Quarterly CERT Error Findings Report
WPS Government Services Part A J5 and J5N MAC

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed January 1, 2025, through March 31, 2025, for Part A J5 and J5N MAC 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 – 31% of total errors

Reasons for Errors:

- Per CERT Medical Review, missing authenticated physician order for skilled nursing services applicable to June, 2023, dates of service. CERT received the authenticated physician orders that do not include orders for reasonable and necessary daily skilled nursing services; Authenticated SNF recertification statement pertinent to billed dates of service; Documentation supporting skilled nursing services were provided on a daily basis; Resident care plan; Physician/NPP progress notes; Physician documentation to support active diagnoses as reported on the MDS; Documentation to support the PT/OT and Nursing functional scores; Hospital records documenting administration of parenteral/IV feedings while not a resident; MDS with ARD [Date redacted]. 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. 1.17.1, 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)).
- Per CERT Medical Review, missing the Physician/NPP documentation with the reason for the delayed certification for the physical therapy (PT) plan of care for period Augst through October of 2023 to support the therapy services provided on two billed dates of service in September; Physical therapy (PT) progress report required for every 10th treatment day applicable to the billed dates of services in September to support the medical necessity of continued therapy services. CERT Received: PT treatment note with updated plan of care for recertification for the period, certified by the physician in May of 2024; PT treatment notes that documents and supports the modalities and UOS billed for dates of service in the full month of September; Initial PT plan of care from 2022 that documents the medical necessity for PT services for beneficiary with right hip pain, balance deficits, and low back pain; PT treatment note dated July of 2023 with an updated plan of care for beneficiary with right hip pain, balance deficits, and low back pain. Late Documentation includes duplicate submission of physical therapy treatment notes and flowsheets for dates in September; Undated letter from Story County Medical/21st Century Rehab that does not support the reason for the delayed certification for the Physical Therapy (PT) Plan of Care for period from August to October to support the therapy services provided for two dates of service in

September of 2023, and does not support the requirements of a Physical Therapy progress report required for every 10th treatment day that is applicable to billed September dates of service. The Decision remains a disagree. 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 4 § 250 (Special Rules for Critical Access Hospital Outpatient Billing), 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), PUB 100-08 Chapter 12 § 12.11 (Late Documentation Received by the CERT Review Contractor).

- Per CERT Medical Review, missing the preadmission screening for billed dates of service; PT, OT and ST notes and therapy minutes for the IRF stay. CERT received PT, OT, ST initial evaluations as well as treatment notes for January of 2024 with a gap in documentation; Orders; Overall individualized plan of care; H&P; MD progress notes and DC summary; Team Conference/Update plan of care; Nursing notes; Case management notes; MAR; Labs/Diagnostic test results. SSA 1862(a)(1)(A); 42 CFR §424.5(a)(6) (Sufficient Information); 42 CFR §412.622 (Basis of payment); CFR 42 § 412.622 (a)(4)(i); PUB 100-02, Chapter 1, §110 (Inpatient Rehabilitation Facility (IRF) Services); §110.1.1 (Required Preadmission Screening); §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 Billed Code; Recoded - 23% of total errors

Reasons for Errors:

