.

If you receive an ADR for one or more claims that you have submitted to Medicare for payment, it is important that your documentation comply with the following instructions.

1. Provide the documents listed on the ADR and any related physician's orders.
2. Each page of the medical record should contain the name of the beneficiary and the date of service.
3. Make sure the physician's signature is legible or include an attestation of signature, or a signature log.
4. Include a copy of the ADR with your documents

Medicare requires the individual who ordered/provided services be clearly identified in the medical records. The signature for each

entry must be legible and should include the practitioner's first and last name. For clarification purposes, Palmetto recommends you include your applicable credentials (e.g., M.D., D.O. or P.A.).

The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, operative reports, orders, test findings, etc., is to demonstrate the Part B services have been accurately and fully documented, reviewed and authenticated. Furthermore, it confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to the Medicare program for payment consideration.

Most often medical records support the services billed, but missing or illegible signatures will result in denials or requests for overpayment refunds. Examples of problems noted include:

- Illegible, unrecognizable handwritten signatures or initials
- Unsigned "typewritten" progress notes with a typed name only
- Unverified or unauthorized electronic signatures
- No indication of the rendering physician/practitioner

If a signature or initial is illegible or missing, physicians may submit an attestation statement with the medical record. Should a provider choose to submit an attestation statement, Palmetto has supplied this example:

"I, _____ [print full name of the physician/practitioner], hereby attest that the medical record entry for _____ [date of service] accurately reflects signatures/notations that I made in my capacity as _____ [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability."

Another way of providing proof of signature is through the use of a signature log. Anyone who makes annotations in the medical record should have their signature and initials on file. This can be accomplished simply by typing the name of the physician/practitioner on office letterhead, having that person sign above the typewritten signature the way it appears in medical records and dating it. Signatures change over time, so an additional log may be required. Do not discard old logs. Signature logs are especially useful if medical records are requested for someone who is no longer with your practice.

If CERT or Palmetto requests documentation for E&M services, documentation submitted should include but is not limited to:

- The patient's name and date of service on every page
- Signed physician's orders, if applicable
- Test results for lab or scans, x-rays, etc., if applicable
- Medication list, if applicable
- Documentation based on counseling or coordination of care, to include:
 - Total time
 - Amount or percent of time involved in counseling or coordination of care
 - Description of the discussion
- Signed physician progress notes, if applicable, to include:
 - History
 - Physical exam
 - Decision making for the dates of services in question
- If using electronic medical records/signatures, include documentation validating the process
- Any other documentation you deem necessary to support the level of service and medical necessity of the services rendered.

For More Information

CMA's online resource library at <http://www.cmanet.org/resource-library> contains a comprehensive medical-legal document on Medicare audits. The document, #0625 "Medicare Audits" is available free to members. Nonmembers can purchase medical-legal documents for \$2 per page.

Additional Resources

Palmetto article on Acceptable Signature Requirements

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%201%20Part%20B~Articles~General~8EEM4Q2610?open&navmenu=%7C%7C>

Palmetto Progressive Corrective Action

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%201%20Part%20B~Resources~Medical%20Review~84WREC0587?open&navmenu=ResourcesIII>

The CERT Program

<https://www.cms.gov/cert/>

Medicare Internet Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

CMS MLN Matters Signature Guidelines for Medical Review Purposes

<http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf>

Dear Jurisdiction 1 Health care Professional:

The soon to be released November 2010 Medicare fee-for-service (FFS) claims error rate will unveil a paid claims error rate result nearly TWICE the national average for services rendered by Part B health care professionals in the J1 region (an approximate 22% error rate for California, Nevada and Hawaii). An error rate of this magnitude can quickly evolve into a negative perception of the quality of care provided to Medicare beneficiaries, and implies a significant level of CMS improper payments being made to health care professionals nationally, and specifically those located within the J1 region. By far, the major component to the J1 claims paid error rate is the lack of adequate documentation to support services billed.

You control the documentation describing what services your patients received, and your documentation serves as the basis for the bills sent to Medicare for the services you provided. If your documentation does not support the services on the claim, then a payment error exists.

This letter is intended to highlight this critical lack of documentation issue and to encourage ALL providers' assistance by ensuring that you are not contributing to the J1 claims paid error rate due to poor documentation.

