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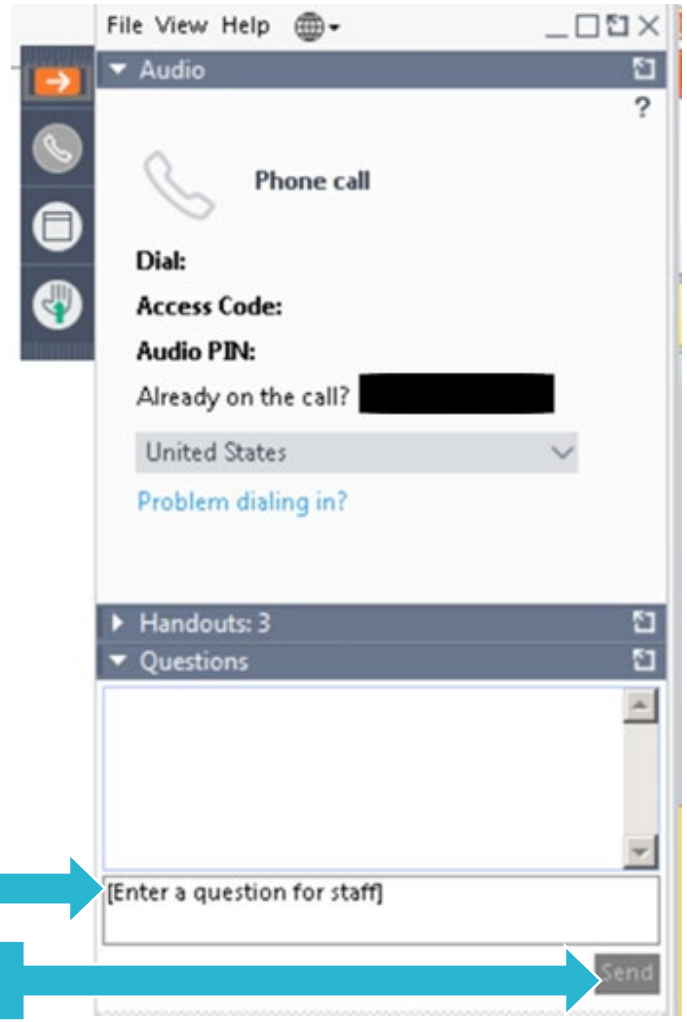
Question Box

To ask a question in the question box . . .



Type it here.

Hit send.

Comprehensive Error Rate Testing (CERT) 2022 November Report

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CGS J15
Provider Outreach and Education
December 15, 2022| HHH/Part A and B

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Today's Session

- Sampling Process
- 2022 Comprehensive Error Rate Testing (CERT) Results
- Nationally Identified Top Drivers for 2022 Improper Payments
- Common CGS J15 Errors
- CMS Key Actions to Address Top Drivers
- Resources
- Questions

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Medicare Fee-for Service (FFS) Statistical Sampling Process

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Sampling Process

HHS reviews a stratified random sample of Medicare FFS claims to determine if HHS properly paid claims under Medicare's policies on coverage, coding, and billing.

