Who We Are

CGS JURISDICTION 15

CGS provides a variety of services for Medicare beneficiaries, health care providers, and medical equipment suppliers in 33 states support the needs of over 16 million Medicare beneficiaries nationwide. CGS Jurisdiction 15 operates as a Part A, Part B, Home Health & Hospice (HH&H) Medicare Administrative Contractor for the Centers for Medicare & Medicaid Services (CMS).

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Home Health & Hospice

CGS handles the home health and hospice workload for the Jurisdiction 15 Medicare Administrative Contractor (MAC). This jurisdiction covers a vast geographic area, with our primary states of Colorado, Delaware, the District of Columbia, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, South Dakota, Pennsylvania, Utah, Virginia, West Virginia, and Wyoming. However, we also serve home health and hospice agencies in other states.

Home Health Issue

Face-to-face encounter (FTF) documentation does not support clinical findings to support services/ homebound status

Several errors were identified where the FTF documentation for the encounter lacked a narrative of clinical findings to support the services provided, and/or the homebound status of the patient. As a reminder, for dates of service prior to January 1, 2015, a physician narrative must include the clinical findings that support the reason why the patient needs home health care. In addition, the narrative the must also indicate the clinical findings to support the reason the patient is homebound. The most recent CERT errors for home health indicate that the homebound narrative is the most common error.

Hospice Issue

Documentation does not support the patient's terminal status.

The most common CERT error for hospice was documentation not supporting the terminal status of the patient. As a reminder, the documentation describing the patient's condition must warrant a hospice admission, as well as continued hospice care. The documentation should be quantifiable to assist the review in the patient's continued appropriateness for the hospice benefit. CGS has two quick resource tools available to assist hospices in assessing their patient's continued appropriateness for hospice, as well as a tool to assist you staff in improving their documentation to support that patient's need for hospice care. These tools are listed below for your reference:

Appropriate Clinical Factors to Consider During Recertification of Medicare Hospice Patients
http://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_clinical_factors_recert_tool_h-020-01_07-2011.pdf

Suggestions for Improved Documentation to Support Medicare Hospice Services
http://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_documentation_tool_h-021-01_07-2011.pdf

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Part A

CGS is the MAC Contractor for Part A Medicare claims processing, medical review, appeals/redeterminations, provider enrollment, provider reimbursement, customer support, and provider education activities in the states of Kentucky and Ohio. Medicare claims are processed and paid according to the Congressional Laws and the Centers for Medicare and Medicaid Services (CMS) rules and regulations.

We do not determine who is eligible for Medicare. Medicare.gov can assist with eligibility: http://www.medicare.gov/eligibilitypremiumcalc

Furnishing Documentation to Support Medicare Services

For any item to be covered by Medicare, the patient's medical record must contain sufficient information about the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information, as applicable, such as duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature, and results, past experience with related items, etc. For selected claims, the MAC Contractor may request this information from you in order to verify that Medicare coverage criteria have been met.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits disclosure of protected health information without beneficiary authorization when necessary to carry out treatment, payment, or health care operations. The CERT and MAC Contractors perform health care operations as agents of the Centers for Medicare and Medicaid Services (CMS). Providing the requested documentation is in keeping with the HIPAA Privacy Rule.

Finally, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act mandates that:

> [i]n case of an item or service . . . ordered by a physician or a practitioner . . . but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Documentation Tips for Part A Review

- The medical record should be complete and legible
- For Skilled Nursing Facility Claims, Records should include:
  - Certification/Recertification
  - Physician Orders
  - Therapy documentation to include evaluation, minutes, and re-evaluations
  - Pertinent documentation to support medical necessity of RUG code billed.
  - MDS should be located in the National Repository for medical review
  - Hospital Discharge/Transfer Summary
- For Inpatient Claims, Records should include:
  - Hospital History and Physical
  - Physician's Orders for the admission and all services billed
  - Plan of Care
  - Diagnostic Test results/reports including imaging reports
  - Itemized list of all charges
  - Clinical/Therapy notes
  - Hospital admission assessment
  - Consultation reports
  - Physician Progress Notes
  - Hospital Discharge Summary
- For Cardiac/Pulmonary Rehabilitation Claims:
  - Physician's Orders for all services billed
  - UB-04
  - Any Documentation that supports medical necessity for continuous ECG monitoring
  - Documentation that the physician was immediately available for each ECG monitored session billed
  - Nursing Notes
  - Progress Notes
  - Lab/X-Ray reports
  - Radiology test results
  - Therapy notes
  - Any other diagnostic reports
  - Itemized supply or medication lists for all items billed for these dates of service.
  - All documentation as required in the LCD or NCD
- Bill the DRG/RUG codes that most accurately reflect the services rendered and documented.
- All entries to the medical record should be dated and authenticated by the provider's signature.

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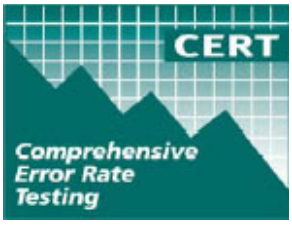
Part B

The Part B Office is located in Nashville Tennessee and handles the Part B workload for the Jurisdiction 15 Medicare Administrative Contractor (MAC). This jurisdiction covers Kentucky and Ohio and is responsible for claims processing, medical review, appeals, provider enrollment and provider reimbursement, as well as provider education activities.



Documentation Tips for Part B Review

The medical record should be complete and legible.

