IHS CERT Errors Report
November 2009

The findings below were taken from recent feedback files from the Comprehensive Error Rate Testing (CERT) contractor and reflect the accuracy of claims submitted to Medicare for processing along with the Medicare claim processing system edits. These findings reflect the providers' understanding of and compliance with the Medicare program's payment rules and coverage policies.

In an effort to reduce the provider billing error rate and achieve positive CERT findings in the future, providers are encouraged to use this report and other educational tools available on the TrailBlazer Web site to assist in correct billing and reduce future billing errors:

http://www.trailblazerhealth.com/Education/Comprehensive%20Error%20Rate%20Testing/Default.aspx?DomainID=1

To find tips for appropriate Evaluation and Management (E/M) medical record documentation, view the TrailBlazer E/M Web page at:

http://www.trailblazerhealth.com/Specialty%20Services/Evaluation%20and%20Management/default.aspx.

Part A

Error Description	Revenue Code	HCPCS/CPT	CERT Review Comments	Resolutions
Insufficient Documentation	519	99213	Insufficient documentation submitted to support services billed. Billed is revenue code 519, Clinic-other, with CPT code 99213©, office/outpatient visit, est. Documentation submitted consists of physical therapy records.	Indian Health Service (IHS) hospitals should be using revenue code 510 for outpatient clinic visits. Documentation must support services billed. If Physical Therapy (PT) is being performed and documented, then PT procedures must be billed. Refer to the Part A IHS manual or UB-04 IHS billing examples located on the TrailBlazer Web site under Publications.

Error Description	Revenue Code	HCPCS/CPT	CERT Review Comments	Resolutions
Insufficient Documentation	851	99211	Insufficient documentation; missing documentation to support a clinic visit that may not require the presence of a physician. Submitted documentation supports visit was for laboratory services only, without notation of other face-to-face services.	Submit all records pertaining to the lab-only visit. For code 99211, services performed by ancillary staff and billed as an "incident to" service, the documentation should demonstrate the "link" between the non-physician service and the precedent physician service to which the non-physician service is incidental. Therefore, documentation of code 99211 services provided "incident to" should include the identity and credentials of both the individual who provided the service and the supervising physician. Documentation of a code 99211 service provided "incident to" should also indicate the supervising physician's involvement with the patient care. Refer to the "incident to" guidelines located in the CMS IOM *Benefit Policy Manual*, Chapter 6, Sections 20.5.1 and 20.5.2. TrailBlazer has posted a job aid titled "Documentation Requirements for CPT 99211."

Part B

Error Description	HCPCS/CPT	CERT Review Comments	Resolutions
Insufficient Documentation	99213	Missing office visit note that was performed by the performing provider submitted on the claim to support the services billed on this date of service. Documentation received consists of an emergency physician record and labs that were performed by a different provider than what was billed.	Documentation must support services billed. Submit all records pertaining to the requested date of service. If the patient had an office visit and later the same day had an emergency room visit, submit all medical records for that day.

Recommendations for Improvement

- Ensure your documentation is complete and supports the service provided.
- Code correctly the first time.
- Respond in a timely manner to requests for documentation.
- Submit complete, legible documentation.
- Medicare requires a **legible** identifier for services ordered and provided.