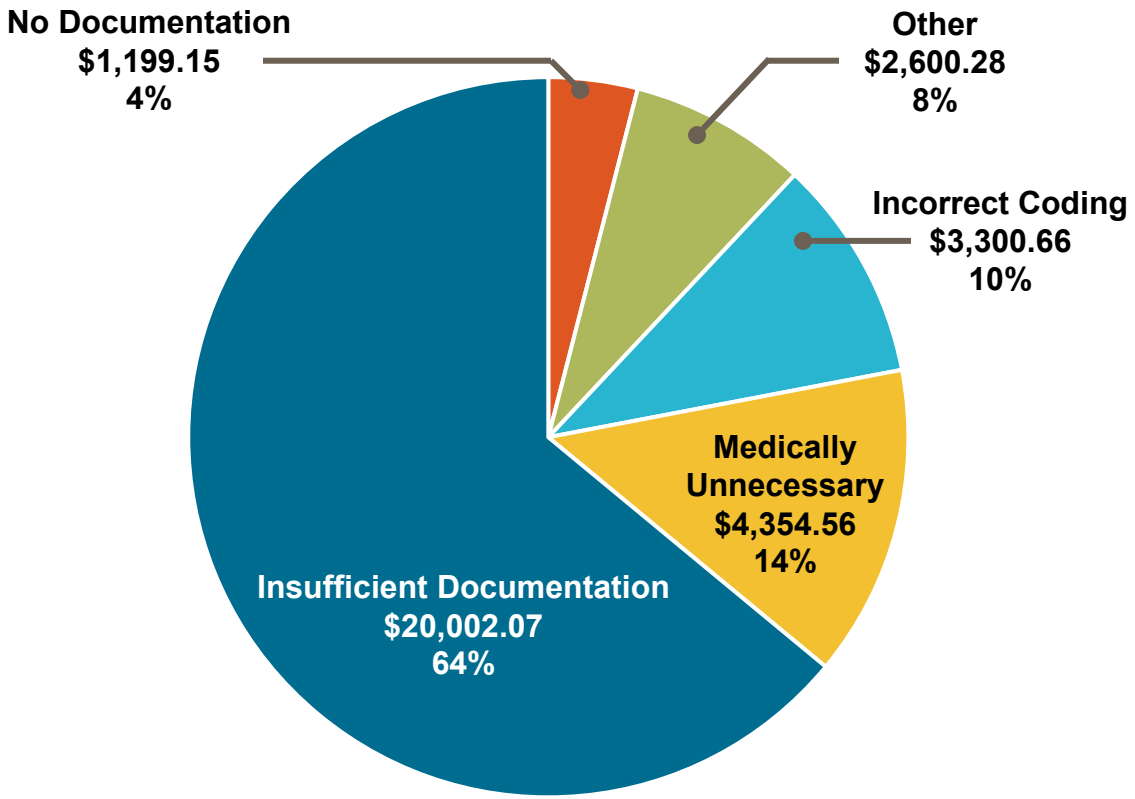
The sampling process ensures statistically valid random sampling across four claim types:

- Part A claims excluding hospital Inpatient Prospective Payment System
  - (including but not limited to home health, Inpatient Rehabilitation Facility [IRF], SNF, and hospice);
- Part A hospital Inpatient Prospective Payment System claims;
- Part B claims
  - (e.g., physician, laboratory, and ambulance services); and
- DMEPOS.

Calculations & Findings

Medicare FFS properly paid an estimated 92.54 percent of total outlays or $390.46 billion. The improper payment estimate is 7.46 percent of total outlays or $31.46 billion. The improper payment estimate due to missing or insufficient documentation is 5.03 percent or $21.20 billion, representing 67.40 percent of total improper payments.

RY 2022 Medicare FFS Estimated Payment Error Types1 (Dollar Amounts in Millions)



[1] Figure may not equal 100 percent or add up precisely to other tables in this document due to rounding

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Improper Payments

SNF, hospital outpatient, hospice, and home health claims were major contributing factors to the Medicare FFS estimate, comprising 47.34 percent of the overall estimate.

- While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be
  - insufficient documentation and
  - medically unnecessary errors

Identifying The Four Driver Service Areas

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Skilled Nursing Facility (SNF)

1. SNF:
   - Insufficient documentation continues to be the major error reason for SNF claims. The improper payment estimate for SNF claims **increased from 7.79 percent in RY 2021 to 15.10 percent in RY 2022.**
   - The primary reasons for these errors are missing documentation to support the level of care requirements and missing documentation to support the required components for the billed code.

