Quarterly CERT Error Findings Report
WPS Government Services Part A J8 MAC
Indiana and Michigan

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed January 1, 2025, through March 31, 2025, for Part A J8 providers. The findings below are reported based on the type of error assessed by the CERT Contractor (e.g., insufficient documentation, incorrect coding, etc.).

Insufficient Documentation – 30% of total errors

Reasons for Errors:

- Per CERT Medical Review, missing the Physician/NPP certification of Physical Therapy plan of care for the billed period to support the 4 units of service of therapeutic exercises. CERT received an order with identification of the ordering provider; PT plan of care, part of initial evaluation, not certified by the attending physician/NPP; PT progress report that documents functional documentation, slow and steady progress towards goals, and plans to continue therapy treatment to be able to transition to an independent program in the next of couple of weeks; PT treatment notes that documents and supports the modalities and UOS billed for the dates of service; PT discharge note; Patient profile; Consent to treat; Demographics; Provider letter dated 11/07/2023 that states, in part, "We need patient's name, DOB, and DOS specified to be able to pull the records needed." SSA 1862(a)(1)(A), 42 CFR 424.5(a)(6) (Sufficient Information), 42 CFR § 410.61 (Plan of treatment requirements for outpatient rehabilitation services), 42 CFR § 424.24(c) (Requirements for medical and other health services furnished by providers under Medicare Part B/Outpatient physical therapy and speech-language pathology services), PUB 100-02 Chapter 15 § 220.1 (Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services), § 220.2 (Reasonable and Necessary Outpatient Rehabilitation Therapy Services), § 220.3 (Documentation Requirements for Therapy Services), PUB 100-04 Chapter 5 § 10 (Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General), § 20.2.C (Counting Minutes for Timed Codes in 15 Minute Units), and PUB 100-08 Chapter 3 § 3.3.2.4 (Signature Requirements).
- Per CERT Medical Review, missing the treating physician/NPP's authenticated clinical documentation to support the medical necessity of the billed lab services for renal function panel, urine albumin, urine creatinine, parathormone level and urine protein. CERT received authenticated physician orders for billed lab test's renal function panel, urine albumin, urine creatinine, parathormone level and urine protein; Diagnostic lab results for billed tests for the date of service. SSA 1862(a)(1)(A); 42 CFR § 424.5(a)(6) (Sufficient Information); PUB 100-02 Chapter 6 § 20.3 (Outpatient Hospital Encounter); and PUB 100-08 Chapter 3 § 3.3.2.4 (Signature Requirements), § 3.6.2.2 (Reasonable and Necessary Criteria).
- Per the CERT Medical Director, the LAAC procedure and thus inpatient admission are not reasonable and necessary. The submitted documentation is insufficient to support the planned elective inpatient only procedure. Missing documentation to support a formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. This 75 year old beneficiary with a history of NVAF underwent elective LAAC and was discharged on the day of the procedure. Although the Interventional Cardiologist's assessment includes risk of major hemorrhage on anticoagulation, this doesn't meet NCD requirements. CERT received history and physical performed by [Cardiologist]; admission and treatment orders; operative report performed by [Electrophysiologist]; discharge summary performed by [Interventional Cardiologist];

diagnostic lab test reports; radiology reports; EKG records; medication administration records. SSA 1862(a)(1)(A); 42 CFR § 412.3 (Admissions); 42 CFR § 424.11 (General procedures); 42 CFR § 424.5(a)(6)(Basic Conditions-Sufficient Information); PUB 100-03, Chapter 1 § 20.34 (Percutaneous Left Atrial Appendage Closure (LAAC)); PUB 100-04, Chapter 1 § 110 (Provider retention of Health Insurance Records); PUB 100-08: Chapter 3 § 3.3.2.4 (Signature Requirements) and Chapter 6 § 6.5 (Medical Review of Inpatient Hospital Claims Part A Payment); and Official ICD-10 Coding Guidelines.

Incorrect Coding – 27% of total errors

Reasons for Errors:

