What You Need to Know About Comprehensive Error Rate Testing

BY SUE VICCHRILLI, COT, OCS,
ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT

Thirty-six billion dollars. That is the amount that CMS spent in improper payments for fiscal year 2013, according to Comprehensive Error Rate Testing (CERT) audits. This is up from $29.6 billion in 2012.

This month, *EyeNet* provides an overview of the CERT audit program.

What Does CERT Do?

The CERT program monitors payment decisions made by Medicare Administrative Contractors (MACs). CMS uses CERT data to calculate improper payment rates and to gain insights into the causes of errors. Each year, CMS publishes a review of its findings.

The CERT audit process. Twice a month, the CERT program selects a random sample of claims processed by MACs. If any of your claims are selected, a CERT documentation contractor will ask you for the documentation that supports those claims. This is then forwarded to the CERT review contractors, who decide whether the claim was paid properly. In short, CERT contractors audit Medicare Part B by auditing you.

If a CERT reviewer determines that a MAC's payment decision was incorrect, the claim may be subject to payment adjustments, postpayment denials, or other actions.

You have 75 days to respond to the request for documentation. If you miss that deadline, the CERT reviewer flags your claim(s) as having a "no documentation" error, and your Medicare contractor may initiate claims adjustment. If the documentation is submitted late (past the required 75 days), CERT will still review the claim for data-gathering purposes.

Types of Improper Payment

Improper payment categories, as defined by CERT, are listed below.

- **Payment to an ineligible recipient:** e.g., a physician who is prohibited from billing Medicare Part B claims.
- **Payment for an ineligible service:** e.g., a payment incorrectly made for a cosmetic service.
- **Duplicate payments:** e.g., multiple claim submissions for the same service.
- **Services not received:** e.g., billing for exams, tests, or surgeries that didn't, in fact, take place.
- **Incorrect amount:** e.g., inappropriate unbundling of CCI edits.
- **No documentation:** e.g., the chart note is lost.
- **Insufficient documentation:** e.g., CPT code 99214 submitted for E&M established patient, level four—however, reviewers deem that the documentation supports only a lower level of service.
- **Medical necessity:** e.g., a comprehensive exam was performed on an established patient when the chief complaint was just an eyelid "bump."
- **Incorrect coding:** e.g., bilateral fundus photography (CPT code 92250) and fluorescein angiography (FA) (CPT code 92235) are performed. The claim is incorrectly submitted as 92250 and 92235-50 when pathology is in only one eye. FA should not be billed for the eye without pathology. ■

One MAC's Findings

Each MAC publishes its CERT findings online. For instance, when Novitas listed its CERT findings from January to March 2014, errors included:

- Documentation requirements to support the need for a service based on a related Local Coverage Determination (LCD) were missing.
- Medical record documentation and/or physician signature was missing, was not legible, or was missing a date of service.
- Incorrect date of service.
- Most E&M services found to be incorrectly coded consisted primarily of subsequent inpatient visits; others included new and established office visits, new and subsequent nursing visits, emergency room visits, and initial inpatient visits.
- The patient canceled a visit and made a new appointment. Two services were mistakenly billed for.

To find your MAC's website, visit Coding Tools at www.aao.org/coding.