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Hospital Outpatient

2. Hospital Outpatient:
   - Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment estimate for hospital outpatient claims **increased from 4.57 percent in RY 2021 to 5.43 percent in RY 2022; however, this change is not statistically significant.**
     - *Although increases and decreases are identified, some are not statistically significant. An increase or decrease estimated from a statistical sample is said to be "not statistically significant" if the estimate's margin of error is too wide to conclude that the improper payment rate is different from the previous year.*
   - The primary reason for these errors is missing documentation to support the order, or the intent to order for certain services

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Hospice

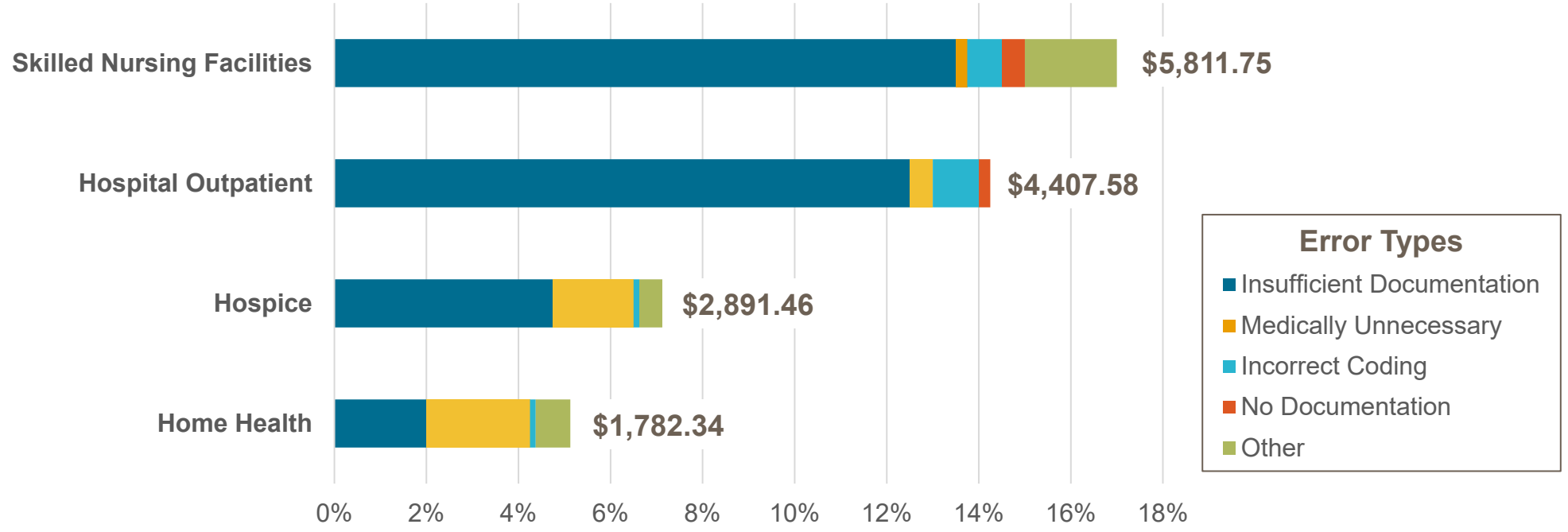
3. Hospice:
   - Both insufficient documentation and medically unnecessary were the major error reasons for hospice claims. The improper payment estimate for hospice claims **increased from 7.77 percent in RY 2021 to 12.04 percent in RY 2022.**
   - The primary reasons for these errors are missing or insufficient documentation to support the certification or recertification and the hospice coverage criteria for medical necessity was not met

Home Health

4. Home Health:
   - Medically unnecessary was the major error reason for home health claims. The improper payment estimate for home health claims **decreased from 10.24 percent in FY 2021 to 10.15 percent in FY 2022; however, this change is not statistically significant.**
     - *Although increases and decreases are identified, some are not statistically significant. An increase or decrease estimated from a statistical sample is said to be "not statistically significant" if the estimate's margin of error is too wide to conclude that the improper payment rate is different from the previous year.*
   - The primary reason for these errors is that the home health coverage criteria for medical necessity was not met.

