mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

Complying With Medical Record Documentation Requirements

CPT codes, descriptions and other data only are copyright 2020 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply. CPT is a registered trademark of the American Medical Association. Applicable FARS/HHSAR Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®
CERT A/B MAC Outreach & Education Task Force for Error-Free Medicare Claims

Updates

Note: No substantive content updates.

This fact sheet was developed by the Medicare Learning Network® (MLN), in conjunction with the Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces, to provide nationally-consistent education on topics of interest to health care professionals.

This fact sheet describes common CERT Program errors related to medical record documentation. It is designed to help providers understand how to provide accurate and supportive medical record documentation.

Visit the Centers for Medicare & Medicaid Services (CMS) CERT webpage to review the Introduction to CERT presentation, Improper Payments Reports, CMS fact sheets, and more helpful tips.

This fact sheet discusses:

- Third-Party Additional Documentation Requests
- Insufficient Documentation Errors
  - Vertebral Augmentation Procedures (VAPs)
  - Physical Therapy (PT) Services
  - Evaluation and Management (E/M) Services
  - DME
  - Computed Tomography (CT) Scans
- Resources

CMS implemented the CERT Program to measure improper payments in the Medicare FFS Program. Under the CERT Program, a random sample of all Medicare FFS claims are reviewed to determine if they were paid properly under Medicare coverage, coding, and billing rules. Once the CERT Program identifies a claim as part of the sample, it requests via a faxed or mailed letter the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim. If there is no response to the request for medical records, the CERT may also make a telephone call to solicit the documentation. Once the documentation is received, it is then examined by medical review professionals to see if the claim was paid or denied appropriately.

The CERT Program is managed by two contractors, the CERT Statistical Contractor (CERT SC) and the CERT Review Contractor (CERT RC). The CERT SC determines how claims will be sampled and calculates the improper payment. The CERT RC requests medical records from providers and suppliers who billed Medicare. The selected claims and associated medical records are reviewed for compliance with Medicare coverage, coding, and billing rules.

Remember: Providers should submit adequate documentation to ensure that claims are supported as billed.

Third-Party Additional Documentation Requests

Upon request for a review, it is the billing provider's responsibility to obtain supporting documentation as needed from a referring physician's office (for example, physician order, notes to support medical necessity) or from an inpatient facility (for example, progress note). The Medicare Program Integrity Manual, Chapter 3, Section 3.2.3.3, "Third-Party Additional Documentation Request" states:

The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the 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 by the MAC, CERT, Recovery Auditor and ZPIC.

Insufficient Documentation Errors

Reviewers determine that claims have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, or were medically necessary). Reviewers also place claims into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

Insufficient documentation errors identified by the CERT RC may include:

- Incomplete progress notes (for example, unsigned, undated, insufficient detail)
- 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)
- No documentation of intent to order services and procedures (for example, incomplete or missing signed order or progress note describing intent for services to be provided)

Some of the more common procedures that have resulted in insufficient documentation errors, description of errors, and links to the requirements are summarized below.

Vertebral Augmentation Procedures (VAPs)

- Missing signature and date for clinical documentation that supports patient's symptoms—hardcopy physician signature (with signature log if illegible or protocol as above if electronic)
- No evidentiary radiographs performed to support medical necessity of procedure
- Insufficient medical record documentation supporting that the provider tried conservative medical management but it failed (for example, medication administration records, therapy discharge summary) or was contraindicated
- No signed and dated attestation statement for the operative report if a physician signature was missing or illegible; if the operative report is electronically signed, the protocol should also be submitted

Physical Therapy (PT) Services

- Documentation did not support certification of the plan of care for physical therapy services. The physician's/non-physician practitioner's (NPP's) signature and date of certification of the plan of care or progress note indicating the physician/NPP reviewed and approved the plan of care is required.

Evaluation and Management (E/M) Services

- Office Visits Established, Hospital Initial, and Hospital Subsequent were identified as the top three CERT errors in E/M service categories
- High errors consisted of insufficient documentation, no documentation, and incorrect coding of E/M services to support medical necessity and accurate billing of E/M services

Durable Medical Equipment (DME)

- Certain DME Healthcare Common Procedure Coding System (HCPCS) codes (such as, hospital beds, glucose monitors, and manual wheelchairs) require a valid detailed written order prior to delivery, per MLN Matters® Article MM8304
- The physician's National Provider Identifier (NPI) must be on the valid detailed written order
- Medicare will pay claims only for DME if the ordering physician and DME supplier are actively enrolled in Medicare on the date of service
- As a condition for payment, a physician, Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Specialist (CNS) must document a face-to-face encounter examination with a beneficiary in the 6 months prior to the written order for certain items of DME

Computed Tomography (CT) Scans

- Documentation of the plan or intent to order a CT scan was insufficient to support medical necessity. If the handwritten signature is illegible, include a signature log, and if electronic, the protocol should also be submitted.

Resources

For more information about provider compliance, visit the CMS Provider Compliance webpage.

- Certification and Recertification of Need for Treatment and Therapy Plans of Care Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3
- Complying With Medicare Signature Requirements fact sheet
- Evaluation and Management Service Codes—General (Codes 99201–99499): Medicare Claims Processing Manual, Chapter 12, Section 30.6
- Functional Reporting: Medicare Benefit Policy Manual, Chapter 15, Section 220.4
- Medicare Coverage Database (MCD) for Local Coverage Determinations (LCDs)
- Order for Care of a Physician/Non-physician Practitioner (NPP): Medicare Benefit Policy Manual, Chapter 15, Section 220.1.1
- Requirements for Ordering and Following Orders for Diagnostic Tests: Medicare Benefit Policy Manual, Chapter 15, Section 80.6
- Signature Requirements: Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

CPT only copyright 2020 American Medical Association. All rights reserved.

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces are 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.

Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).