- Per CERT Medical Review, the billed HIPPS re-coded from KAKC1 to KAPE1 because review does not support MDS reporting of Item #M1040A. Other skin problems: infection of the foot, Item #I5600.Malnutrition (protein, calorie) risk for malnutrition and Item #I2500.Wound infection (other than the foot). Correction in QC Module results in recalculation of the PT/OT, Nursing and NTA CMG components. Missing Orders for infection of the foot treatment as reported on the MDS; Physician/NPP documentation to support Active Diagnoses Wound infection other than the foot, Malnutrition/risk of as reported on the 02/10/2024 MDS; Records documenting presence of infection of the foot treatments to support the billed MDS. CERT received the SNF orders that does not include treatment orders for infection of the foot as reported on the MDS; Physician visit notes during the look back period that does not include the diagnoses of Wound infection other than the foot and Malnutrition/risk for as reported on the MDS; Treatment records for the month of February 2024 that does not include treatment records for the infection of the foot to support the billed MDS; Valid 14 Day recertification of skilled services; PT/OT Initial evaluations, treatment orders and notes for the billed date of service; Nursing notes; Physician visit notes documenting Cellulitis of toe as an active diagnosis; Hospital records documenting Osteomyelitis as an active diagnosis; PT/OT Functional scoring that supports the coded items on the 5 Day MDS; 5 Day MDS; IDT notes; MAR. 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); PUB 100-04 Chapter 6 §30 (Billing SNF PPS Services); PUB 100-04 Chapter 6 §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 Version 1.18.11 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))
- Per CERT Medical Review, the billed HIPPS has been re-coded from DAYD1 to CAXD1. Review does not support the MDS reported values for the section GG items required to calculate the PT/OT and Nursing Functional scores (Items# GG0130A1, GG0130B1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170F1, GG0170I1, GG0170K1). Correction in QC Module results in recalculation of the PT/OT and Nursing CMG components. Missing the clinical assessment performed by a qualified clinician to support the PT/OT and Nursing functional scores for the admission/start of care. Per RAI Manual CH 3: MDS items [GG] page 270, “CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.” A qualified clinician is defined (per the RAI Manual) as “Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations." CERT received documents titled “Section GG Assessments by Patient” do not support the PT/OT and Nursing functional scores for the MDS billed; Document titled “Documentation Survey Report V2” does not support PT/OT and Nursing Functional Scores (performed by a qualified clinician); Document titled “Follow Up Question Report” listing (GG0130A1 and GG0130B1), lacks credentials (performed by a qualified clinician); Authenticated SNF initial certification statement applicable to Medicare Part A billed dates of service; Physical and occupational therapy initial evaluations/POC, treatment records including CPT treatment logs; Physician/NPP documentation supporting approval of

therapy (PT/OT) plans of care; Resident care-plan; Physician/NPP documentation to support Active Diagnoses (S12.191D Other nondisplaced fracture of second cervical vertebra, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus); Physician/NPP H&P and progress notes for Medicare Part A SNF admission through billed DOS; UB-04, Face Sheet/Admission Record; Nurse's notes, IDT notes and assessments, order summary, MAR/TAR; MDS for ARD including all signature pages; Signature attestation (PA); Inpatient/Hospital records. 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); PUB 100-04 Chapter 6 §30 (Billing SNF PPS Services); PUB 100-04 Chapter 6 §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 Version 1.18.11 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))

Incorrect Coding – 20% of total errors

Reasons for Errors:

- Per CERT Medical Review, the billed service is incorrectly coded. The provider billed CPT 43762 (Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract). Documentation supports code change to CPT 49450 (Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report). CERT Received a handwritten order for Gastrostomy Tube Replacement by a PA-C that documents the diagnosis as "Malfunctioning G-tube" supporting medical necessity; Electronic order for Gastrostomy or Cecostomy tube replacement that identifies the ordering provider as the same PA-C and documents the reason for the procedure as "Gastrostomy Malfunction" supporting medical necessity; Operative report of the Percutaneous Gastrostomy Tube Replacement by an MD that documents use of fluoroscopic guidance for removal and replacement; Post-op progress note by the physician; Medication administration record; and Progress note by a separate Infectious Disease physician. SSA 1862(a)(1)(A); 42 CFR § 424.5(a)(6) (Sufficient Information); PUB 100-02 Chapter 6 § 20-20.3 (Outpatient Hospital Services); PUB 100-04 Chapter 4 § 180 (Reporting of Surgical and Medical Procedures and Services), § 180.1 (General Rules), § 180.2 (Selecting and Reporting Procedure Codes); PUB 100-08 Chapter 3 § 3.3.2.4 (Signature Requirements), § 3.6.2.2 (Reasonable and Necessary Criteria), § 3.6.2.4 (Coding Determinations) and Chapter 12 § 12.11 (Late Documentation Received by the CERT Review Contractor); and CPT 2024.
- Per CERT Medical Review, the discharge disposition 06- Home health as coded by the facility should be 03- SNF. After review of submitted medical record and CWF, the beneficiary was discharged to 03- SNF, and not 06 - Home Health as coded by facility. Agree with facility coded DRG, no change of POA indicators. Inpatient admission and left total hip arthroplasty were 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.