RY 2022 Medicare FFS Drivers for SNF, Hospital Outpatient, Hospice, and Home Health Claims By Error Type

RY 2022 Medicare FFS Service Areas with the Largest Estimated Improper Payment Dollar Amounts:
Percentage Share of Medicare FFS Improper Payments by Error Type (Dollar Amounts in Millions)



https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf

Common CGS J15 Errors

Home Health

- Incorrectly Coded
  - was HIPPS code 4HC11 (MMTA-Cardiac-High, Late, Institutional). However, when the OASIS data is entered to HH Grouper Reviewer it generates a HIPPS of 3HC11 (MMTA-Cardiac-High, Late, Community). The provider submitted the claim with an occurrence code (OC) 61 which is the "Through" date of an acute care hospitalization within 14 days prior to the "From" date of any home health claim. The OC 61 dated submitted is 02/19/2021, however there is no documentation of an acute care inpatient hospitalization ending on 02/19/2021
- Billing Requirement Error
  - Visit for billed DOS was the OASIS recertification performed for administrative purposes with no evidence of a skilled service provided and is considered non-chargeable.
- Signature Missing
- Physician Certification/Recertification inadequate
  - MISSING: 1) Authenticated certification/POC for home health period of care 2) OASIS SOC assessment that supports the billed HIPPS code; 3) PT order #7625813 that that was signed and dated by the physician.

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Hospice

- Incorrectly Coded
  - Billed were 5 UOS for RN visit (G0299 - Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes) for date of service 05/17/2021 that qualified for SIA payment. Submitted documentation supports the RN visit for date of service 05/17/2021 was from 0800 to 0930 or 90 minutes. Change UOS from 5 to 6.
- Physician certification was signed and dated after the claim was submitted
- MISSING: Documentation to support that the Hospice Election Statement Addendum, “Patient Notification of Hospice Non-Covered Items, Services, and Drugs” was provided to the beneficiary and /or representative as requested

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Part A

- CORF: Therapeutic Exercise
  - Missing Plan of Care established and authenticated by the physician prior to start of care
- TAVR:
  - Missing pre-op evaluation by independent cardio surgeon
- IRF
  - IDT Meeting notes/records inadequate
  - Missing preadmit screening
- SNF
  - Inadequate Physician's Certification/Recertification
  - Missing orders for mechanically altered diet
- Hospital Inpatient
  - Missing Orders

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Part B

- CPT 93010 (Electrocardiogram Report)
  - Missing Order
  - Missing results
  - Inadequate documentation to support Medical Necessity
- CPT 99223 (Initial Hospital Care)
  - Incorrectly Coded (99222 and 99232)
  - No Response
  - Missing documentation for billed Date of Service
- CPT 98941 (Chiro manipulation 3-4 regions0
  - Incorrectly Coded (98941/AT to 98940/AT)
  - Inadequate/Missing Treatment Plan
- CPT 99291 (Critical care first hour)
  - Incorrectly coded (99291-99285 and 99291-99233)
  - Error Code 16 (The medical record documentation was not received.)
- CPT G0439 (Annual Wellness Visit)
  - MISSING: 1) Review/update to health risk assessment; 2) Update to family history; 3) Detection of any cognitive impairment

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CMS Key Actions to Address Payment Integrity Risks

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Automation

Automated Edits:

- Due to the high volume of Medicare claims processed by HHS daily and the significant cost associated with conducting medical reviews of an individual claim, HHS relies on automated edits to identify inappropriate claims.
- HHS designed its systems to detect anomalies and prevent payment for many erroneous claims through these efforts. HHS also uses the National Correct Coding Initiative to prevent improper payments of Medicare Part B claims and Medicaid claims.
- HHS will report FY 2022 savings from these edits in the forthcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

