



Affiliated Contractors (ACs) refers to Medicare Administrative Contractors (MACs), Carriers, DMERCs, and FIs. More extensive information on acronyms can be found on the Centers for Medicare website at <http://www.cms.hhs.gov/apps/acronyms/>

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Thank You to First Coast Service FL and EDS

By: Mary Lou V. Crouch, MA, PI CERT CDC Problem Resolution Specialist

The CERT Problem Resolution Office (PRO) regularly sends out Potential Fraud Referral Reports to Affiliated Contractors when a provider fails to meet CMS requirements and becomes a problem provider. Recently, PRO reviewed the attempts to contact a specific provider. The phone number for the provider had been disconnected so no phone contact was made. Mailed medical record requests were returned to the CERT office. As a result, PRO sent a report to First Coast Service FL detailing the efforts. Shortly after the Potential Fraud Referral Report was sent to First Coast Service FL, an

investigator from EDS (the Benefit Integrity Group for First Coast) called a PRO staff member with the news that the provider was under investigation and had gone out of business. Very rarely do we receive any feedback on the referral reports so this was welcome news. Thank you, First Coast and EDS for letting us know about the ongoing investigation.

CERT Background

By: Dave Perez, MD CERT CRC Medical Director/Spokesperson

Formal Program Integrity (PI) activities in the form now implemented by CMS and its contractors had their genesis in the CFO Audit Act of 1990. This Act directed each governmental agency or department to audit its own expenditure of taxpayer monies, and resulted in the Department of Health and Human Services (DHHS) creation of the CFO Audit performed by the Office of Inspector General (OIG) of the Health Care Financing Administration (HCFA, now CMS). The first audit was performed for Fiscal Year (FY) 1996 with a 13.8% error rate of paid claims determination by affiliated contractors (ACs). This error rate was subsequently lowered to 6.3% by FY 2001 and FY 2002, through provider education and contractor diligence in identifying and combating aberrant utilization patterns. During three of the seven years Medicare Fee-for-Service (FFS) error rates were conducted by the OIG, documentation type of errors (no documentation and insufficient documentation) comprised the majority of category and types of errors.

Following recommendations from the OIG, CMS increased the sample size for the CERT program when production began on the Medicare FFS Improper Payment Report for November 2003. CMS calculates the Medicare FFS error rate and estimates of improper claims payments, using a methodology approved by the OIG. The methodology includes:

- Randomly selecting a sample of approximately 128,000 claims submitted in a calendar year (CY2007);
- Requesting medical records from providers who submitted the claims;
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules; and
- When providers failed to submit the requested documentation, treating the claims as errors and sending the providers overpayment letters.

To promote consistency in improper payment reporting across Federal agencies, the Improper Payments Information Act (IPIA) requires agencies to follow a number of methodological requirements when calculating error rates and improper payment estimates. The IPIA mandates that agencies use gross figures when reporting improper payment amounts and rates. A gross improper payment amount is calculated by adding underpayments to overpayments. The CERT program began calculating gross error rates in the November 2004 Report. The November 2004 Report is the last report that used an overall error rate and a gross error rate. Since the November 2005 Report, the CERT program reports gross error rates, exclusively.

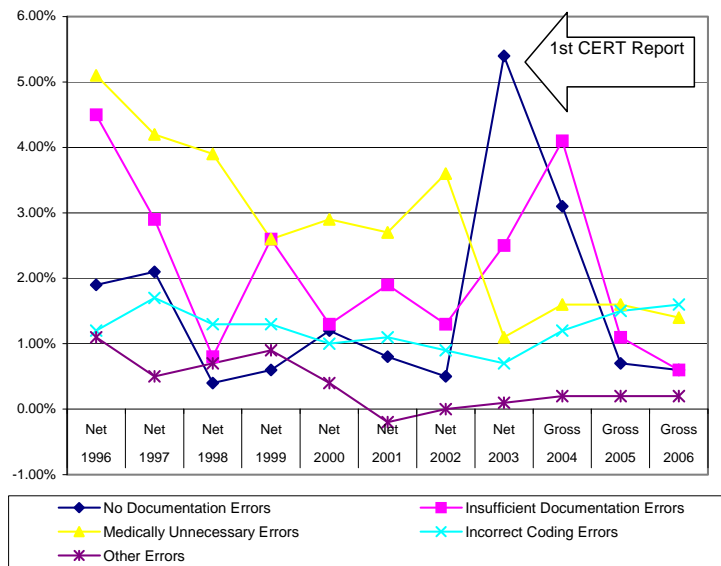
As the Medicare Program changes and traditional ACs transition out of the Medicare Program, the November 2007 Report will be the first that contains error rate estimates for ACs and Medicare Administrative Contractors (MACs). To properly allocate payment error claims, the November 2007 Report will only count for the Medicare contractor who was paid to process and either pay or deny a submitted claim.

Exhibit 1 reveals the payment error rates by major payment error categories during the OIG timeframe and recent CERT estimates. Every year the error rate is allocated to major categories of payment errors:

- No documentation payment errors
- Insufficient documentation payment errors
- Medical necessity payment errors
- Incorrect coding payment errors
- "Other" payment errors (such as never covered services)

Type of Errors for Medicare Fee-for-Service Error Rate Report – A Focus on No Documentation and Insufficient Documentation

Exhibit 1: Medicare Fee-for-Service (FFS) Type of Error by Fiscal Year



The forthcoming November 2007 Report (and all future reports) will continue to use major payment error categories. Recent error rates reveal that the portion of the payment error rate related to incorrect coding and medically unnecessary payment errors are on the rise, and the portion related to insufficient documentation and no documentation, will have markedly declined. CMS and all Medicare Contractors believe in paying claims right the first time.