- Per CERT Medical Review, the discharge disposition of 63-LTAC as coded by the facility, should be 62-Inpatient Rehab. After review of submitted medical record and CWF, the beneficiary was discharged to 62-Inpatient Rehab. The facility coded DRG was correct with no change of POA indicators. Inpatient admission was reasonable and necessary. CERT received the complete inpatient record. SSA 1862(a)(1)(A); 42 CFR § 412.3 (Admissions); 42 CFR § 424.11 (General procedures); 42 CFR § 424.5(a)(6) (Basic Conditions-Sufficient Information); PUB 100-08: Chapter 3 § 3.3.2.4 (Signature Requirements) and Chapter 6 § 6.5 (Medical Review of Inpatient Hospital Claims Part A Payment); and Official ICD-10 Coding Guidelines for Hospitals.
- Per CERT Medical Review, the discharge disposition of 06-Home Health as coded by the facility, should be 01-Home. After review of submitted medical record and CWF, the beneficiary was discharged to 01-Home. The facility coded DRG is correct with no change of POA indicators. Inpatient admission was reasonable and necessary. CERT received the complete inpatient record. SSA 1862(a)(1)(A); 42 CFR § 412.3 (Admissions); 42 CFR § 424.11 (General procedures); 42 CFR § 424.5(a)(6)(Basic Conditions-Sufficient Information); PUB 100-08: Chapter 3 § 3.3.2.4 (Signature Requirements) and Chapter 6 § 6.5 (Medical Review of Inpatient Hospital Claims Part A Payment); and Official ICD-10 Coding Guidelines for Hospitals.
- Per CERT Medical Review, replace secondary diagnosis J96.11, (Chronic respiratory failure with hypoxia) with J96.21 (Acute and chronic respiratory failure with hypoxia). The DRG is changed from billed DRG 657 to DRG 656. Per ICD-10-CM Official Guidelines for Coding and Reporting, Section III, Reporting Additional Diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS), item 11-b as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/ or length of stay.” Per submitted documentation, patient with history of chronic respiratory failure, postoperatively now requiring oxygen supplementation, impression and recommendation noted acute hypoxemic respiratory failure. Inpatient admission and procedure, Left Robotic-Assisted Laparoscopic Nephroureterectomy, was reasonable and necessary. CERT received the complete inpatient record. SSA 1862(a)(1)(A); 42 CFR § 412.3 (Admissions); 42 CFR § 424.11 (General procedures); 42 CFR § 424.5(a)(6)(Basic Conditions-Sufficient Information); PUB 100-08: Chapter 3 § 3.3.2.4 (Signature Requirements) and Chapter 6 § 6.5 (Medical Review of Inpatient Hospital Claims Part A Payment); and ICD-10 Official Coding Guidelines for Hospitals, Section III, Reporting Additional Diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS), item 11-b.

Not medically necessary – 23% of total errors

Reasons for Errors:

- Per the CERT Medical Director, the Inpatient admission was not reasonable and necessary. The beneficiary’s clinical presentation, prognosis and expected treatment did not support the expectation of the need for hospital care spanning two or more midnights. This 68-year-old beneficiary presented to the ED with TIA-like symptoms; investigations in the ED included an MRI brain and a CT head that showed no acute findings and no change from previous studies. She is followed by interventional radiology for a large left SCA

aneurysm that has been treated multiple times with pipeline flow diversion stents and is on alternate day antiplatelet medication. In the ED her physical exam was within normal limits and her symptoms resolved without intervention. CERT received the complete inpatient record. SSA 1862(a)(1)(A); 42 CFR § 412.3 (Admissions); 42 CFR § 424.11 (General procedures); 42 CFR § 424.5(a)(6)(Basic Conditions-Sufficient Information); PUB 100-08: Chapter 3 § 3.3.2.4 (Signature Requirements) and Chapter 6 § 6.5 (Medical Review of Inpatient Hospital Claims Part A Payment); and Official ICD-10 Coding Guidelines for Hospitals.

- Per the CERT Medical Director, Inpatient rehabilitation facility (IRF) services were not reasonable and necessary. The submitted documentation does not support that the beneficiary required the active and ongoing therapeutic intervention of multiple therapy disciplines. This 75-year-old beneficiary was admitted to the IRF with a diagnosis of anoxic brain injury following a myocardial infarction with ventricular fibrillation and cardiac arrest while undergoing percutaneous coronary intervention. At the time of admission to the IRF he had mild cognitive deficits, was Independent to Supervision with all activities of daily living and mobility tasks. CERT received orders; Overall individualized plan of care; Preadmission screening; H&P; MD progress notes and DC summary; PT, OT, ST evaluations, treatment notes and DC notes; Team Conference/Update plan of care; Nursing notes; Case management notes; IRF-PAI; MAR; Labs/Diagnostic test results. Per the SSA 1862(a)(1)(A); 42 CFR §424.5(a)(6) (Sufficient Information); 42 CFR §412.622 (Basis of payment); 42 CFR §412.622(a)(3)(i); PUB 100-02, Chapter 1, §110 (Inpatient Rehabilitation Facility (IRF) Services); §110.2 (Inpatient Rehabilitation Facility Medical Necessity Criteria); PUB 100-04, Chapter 3, §140 (Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)); PUB 100-08 Chapter 6 §6.7 (Medical Review of Inpatient Rehabilitation Facility Services); and §6.7.1 (Reviewing for Intensive Level of Rehabilitation Therapy Services Requirements).