Internal Process or Policy Change

Hospital Outpatient Prior Authorization:

- HHS continued the nationwide prior authorization of Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, Vein Ablation, Implanted Spinal Neurostimulators, and Cervical Fusion with Disc Removal.
- HHS provisionally affirmed (approved) 104,144 services through this process. On July 26, 2022, HHS proposed the addition of Facet Joint Interventions to the nationwide prior authorization process for hospital outpatient department services in the Calendar Year 2023 Outpatient Prospective Payment System/Ambulatory Surgical Center Proposed Rule

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Ambulance Transport Prior Authorization

- HHS successfully expanded the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model nationwide to all remaining U.S. states and territories, as the model has met all expansion criteria under Section 1834(l)(16) of the Act (as added by Section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 [Public Law 114-10]).
- HHS provisionally affirmed (approved) 19,662 ambulance prior authorization requests through this process.
  - *A single prior authorization decision may affirm up to 40 round trips for up to a 60-day period. Beneficiaries with a chronic medical condition are eligible to receive an extended affirmation period. For these beneficiaries, a single prior authorization decision may affirm up to 120 round trips for up to a 180-day period*

Medical Review Strategies

- HHS and its contractors develop medical review strategies using improper payment data to target the areas of highest risk and exposure.
- HHS requires its Medicare review contractors to identify and prevent improper payments due to documentation errors in certain error-prone claim types, such as SNF, hospital outpatient claims, IRF, hospice, and home health

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Medical Review Accuracy Award Fee Metric

- HHS includes the Medical Review Accuracy Award Fee Metric in the Award Fee Plan for Medicare Administrative Contractors (MACs) that process Part A, Part B, and DME claims.
  - This metric measures the accuracy of the MAC's complex medical review decisions.
    - The metric project assists with consistent medical review decisions across MACs, leading to uniform education to providers on all improper payments, including medical necessity and the impact of insufficient documentation errors.
- Additional project goals include identifying unclear and/or burdensome policy requirements that can be clarified or simplified to prevent unnecessary denials.

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Provider Billing Review Evaluation

HHS issued 10 Comparative Billing Reports for 8 unique topics that included:

- Critical Care
- Orthoses (Referring Providers)
- Chiropractic Manipulative Treatment of the Spine
- Podiatry
- Nail Debridement
- Evaluation and Management Services;
  - Lipid Panel Testing with a Focus on Direct Measurement
  - Ambulance Ground Transport
  - Allergy
  - Immunotherapy Services; and Cataract Surgery.

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Audits: Targeted Probe & Educate

- MACs continued the Target Probe and Educate process and continued to offer extensions as needed due to the continued impacts of COVID-19.28
  - This process consists of up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the end of each round.
- HHS uses medical review in the hospital outpatient, IRF, SNF, home health, hospice, and DMEPOS service areas.
- MACs reviewed approximately 3,280 hospital outpatient providers, 1,909 home health agency providers, 1,150 hospice providers, 205 IRF providers, and 5,333 DME suppliers.

Audits: Supplemental Medical Review Contractor (SMRC) Reviews

- SMRC conducted Medicare FFS reviews on a post-payment basis for hospital outpatient, IRF, SNF, hospice, and DMEPOS claims.
  - SMRC shares medical review results with the MACs for claim adjustments upon review completion.
  - The providers receive detailed SMRC review result letters and MAC demand letters for overpayment recovery, which include educational information regarding what was incorrect in the original billing of the claim.
- SMRC performed medical reviews on a post-payment basis for 26,777 hospital outpatient claims; 4,236 SNF claims; 31,744 hospice claims; 59,369 DME claims, and other areas.