To help lower the paid claims error rate, Palmetto GBA will be undertaking an aggressive approach designed to address the causes of documentation errors. We will increase the level and frequency of pre-payment and post-payment medical review of claims across all provider types and services. We will expand and target our provider outreach and education activities to address the specific elements that our reviews of medical records are finding as lacking in supporting documentation. We will be providing you with expanded resources and materials via our web activities to help keep you abreast of documentation requirements and highlight the errors being seen in documentation. We will provide you the tools necessary to support compliance with the Medicare program coverage and billing requirements, as well as the documentation rules you need to follow to support them.

As noted above, the primary contributor to the claim payment error rate determination in the Medicare FFS program for 2010 is insufficient or missing documentation to support services as reasonable and necessary per the Medicare program requirements.

Insufficient documentation errors occur when:

- A provider fails to respond to repeated attempts to obtain medical records
- Medical documents submitted do not contain pertinent patient facts (patient's condition, diagnosis etc.)
- Medical documentation is illegible, has no date, is improperly signed, etc.

Medically unnecessary services are categorically the result of:

- Undocumented service(s)
- Improperly documented service(s)
- Insufficiently documented service(s)

Claim payment reviews are conducted by Palmetto GBA or one of several CMS payment review contractors (RAC, ZPIC, CERT), requesting documentation from samples of claims from a provider's submission. Documentation that does not support the service or fails to comply with medical record/documentation requests results in a claim denial. When the volume of a provider's documentation (missing, insufficient or not returned) is found to be unacceptable, Palmetto GBA will take any or all of the following additional actions:

- Expanded pre-payment medical review of claims, possibly resulting in payment delays
- Referral to Zone Program Integrity Contractor (ZPIC) for expanded review if warranted
- Post-payment medical review that could lead to overpayment determinations for past claims with similar documentation based errors

All J1 health care professionals are encouraged to help in this effort by ensuring the following:

- A proactive approach to reviewing and improving documentation practices as required
- Process improvements to ensure maintenance of records are consistent with Medicare program rules
- A thorough and prompt review of documentation requests to ensure complete records are delivered at the time of submission and in the time frame requested.

Your proactive participation in ongoing Palmetto GBA provider education is also extremely important in keeping your records compliant with the Medicare program requirements. Providers should take advantage of available educational opportunities and resources to become compliant or remain in compliance accordingly.

Reducing Medicare errors and payments for claims with insufficient/missing documentation requires a team effort. We encourage you to share this information with everyone on your staff to ensure that **your** claims and their supporting documentation are properly maintained. We invite you to view the additional resources below to assist in your efforts to help lower the error rates relative to the issues stated in this letter.

Sincerely,
Palmetto GBA
A/B MAC Jurisdiction 1

Resources

- For more information on physician documentation on the CMS Web site, see 'Documentation Guidelines for Evaluation and Management Services' at www.cms.gov/MLNEdWebGuide/25_EMDOC.asp
- Palmetto GBA launches Going Beyond Diagnoses® blog: www.palmettogba.com/gbdbloglaunch
- The blog article 'Reducing the Frequency of Medicare Payments and Denials for Claims with Insufficient Documentation' at <http://bit.ly/gbdblog-documentation>. You can also read the article with your smart phone by scanning the QR code below.





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A/B MAC Jurisdiction 1
California, Nevada, Hawaii,
Guam, American Samoa,
Northern Mariana Islands

October 7, 2011

«First_Name» «Middle_Initial» «Last_Name» «Credential» Provider #: «Provider_Number»
«Provider_Address_1»
«Provider_Address_2»
«Provider_City», «Provider_State» «Provider_ZIP_5» «Provider_ZIP_4»

Dear Administrator:

As a Medicare contractor for the Centers for Medicare & Medicaid Services (CMS), Palmetto GBA is tasked with preventing inappropriate Medicare payments. This is accomplished through provider education and training and the medical review of claims.

As part of a special study on billing patterns and associated documentation for procedure code «Procedure», Palmetto GBA will be selecting a small sample of claims from your office for medical review. The primary goal of this study is to identify areas for potential educational needs. The claims selected during this study will receive medical review determinations based on the documentation submitted by your office. The review of medical records/documentation will be performed on a prepayment basis, by clinical staff. This review of your Medicare claims will enable us to identify areas where we can provide you additional coverage assistance and education.

