FACT SHEET

CERT: PART A

Use this fact sheet to ensure you submit all documentation required for a Comprehensive Error Rate Testing (CERT) contractor review.

When to Send Documentation

You have 45 calendar days from the initial request letter date to furnish the requested documentation. If the CERT contractor doesn't receive documentation after 75 calendar days from the initial request letter date, the claim is assigned a non-response error, and CGS will recoup the payment.

Before You Send Documentation

- Check for signatures on office/progress notes and other medical records.
- For electronic health records, include a copy of your electronic signature policy and procedures that describe how notes and orders are signed and dated. This information is necessary to validate electronic signatures.
- If a signature is missing or illegible, include a completed signature attestation and/or signature log.
- Include documentation to support all CPT/HCPCS codes billed. See the "What to Send" section below.

How to Send Documentation

Place the Barcoded Cover Sheet that accompanies the CERT request letter on top (page 1). This will allow the CERT contractor to easily match the documentation to the claim under review. Use the fax number, mailing address, or other options indicated in the CERT request letter.

What to Send

The table below lists documentation to submit for review by facility type.

Facility Type	Documentation
Comprehensive Outpatient Rehabilitation Facility (CORF) or Outpatient Rehabilitation Facility (ORF)	• Initial evaluation for therapy services • Plan of care (may be part of the evaluation) • POC certification (signature or other evidence of physician/NPP involvement in patient's care) • POC recertification (every 90 days; every 60 days for CORF respiratory therapy) • Re-evaluations (when performed) • Therapy progress reports (1 per each 10 treatment days or 1 per certification interval, whichever is less) • Treatment notes (once per treatment day, including total timed code treatment minutes, total treatment time (in minutes) for the billed date of service, and documentation to support CPT/HCPCS codes billed) • Optional justification statement for therapy services that exceed the KX modifier threshold amount (if present)

CGS®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility Type	Documentation
End Stage Renal Disease (ESRD) Facility	• Diagnostic test results/reports, including imaging reports • Dialysis treatment records • Disposition/discharge notes • History & Physical • Medication Administration Records • Nursing notes • Physician/NPP progress notes • Physician orders for dates of service billed, including any standing orders and treatment/medication protocols
Hospital-based Ambulatory Surgery Center	• Diagnostic test results/reports, including imaging reports • Disposition/discharge notes • History & Physical • Intraoperative and perioperative record • Implant log • Medicare Administration Records • Nursing notes • Operative reports • Pathology reports • Physician orders or intent to order for the date of service billed • Physician progress notes • Physician office/clinic progress notes to support procedures billed and all documentation indicated in a Local Coverage Determination (LCD) or National Coverage Determination (NCD) policy (if applicable) • Pre-, intra-, and post-anesthesia record and/or sedation record • Procedure notes • Recovery room record

Facility Type	Documentation
Inpatient Hospital	Medical records for the entire inpatient hospital stay (not just the specified From and To dates of service on the claim), which may include: • Consultation reports • Disposition/discharge notes & discharge summary • Emergency room records (if applicable) • Evaluation & Management/counseling notes • History & Physical • Medication Administration Records • Nursing notes • Operative reports • Pathology reports • Physician office/clinic progress notes to support procedures billed and all documentation indicated in a Local Coverage Determination (LCD) or National Coverage Determination (NCD) policy (if applicable) • Physician orders or intent to order • Physician/NPP progress notes • Pre-, intra-, and post-anesthesia records and/or sedation record • Procedure notes • Recovery room record • Signed order for inpatient admission • Skin care records
Inpatient Psychiatric Facility (IPF)	• Certification/recertification • Discharge plan • Initial psychiatric evaluation • Individual and group psychotherapy, patient education & training progress notes • Medication Administration Records • Nursing/team member notes • Physician orders • Plan of treatment • Physician progress notes

Facility Type	Documentation
Inpatient Rehabilitation Facility (IRF)	• Medical records for the entire inpatient hospital stay (not just the specified From and To dates of service on the claim) • Admission order • Documentation to support that the supervising physician is licensed with specialized training and experience in inpatient rehabilitation • Individualized overall plan of care • IRF Patient Assessment Instrument • Interdisciplinary team meeting notes • Preadmission screening • Post-admission physician evaluation • Rehabilitation physician/NPP notes • Therapy evaluations, plans of care, and progress/ treatment notes
Outpatient Hospital	• Diagnostic/laboratory test reports/results, including imaging reports (if applicable) • Physician/NPP signed orders or intent to order the billed services • Physician/NPP signed office/clinic progress notes to support medical necessity of the CPT/HCPCS codes billed
Skilled Nursing Facility (SNF)	• Any SNF Advance Beneficiary Notice of Noncoverage (ABN) issued to the beneficiary (for each date of service/ specific service) • Physician certification/recertification • Physician certified plan of care • Documentation to support a 3-day qualifying inpatient hospital stay, such as a hospital discharge summary • Documentation to support medical necessity of services provided and the Patient-Driven Payment Model (PDPM) classification for the billing period under review • Medication Administration Records • Nursing notes • Physician/NPP orders • Physician/NPP progress notes • Therapy evaluations, plans of care, and progress reports/ treatment notes • Documentation/notes related to the assessment reference date(s) and PDPM classification (may extend to days prior to the billing period under review)