Not Medically Necessary – 11% of total errors

Reasons for Errors:

- Per the CERT Medical Director, the inpatient admission was not reasonable and necessary for a procedure that is not on the inpatient-only list. The documentation does not support the expectation that the beneficiary required medically necessary hospital care spanning 2 or more midnights. In addition, coverage criteria were not met per the NCD 20.7. This 88-year-old beneficiary underwent elective angioplasty of the anterior tibial artery (noncovered). Also, the procedure codes 04CP3ZZ (Extirpation of Matter from Right Anterior Tibial Artery, Percutaneous Approach), 047P3ZZ (Dilation of Right Anterior Tibial Artery, Percutaneous Approach) & B41D1ZZ (Fluoroscopy of Aorta and Bilateral Lower Extremity Arteries using Low Osmolar Contrast) are removed from the coding sequence. The DRG is changed from billed 274 to DRG 256. Per CERT Medical Director billed procedure is non-covered. 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 100-03, Chapter 1 § 20.7 (Percutaneous Transluminal Angioplasty (PTA)); 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 § 6.5.4 (Review of Procedures Affecting the DRG; and Official ICD-10 Coding Guidelines for Hospitals.

Billing Requirement Error - 9% of total errors

Reasons for Errors:

- Per CERT Medical Review, the 5 Day MDS with ARD [Date redacted] retrieved from the repository is a modified assessment that was submitted on [Date redacted]; this is after the claim entry date. Additionally, the HIPPS Code for this modified assessment (KDGD1) does not match the HIPPS Code (KDKE1) billed on the Part A SNF claim. Also, missing the physician orders for the MDS reported wound care treatments (Pressure reducing device for bed and/or chair, Nutrition or hydration intervention to manage skin problems, Pressure ulcer/injury care, Application of ointments/medications other than to feet and/or the Application of dressings to feet (with or without topical medications)); Physician order for respiratory therapy as reported on the MDS; Physician/NPP documentation to support the reported active diagnosis of asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease; Records documenting the administration of the reported wound care treatments (Pressure reducing device for bed and/or chair, Nutrition or hydration intervention to manage skin problems, Application of ointments/medications other than to feet and/or the Application of dressings to feet (with or without topical medications). Per PUB 100-04, Ch. 6 §30.1 (Health Insurance Prospective Payment System (HIPPS) Rate Code): The HIPPS rate code that appears on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF may bill the program only after: • An assessment has been completed and submitted to the State RAI Database; • A Final Validation Report indicating that the assessment has been accepted by the state; and • The covered day has actually been used. SNFs that submit claims that have not completed this process will not be paid. It is important to remember that the record will be accepted into the State RAI database, even if the calculated RUG code differs from the submitted values. The