In the near future, Palmetto GBA will request medical records for the claims that are selected as part of this sample review. You will receive a separate Additional Document Request (ADR) letter for each selected claim. Please note that ADR letters may contain multiple dates of service if the claims selected for review are billed with multiple dates of service. Please read the ADR letters carefully and be certain to include documentation for all requested dates of service.

Guidelines pertaining to proper coding and documentation of services have been communicated to the provider community through the following publications:

- CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual at www.cms.gov/manuals/iom/list.asp.
- CMS Manual System, Pub.100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6 at www.cms.gov/manuals/iom/list.asp.
- Medicare Physicians guides at www.cms.gov/mlngeninfo. Once on the website click on MLN Products Catalog.



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The medical review process includes:

- The request of medical records for a sampling of the claims you submit to Medicare (not to exceed 40 claims).
- A request for medical records is called additional development request (ADR) and will be mailed to you for each selected claim.
- Return the records to the address documented on your request.
- Documentation submitted should include but is not limited to physician orders, progress notes, relevant laboratory results, relevant scans / x-ray reports, etc. and any other documentation you deem necessary to support the level of service and medical necessity of the services rendered.
- The request letters are generated through our automated processing system and will be sent to the address on file in the Medicare Claims System (MCS). Because the system address may not be the location of your medical records, it is strongly encouraged that you notify personnel that you are expecting medical records requests.
- Submit the information that supports the requirements and medical necessity of your billed services on or before thirty (30) days from the date of the request letter. If the requested records are not received the final processing of your claims will be determined based upon the information present.
- Honoring our request for records does not violate the Health Insurance Portability and Accountability Act (HIPAA).

Prompt return of the medical documentation will minimize the impact of our review on your practice, both administratively and financially. Sampled claims in which services are denied due to a lack of documentation being received cannot be resubmitted as a new claim. We are required to recover funds for any Medicare overpayments related to these sampled services should you resubmit new claims and subsequently receive payment.

Once our examination of your claims and records is completed, you will be notified of our findings in writing. This small sample review does not exclude you from possible future reviews that may be the result of other specific reasons or issues.

If you disagree with any decisions made on the claims reviewed, you may request a redetermination (appeal). The redetermination must be requested within 120 days from the date of the initial processing, which is the date of the Medicare Remittance Advice. Forms and instructions for filing a Redetermination Request are available on the Palmetto GBA Web site at <http://www.PalmettoGBA.com/J1B>.

Please understand that honoring our request does not violate the Health Insurance Portability and Accountability Act (HIPAA).



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Northern Mariana Islands

Guidelines pertaining to proper coding and documentation of services have been communicated to the provider community in at least the following publications:

- The Physician/Supplier Guide, which can be found on our Web site at <http://www.PalmettoGBA.com/J1B>
- The Medicare National Coverage Determinations Manual 100-03, Chapter 1, Section 20.8.1.1, which can be found on the CMS web site at www.cms.gov/manuals/iom/list.asp. (Example for Transtelephonic Monitoring of Cardiac Pacemakers)
- The Medicare Claims Processing Manual 100-04, Chapter 12 – Physician /Practitioner Billing, 30.6 Evaluation and Management Service Codes, which can be found on the CMS website at <http://www.cms.gov/manuals/iom/list.asp>. (Example for E/M guidelines)
- The Medicare Medical Review Program and Guidelines for Teaching Physicians, Interns and Residents booklets can be found on the CMS website <http://www.cms.gov/mlngeninfo/>. Once on the website, click on MLN Products Catalog and select booklets under the contents section.

The answers to many questions you may have regarding the Medical Review process are readily available on our website at www.PalmettoGBA.com/J1. Information regarding documentation requirements, signature requirements, redetermination and reopening requests and proper submission of documentation for review is all available at your fingertips. With articles, webinars, forms, tools, calendar of events and much more, this site offers helpful information and links to aid in enabling your office to reach and maintain compliance with Medicare guidelines.

For inquiries regarding specific claims, coverage, billing, or educational opportunities you may also contact the Provider Contact Center (toll-free) at (866) 931-3901.

If you have specific questions regarding this letter, you may contact the J1 Medical Review Provider Message Line at (803) 763-4533.

Sincerely,

Medical Review Department