Validation of Automated Denials in the CERT Medical Review Process

By: Ellen S. Cartwright, BSN, CCS, CCS-P CERT CRC Medical Review Manager

The CERT Review Contractor (CRC) has been directed through their scope of work with CMS to review all paid claims in their sample as well as any automated denials (both technical and medical) since inception in 2000. Originally, the CRC was tasked with requesting screen prints and any other supporting documentation from the affiliated contractors (ACs) on all automated denials that fell out in the monthly sample. No medical records would be requested on these denied lines of service. The CRC would then validate the applied edit based on the resolution file's ANSI code definitions applied to the claim. The contractor supplied screen prints showing the actual reason codes applied and their definition were a beneficial component to the review. This requirement lasted for approximately one year after CERT initial medical review began. By the beginning of 2002, CMS directed the CRC to stop requesting documentation from the contractors on denied claim lines in the sample based on the volume of claims containing automated edit denials. These claims were known as "T" lines or "T" claims based on CRC's former designation of claim review tasks from CMS. The letter T stood for "technical".

In the ensuing years, the CRC has validated these technically edited claim lines based on the ANSI code supplied by the resolution file on the line and/or the claim level. In general, ANSI codes were found to be broadly defined. These broad definitions led to some reviewer validation problems with determining specific or complex edit denials. Currently, CRC reviews the ANSI code, refers to the specific LCD or NCD, NCCI, or other conventions when the ANSI code is specific enough to follow that lead. The CRC also refers to CWF for other determinations based on the ANSI code's description for utilization and/or beneficiary enrollment or death information. While most edits can be validated rather quickly, there are some edit denials in which the CRC reviewer has either found no reason for the edit denial through the definition of the ANSI code or has found evidence that contradicts the ANSI code. In such cases, all claim lines that have been technically denied and in which the reviewer has a potential disagreement with the denial— these claims are referred to the Lead Medical Reviewers and Medical Review Manager for further information and clarification from the contractor.

As a result, the Medical Review Manager or Deputy Medical Review Manager will place a call to the contractor's CRC contact. A particular CID number from a claim line in question will be referenced and a request will be made for further information on the edit description and reason code behind the denial. This information is recorded in the CRC review database and serves as the basis for the agreement and/or disagreement decision.

CRC has appreciated the contractors' clarification on these validations and continues to look forward to their assistance in the future. These associations have demonstrated a continuing informative approach to claims processing as well as demonstrating the importance of automated edit applications for the future of the Medicare program.

Updating Address and Point of Contact Information on the CERT Provider Website

By: Pat Rodriguez, MBA, RHIA CERT CDC Deputy Director/Medical Record Manager

Providers updating their address and point of contact information on the CERT provider website www.certprovider.org that are associated with multiple Affiliated Contractors should update the information on the website for each AC the provider is associated with. The information will not automatically transfer if the provider is associated with more than one AC. Therefore, if the provider has one point of contact for CERT and is associated with multiple ACs, the information must be entered multiple times on the CERT provider website under the individual contractor number in order for the POC information to appear when a search is conducted for a particular AC.

Preparation Increases Efficiencies

By: Joseph A. Gorgone, BA CERT CDC Operations Supervisor

You may have noticed that the last two CERT Newsletters contained some helpful hints for providers in assisting us with legibility of images. Here are a few more suggestions when preparing the medical record prior to faxing or mailing.

- If at all possible, do not staple, paperclip, or mail documents in binders. Even though each page is reviewed before it is scanned in, the process can be dramatically improved if there is less time spent on preparation. It is not necessary to separate the pages unless they belong to more than one patient.
- Place the bar coded cover sheet on top of the medical records/documentation when mailing records in. That coversheet, which has the CID number on it, can be recreated, but if it cannot be located, then the process may be affected.
- Avoid sending copies of copies. The nurse reviewers do a great job in deciphering the images, but to make their jobs easier, please try to only send copies of the originals. That will reduce the time it takes to lighten or darken a page for legibility.
- When sending copies of records, please try to not send double-sided pages. This will increase the time it takes to image the entire record.

Thank you for your efforts. We are always striving to improve and welcome any suggestions you may have.

Update on National Provider Identifier (NPI)

By: Matt Shlosberg, MBA

CERT CDC Chief Information Officer

CDC started receiving NPI addresses for DME providers on July 10, 2007. Our concern was, would providers be using the same addresses for NPI as their legacy address? We are pleased to announce the DME addresses are generally the same as the legacy addresses.

Providers use their NPI numbers when they speak with the CERT Customer Service Representatives. At this point, we only have NPI numbers for DME suppliers; however, we look forward to enhancing the provider experience with the receipt of NPI numbers for the rest of the providers.

The purpose of the CERT Newsletter is to provide for an exchange of information among the Centers for Medicare and Medicaid Services (CMS), the CERT Review Contractor (CRC), the CERT Documentation Contractor (CDC), Medicare Administrative Contractors (MACs), Affiliated Contractors (ACs) and Providers. The Newsletter is not intended to set CMS policy or replace CMS directives. The newsletter is published quarterly by CDC. Archived copies are available on the CERT Website: <http://www.certprovider.org>

Send in questions, suggestions, and/or articles for inclusion in the newsletter to gkarge@certcdc.com
Deadline for December 2007 issue is November 16, 2007.