Audits: Recovery Audit Contractor (RAC) Reviews

- Medicare FFS RACs identified and collected improper payments related to IRF, SNF, professional services, home health, and DMEPOS claims.
- The largest share of Medicare FFS RAC collections (37.4 percent) were from hospital outpatient overpayments and an additional 5.8 percent were from SNF overpayments

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Predictive Analytics; Fraud Prevention System Models

The Fraud Prevention System analyzes Medicare FFS claims using sophisticated algorithms to target investigative resources;

- generate alerts for suspect claims or providers and suppliers;
- facilitate and support investigations of the most egregious, suspect, or aberrant activity.
- The Fraud Prevention System generated alerts that resulted in 960 new leads for program integrity contractors and augmented information for 759 existing leads or investigations. Contractors reported initiating attributable actions against 786 providers.

Resources

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CERT C3HUB Website

C3HUB: https://c3hub.certrc.cms.gov/

This website contains information on:

- About CERT
- Submitting Records to CERT
- Letter and Contact Information
- Completion Status Chart
- Claim Status Search
- Attestation Letters
- Sample Request Letters
- Documentation Request Listings
- Psychotherapy Notes
- FAQs
- CMS Links
- Contacting CERT Contractors

CGS J15 CERT Contact Information:

Need assistance with your CERT questions or individual training don't hesitate to contact our J15 CERT Coordinator:

Julene Lienard
CERT Coordinator
CGS Administrators, LLC
1.615.782.4591 (voice)
1.615.664.5961 (fax)
julene.lienard@cgsadmin.com

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Resources

- Department of Health & Human Services Agency Financial Report Fiscal Year 2022 (page 229)
  https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf
- CMS Comprehensive Error Rate Testing (CERT)
  https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT
- CGS J15 CERT:
  - Part A CERT Program: https://www.cgsmedicare.com/parta/cert/index.html
  - Part B CERT Program: https://www.cgsmedicare.com/partb/cert/index.html
  - HHH CERT Program: https://www.cgsmedicare.com/hhh/cert/index.html
- The CERT A/B MAC Outreach & Education Task Force
  https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-A-B-MAC-Outreach-Education-Task-Force

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GET EVEN MORE RESOURCES:

- CMS MLN Web page: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo. This includes the MN Connects, MLN articles, and more.
- Electronic Mailing List page at: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists
- CMS e-mail updates at: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

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CGS values your feedback!

- It is important for you to complete the online evaluation.
- The survey link is located in the **CHAT Box**.
- Or you can us this QR Code to complete the survey.
- Just scan with your smart phone!

Survey link: https://cmsmacfedramp.gov1.qualtrics.com/jfe/form/SV_6RVgNiFPZ90ir65?EventType=Webinar&Title=Final%20CERT%20Results%202022&Topic=CERT&Date=12%2F15%2F2022&Presenter=Vanessa%20Williams&Location=&Channel=&LOB=A%2CB%2CHHH&Jurisdiction=J15

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Thank You For Joining Today's Discussion!

Questions?

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Pre-Submitted Questions

Pre-Submitted Questions

Question: What is the best way to bill Medicare?

