CERT Contractor Finding – Part 2

In last month's Newsletter we published the general report of recent errors that were published by several of the MACs. Here is the second part of that article in which you will find our suggestions for implementation of some corrective action you can implement in your facility or clinic. For other information on the CERT report view the article in the "Update on Medical Review Activities" in this month's News and Rules Newsletter.

Solutions

Prevention: Don't wait for a Medical Review

1. Create a compliance program and institute an audit system. Do an initial minimum audit of approx 10% to 15% of your current charts, depending on clinic size.
2. Perform a content and quality audit.
3. Initial emphasis on legibility, completeness of documentation, physician certification of plan of care and billing compliance.
4. Depending on findings, initiate corrective action which can include but not limited to:

    a) Regular audit at a defined frequency, (weekly, monthly or quarterly)

    b) In servicing of staff of audit deficits.

    c) Instituting different paperwork to cover deficits.

    d) Specific training of staff in documentation requirements

Correction:

1. ADR request put on high priority. Needs to be ***coordinated*** by one person but other staff must be involved. Never let a medical record or billing/front office staff just make copies and send to the requester. Make sure appropriate clinical staff review all documentation prior to sending and add additional supplementary information if needed.
2. ADRs are urgent; ensure that all requested documentation is included. If need to get other information from a difference source (hospital, labs, etc)
3. If documentation is illegible, get it transcribed before sending.
4. Always ensure that time is clearly documented either on an attendance flow sheet or in the daily treatment encounter note. Remember that for Part B, CMS requires 2 times recorded, total treatment time which includes time spent providing both direct one-on-one timed codes and non-timed codes. CMS also requires the total direct one-on-one time separately documented as this reflects units billed.

    Part A only requires the total amount of treatment counted from the time the patient starts treatment to the end of the session. Set up time can be included for Part A. Documenting time started and time finished may also be included but this does not replace the other requirements. (Check your LCD if the MAC requires additional information.)
5. If the physician's signature is not legible (and whose is?) institute a certified signature sheet. The physician only need to do this once and then a copy can be included with every referral.

6. Same thing applies as #5 for illegible therapist's signatures. Add the therapist's signature to the certified sheet, or have them print clearly their name, title and signature. Remember initials do not constitute the requirement for a legible identifier.
7. Make sure the therapist clearly understands Medicare Part B 8 minute rule. For Part A providers, CMS does not have a requirement to document in CPT codes, but it has become a standard for assessing billing. Remember to go with the site of service regulation as to what is considered billable time.
8. Flow sheets are not stand alone documentation for skilled care. Exercise logs, etc do not necessarily prove that the service was skilled. Documentation must clearly identify what the skill was that the therapist was performing.
9. Always make sure that the days and minutes of service for each discipline on the MDS matches the therapy log or other documentation of time before the MDS is locked and transmitted to state.
10. Lastly, document what you do that is skilled. Check lists, while convenient, can relate to a reviewer that treatment is repetitions and therefore non-skilled. Doing the same treatment every day / week is going to get you a denial.

Disclaimer:

Encompass Consulting & Education, LLC has produced this article as an informational reference for the readers of our E-Zine. The information contained in this article is current as of the time of publication.

Medicare regulations are constantly changing and it is the responsibility of the provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited are subject to change at any time. Current Medicare regulations can be found on the CMS website at www.cmc.hhs.gov

As always, the provider should be aware of other regulations that might supersede the Medicare payment guidelines such as the State Practice Act and the State Administrative Code. In any scenario, the practitioner must go with the most stringent requirement in order to be compliant.

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