- Each patient encounter should include:
    1. The date
    2. The reason for the encounter
    3. Appropriate history
    4. Review of lab, x-ray data, and other ancillary services
    5. Assessment and a plan of care, physical exam including discharge plan (if appropriate)

The CPT/ICD-9-CM codes reported on the CMS-1500 form should reflect the documentation in the medical record.

Medicare's Medical Review (MR)

Through data analysis and evaluation of other information (i.e., complaints) suspected billing problems are identified. To ensure activities are targeted at identified problem areas and that the corrective actions are appropriate for the severity of the problem, MR uses Progressive Corrective Action (PCA). Prior to assigning significant resources to examine claims identified as potential problems, MR validates claim errors through the use of probe reviews.

The purpose of the MR process is to make sure claims are paid correctly. You can help meet this goal by:

- Review and read all publications and Local Coverage
- Determinations (LCDs), so you are aware of coverage requirements
- Familiarize office staff and billing vendors of filing rules
- Check your records against billed claims
- Perform self audits

MR may request documentation to support the services under review. Please keep in mind the following points:

- You must supply documentation
- Documentation should support medical necessity
- Documentation must be legible and signed
- Services must be coded correctly

You have the right to be educated on how to bill correctly and to have questions answered in a timely manner. You have the right to appeal as long as the appeal is filed in accordance with appeal regulations.

What is the CERT Program?

The Centers for Medicare & Medicaid Services (CMS) implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare fee-for-service (FFS) program. CERT is designed to comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA); Public Law 111-204). The Department of Health and Human Services (HHS) Office of Inspector General (OIG) estimated the Medicare FFS error rate from 1996 through 2002. The OIG designed its sampling method to estimate a national Medicare FFS paid claims error rate. Due to the sample size – approximately 6,000 claims – the OIG was unable to produce error rates by contractor type, specific contractor, service type, or provider type. Following recommendations from the OIG, the sample size was increased for the CERT program when CMS began producing the Medicare FFS error rate for the November 2003 Report.This methodology includes:CERT randomly selecting a sample of approximately 50,000 claims submitted to Carriers, FIs, and MACs during each reporting period. Requesting medical records from the health care providers that submitted the claims in the sample. Where medical records were submitted by the provider, reviewing the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules, and, if not, assigning errors to the claims. Where medical records were not submitted by the provider, classifying the case as a no documentation claim and counting it as an error. Sending providers overpayment letters/notices or making adjustments for claims that were overpaid or underpaid.The CERT program cannot be considered a measure of fraud. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent. All public reports produced by the CERT program are available through the "CERT Reports" link on the section navigation tray to the left.

Be assured that forwarding specifically requested records to the designatred contractor does NOT violate privacy provisions under the HIPAA law. The Centers for Medicare & Medicaid Services (CMS) has contracted with the various entities to conduct the activities of the review process. As Medicare contractors and in accordance with Section 1816 and 1842 of the Social Security Act, these contractors are authorized to request claims and medical records from providers and suppliers of Medicare services. Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated contractor.

Orders

Concerns have emerged involving the requirements for physician signatures on orders for diagnostic tests. The following information is intended to clarify the requirements for providers.

IOM Pub 100-2, Ch 15, sect 80.6 et sub concerning physician's signatures reads (in part) as follows:

An order may be delivered via the following forms of communication:

> A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; NOTE: No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services.
>
> If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records. While a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.

Keep in mind that while the lab request itself does not require a signature, there must be a signature in at least one of two places – either on the office note in which the intent to order the specific test was clearly documented, or on the requisition or lab order slip.

Remember, providers have the same appeal rights for CERT initiated denials as they do for denials initiated through CGS. All of the same Medicare guidelines apply, including those regarding the 120-day time frame allowed for an appeal (redetermination). The Redetermination (Appeal) Request Form can be found at: http://www.cgsmedicare.com/pdf/partb_redeterminationform.pdf

Signatures

Simple Steps to Remember:

- ALWAYS sign your notes/orders – submitted records with just a typed signature/signature line with no handwritten or electronic signature are not acceptable.
- You may print your name along with your written signature for clarification.
- Initials must also have a printed name for clarification - when a note is from an inpatient setting, a full signature is preferred along with a printed name.
- Notes that have been transcribed should always be reviewed and signed – either electronically or with a hand-written signature - by the author of the note.
- Signatures should be legible.
- Late signatures are not acceptable you must complete an attestation.

Acceptable forms of signature:

- Legible handwritten signatures or initials (Note: Handwritten signatures must be legible and the reviewer must be able to determine whose signature is used.)
- Electronic signatures: Electronic signatures should preferably contain date and timestamps and include printed statements, e.g., "electronically signed by," or "verified/reviewed by," followed by the practitioner's name and preferably a professional designation. Note: The responsibility and authorship related to the signature should be clearly defined in the record.
- Digitized signature: An electronic image is an individual's handwritten signature reproduced in its identical form using a pen tablet. (Note: This is an "actual" real time signature done electronically, like the digital sign-out with a credit card transaction.)

A sample attestation statement can be found in the Medical Review "General" Section.

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Helpful Resources

CGS Home:
http://www.cgsmedicare.com

Home Health & Hospice Home:
http://www.cgsmedicare.com/hhh/index.html

DME MAC Jurisdiction C:
http://www.cgsmedicare.com/jc/index.html

KY & OH Part B Home:
https://www.cgsmedicare.com/partb/index.html

KY & OH Part A Home:
http://www.cgsmedicare.com/parta/index.html

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