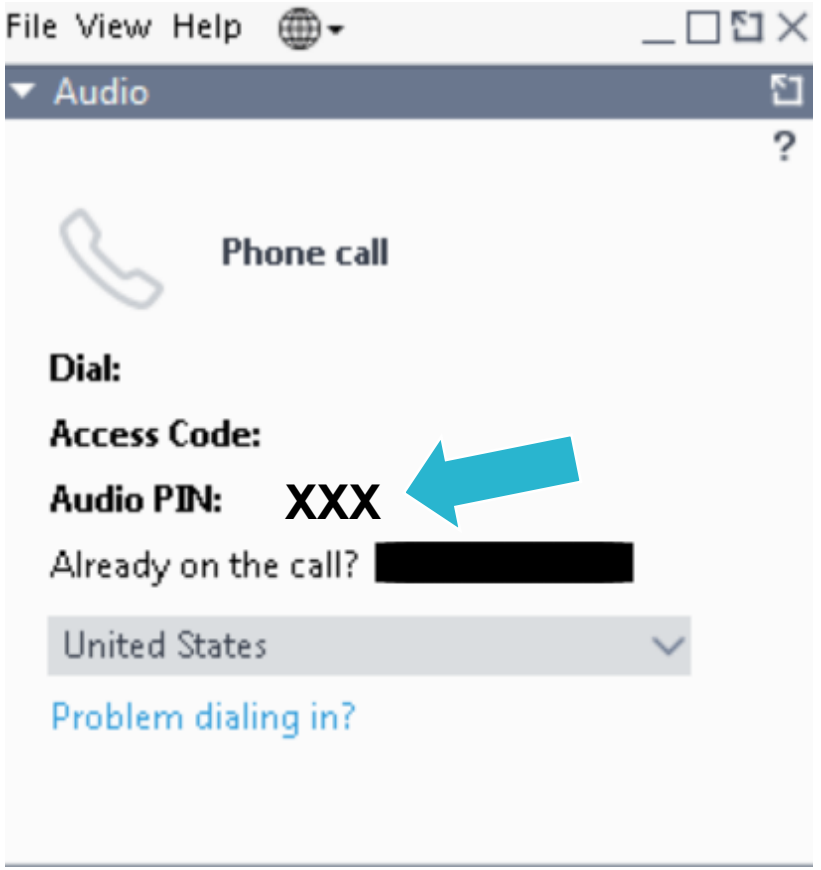
- *"I'm new to Medicare and would like to know the ends and outs of portal usage"*

Answer: myCGS is a web-based application developed specifically to serve the needs of health care providers and their staff in Jurisdiction 15

- Access to myCGS is available 24/7 and is free of charge to all CGS providers
- myCGS offers a variety of functions, such as, access to beneficiary eligibility, claim and payment information, forms allowing you to submit redetermination requests, and respond to Medical Review Additional Documentation Requests (ADR), and much more
- Refer to the myCGS User Manual (http://www.cgsmedicare.com/mycgs/mycgs_user_manual.html) Web page for more details

How to Participate Today

- To ask your question by phone you will have had to or will have to key in your **Audio PIN**
- Located in the Audio section of your tool bar
- The Audio PIN will have 2 to 4 digits to key then press your # key



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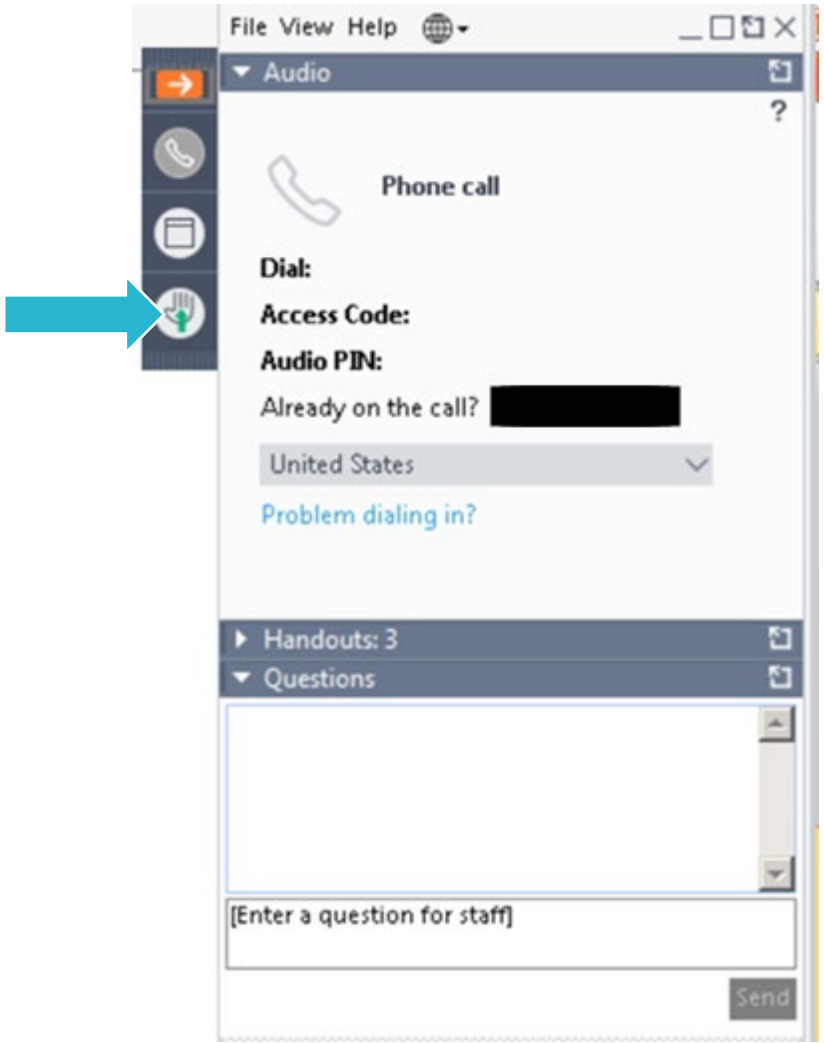
- The **Green Arrow** means your hand is not raised (Click to raise your hand)
- The **Red Arrow** means your hand is raised (Click to lower your hand)