error will be flagged on the final validation report by issuing a warning message and listing the correct RUG code. When such discrepancies occur, the RUG code reported on the Final Validation Report shall be used for billing purposes. Per MDS 3.0 RAI Manual v1.18.11 - Section O (Page 529): For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met: — the physician orders the therapy; — the physician's order includes a statement of frequency, duration, and scope of treatment; — the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel." And (Page 752): "Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse." CERT received the physician orders for pressure injury care dated after the ARD; Physician/NPP documentation supporting reported diagnoses (Urinary tract infection, site not specified, Malnutrition, Infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter); TAR documenting pressure injury care during the look-back period but records supporting provision of Pressure reducing device for bed and/or chair, Nutrition or hydration intervention to manage skin problems, Application of ointments/medications other than to feet and/or the Application of dressings to feet (with or without topical medications) during the look-back period not received; Authenticated SNF delayed certification for the billed claim period; Physician order for oxygen therapy; Resident care plan; Documentation to support the PT/OT and Nursing functional scores as documented in section GG of the MDS; Records documenting performance of the Brief Interview for Mental Status/BIMS; Skin care records documenting the presence of a stage 3 pressure injury; Administration records documenting "Respiratory Assessment" for 7 days in the look-back period; IDT progress notes and assessments; MAR/TAR; Modified MDS for ARD [Date redacted] that documents HIPPS score of KDKE1; Validation report for the modified record (July 2024) 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); 42 CFR 424.44 (Time Limits for Filing Claims); PUB 100-02 Chapter 8 §30 (Skilled Nursing Facility Level of Care); PUB 100-04, Chapter 1 §70 (Time Limitations for Filing Part A and Part B Claims), Chapter 6 §10 (Skilled Nursing Facility Prospective Payment System and Consolidated Billing Overview), §30 (Billing SNF PPS Services), §30.1 (Health Insurance Prospective Payment System (HIPPS) Rate Code) 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 (Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)).

No Documentation - 4% of total errors

Reasons for Errors:

- Per CERT Medical Review, missing medical record documentation to support the billed inpatient hospitalization for the dates of service. No medical records were received from the billing provider to support the billed inpatient hospitalization and no reason was given for the reimbursement to

Medicare for these services. The service was not reasonable and necessary per Medicare requirements. CERT received a CERT barcoded cover letter; CMS First letter request; Letter from HCA Fl Oak Hill Hospital dated 12/16/2024 stating unable to comply with your request at this time for the following reason(s): “Non-HCA Facility” We do not release records for the facility notated. Please re-route your request to the appropriate location. 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).

Insufficient Documentation to Support the Procedure - 2% of total errors

Reasons for Errors:

- Per the CERT Medical Director, the submitted documentation is insufficient to support that coverage criteria for an ICD is met. Missing a formal shared decision making encounter between the beneficiary and a physician or qualified non-physician practitioner using an evidence-based decision tool on ICDs prior to initial ICD implantation. Procedure code 0JH608Z, (Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach); 02HK3KZ, (Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach) 02PA3MZ, (Removal of Cardiac Lead from Heart, Percutaneous Approach); and 02HK3KZ, (Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach) are removed from the coding sequence. The DRG is changed from billed DRG 276 to DRG 291. However, inpatient admission was reasonable and necessary to manage this 78-year-old beneficiary’s congestive heart failure. CERT received consult by an MD (Interventional Cardiologist). Note states a discussion was held on the risks and benefits of ICD placement, but does not mention use of evidence-based decision tool on ICDs; Procedure note by the Interventional Cardiologist. Note states a discussion was held on the risks and benefits of ICD placement, but does not mention use of evidence-based decision tool on ICDs; Orders to include inpatient admission order;. ED note; H&P; Progress notes by physicians and nursing; MAR; Discharge Summary. 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 § 20.4 (Implantable Cardioverter Defibrillators (ICDs)) PUB 100-04, Chapter 1, § 110.1.C (Provider Retention of Health Insurance Records/Medical Record Material); 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.

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

RAI 3.0 Manual v. 1.17.1, 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)) https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

RAI 3.0 Manual v. 1.18.11: https://www.cms.gov/files/document/draftmds-30-rai-manual-v11811october2023.pdf

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

Note: Review results are based on the documentation submitted and Medicare regulations in place at the time services were rendered. Medicare providers are responsible for compliance with all current applicable Medicare coverage, coding and billing regulation upon claim submission.