Insufficient Documentation to Support the Billed Code – 17% of total errors

Reasons for Errors:

- Per CERT Medical Review, the billed HIPPS re-coded from NDDB1 to NDDC1. Review does not support MDS reporting of Item # I1300.Ulcerative colitis, Crohn's, inflammatory bowel disease. Correction in QC Module results in recalculation of the NTA CMG component. Missing the Physician/NPP documentation to support active diagnosis of Ulcerative Colitis or Crohn's disease or inflammatory bowel disease. CERT received Physician/NPP documentation to support active diagnosis of diverticulosis, which is not an inflammatory bowel disease; Physician/NPP documentation to support active diagnosis of Metabolic Encephalopathy, Diabetes Mellitus, Malnutrition/risk of malnutrition, COPD/asthma, Respiratory Failure, Pulmonary Fibrosis and Morbid Obesity; Valid SNF initial certification; Physician orders, including orders for skilled therapy (PT/OT/ST) services; PT/OT/ST evaluations/POCs, treatment records for and treatment logs that support R&N skilled rehab services were provided on a daily basis; Resident care-plan; Physician/NPP progress notes; Documentation to support the PT/OT and Nursing Functional Scores; Records documenting performance of the PHQ-9 interview; TAR documenting shortness of breath while lying flat; Records from the qualifying hospital stay; MDS for the ARD. SSA 1862(a)(1)(A); 42 CFR §424.5(a)(6) (Basic Conditions-Sufficient Information), 42 CFR §409 Subpart D (Requirements for Coverage of Posthospital SNF Care), 42 CFR §413.343 (Prospective Payment for Skilled Nursing Facilities-Resident Assessment Data), 42 CFR §424.11 (Conditions for Medicare Payment-General Procedures), 42 CFR §424.20 (Conditions for Medicare Payment-Requirements for Posthospital SNF Care); PUB 100-02 Chapter 8 §30 (Skilled Nursing Facility Level of Care); PUB 100-04 Chapter 6 §10 (Skilled Nursing Facility Prospective Payment System and Consolidated Billing Overview), §30 (Billing SNF PPS Services) and §120 (Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM); PUB 100-08 Chapter 6 §6.1 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Claims); RAI 3.0 Manual v. 1.18.11 Chapter 3 (Overview to the Item by Item Guide to the MDS 3.0) and Chapter 6 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS))
- Per CERT Medical Review, the billed HIPPS re-coded from FDNF1 to FDPF1. Review does not support MDS reporting of Item #D0160 (Total severity score). Correction in QC Module results in recalculation of the

Nursing CMG component. Missing clinical documentation supporting completion of the PHQ-9 assessment on or before the MDS look-back period. CERT received the SNF certification statement pertinent to the billed dates of service; SNF physician orders; Therapy (PT/OT/SLP) evaluations/POCs and treatment records supporting level of care and timely BIMS completion; Physician/NPP progress notes supporting Active Diagnosis: Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing; Nursing/IDT notes and treatment records; Resident care plan; Documentation supporting admission GG PT/OT and Nursing Functional Scores; MDS ARD and Validation Report supporting timely repository submission Acute hospital records. SSA 1862(a)(1)(A)(Exclusions from Coverage and Medicare as Secondary Payer); 42 CFR §424.5(a)(6) (Basic Conditions-Sufficient Information); 42 CFR §409 Subpart D (Requirements for Coverage of Posthospital SNF Care); 42 CFR §413.343 (Prospective Payment for Skilled Nursing Facilities-Resident Assessment Data); 42 CFR §424.11 (Conditions for Medicare Payment-General Procedures); 42 CFR §424.20 (Conditions for Medicare Payment-Requirements for Posthospital SNF Care); PUB 100-02 Chapter 8 §30 (Skilled Nursing Facility Level of Care); PUB 100-04 Chapter 6 §10 (Skilled Nursing Facility Prospective Payment System and Consolidated Billing Overview), §30 (Billing SNF PPS Services) and §120 (Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM); PUB 100-08 Chapter 3 §3.3.2.4 (Signature Requirements); PUB 100-08 Chapter 6 §6.1 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Claims); RAI 3.0 Manual v. 1.18.1, Chapter 3 (Overview to the Item by Item Guide to the MDS 3.0) and Chapter 6 (Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)).

No Documentation – 3% of total errors

Reasons for Errors:

Per CERT Medical Review, no medical records were received. Per the SSA 1862 (a) (1)(A) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services— which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; Per the SSA 1833 (e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period. Missing medical record documentation to support the billed inpatient hospitalization. The service was not reasonable and necessary per Medicare requirements. CERT received the CERT barcoded cover sheet and second letter requesting medical records; Letter from billing provider stating they were unable to comply with request. SSA 1862(a)(1)(A); 42 CFR 424.5(a)(6)(Basic Conditions-Sufficient Information); PUB 100-04, Chapter 1 § 110 (Provider retention of Health Insurance Records) and PUB 100-08, Chapter 12 § 12.11 (Late Documentation Received by the CERT Review Contractor).

Resources

Social Security Administration: https://search.ssa.gov/search?affiliate=ssa

Code of Federal Regulations: https://www.govinfo.gov/help/cfr

Internet Only Manuals: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

Official ICD-10 Coding Guidelines for Hospitals https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

RAI 3.0 Manual v. 1.18.1 https://www.cms.gov/files/document/draftmds-30-rai-manual-v11811october2023.pdf