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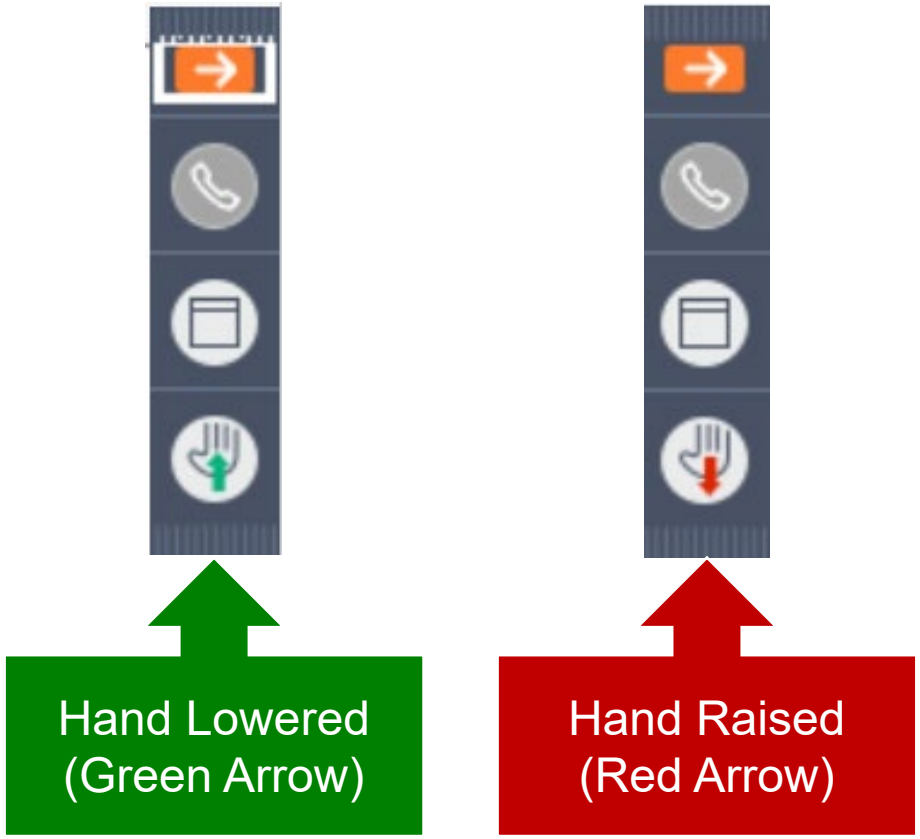

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