CERT Reviews Identify Need for Hard Look at Oncology Documentation Practices

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The Comprehensive Error Rate Testing (CERT) for improper payment analysis was implemented by the Centers for Medicare & Medicaid Services to identify and measure improper payments in the Medicare Fee-for-Service program. To accomplish this, CERT randomly selects approximately 50,000 claims submitted to Part A and B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs during each reporting period. The size of the review allows the agency to calculate a national improper payment rate along with a service-specific improper payment rate. Because the sample of medical records reviewed is random, the calculation of the overall improper payments is considered appropriately applicable to all claims processed.

CERT has five assigned error categories to make a determination of whether the claim was paid or denied appropriately:[1]

1. ***No documentation.*** Claims are placed into this category when the provider or supplier fails to respond to repeated requests for the medical records or when the provider or supplier responds that they do not have the requested documentation.
2. ***Insufficient documentation.*** Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order or a form that is required to be completed in its entirety.
3. ***Medical necessity.*** Claims are placed into this category when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.
4. ***Incorrect coding.*** Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.
5. ***Other.*** Claims are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, noncovered or unallowable service).

Findings published in the calendar year 2018 CERT demonstrate that radiation oncology, medical oncology, and hematology continue to have issues with documentation.[2] The analysis found an overall accuracy rate of 91.9 percent, but included an 8.1 percent improper payment rate for the medical records reviewed. Within the improper rate findings for Part B, the results do not paint a flattering picture for radiation or medical oncology.

Medical oncology was the 19th highest speciality overall, with an improper payment rate of 12.7 percent of the 112 claims reviewed.[2] Ninety percent of those improper claims had insufficient documentation. Radiation oncology was projected to be in the top 20 of most improperly paid claims, with a 10.3 percent overall rate; 100 percent of those improper claims were projected to be due to insufficient documentation. The actual findings showed a 10.8 percent improper payment rate on 60 reviewed claims, which had a 96.9 percent error rate due to insufficient documentation; 0.5 percent were due to medical necessity, and 2.6 percent were due to incorrect coding.

According the to the fiscal year 2018 results, "oncology-radiation therapy" was listed as 20th on the list of Projected Improper Payment Rates by Service Type: Part B.[2] As reference, "other drugs" and "office visits-established" were listed as first and second respectively; chemotherapy was 29th, and "oncology-other" was 51st.

The results from the fiscal year 2018 CERT review are concerning for radiation oncology, because they continue to reflect data that show ongoing issues with documentation of services. On Jan. 15, 2014, CGS, the MAC for Ohio and Kentucky, published data on its website that indicated that radiation therapy had a projected error rate of 42.7 percent and was listed among the top 10 errors by type of service.[3] These data came from a CERT sampling period of July 2012 through June 2013.

The cases presented as an example on the CGS website indicated that medical records submitted to support codes such as treatment delivery and portal imaging (**CPT 77414** and **CPT 77417**) included no patient treatment history information, notes for dates of service other than requested, insufficient signatures, and images with no patient identifiers. Still other cases to

support IMRT treatment delivery (**CPT 77418**) submitted the prescription, plan, consult notes, and other radiation oncology notes, but no documentation that the treatment was administered or that supported IMRT over other forms of therapy. Lastly, medical records for **CPT 77427** (physician management services) were submitted but in no way supported the actual code. Records submitted included chemotherapy records, lab results, unsigned physician's notes, unsigned discharge instructions, and, upon second request, computed tomography imaging records and colonoscopy and EGD results.

CERT findings on the CGS website included the following tips for improving accuracy of submitted records:[3]

- The two most common errors noted among claims for radiation oncology services are failing to send supporting documentation and submitting records without a valid signature. These errors are preventable, and we encourage you to take immediate steps to ensure that your medical records staff understands what records to submit. We recommend that you review all medical records, before submitting claims, to ensure that they contain valid signatures that meet Medicare's signature requirements.
- Although the CERT process involves a very small sample of records, we have found that any errors identified in the sample are often present in other records.
- We strongly encourage you to review these errors and incorporate awareness of these errors into your practice's quality procedures.

The first tip provided by CERT and CGS to improve accuracy of submitted records is an extremely important and valid point: ensure that the staff tasked with submitting medical records know what medical records to submit in response to inquiry or denial. The findings of the CERT review reveal a lack of knowledge or training on radiation oncology documentation by the staff submitting and answering the requests. Documentation for radiation oncology services is not typically supported with consultative or procedure-type notes as commonly found with other specialties. Much of radiation oncology documentation is image based or housed in such a way that a report can be obtained—it just requires knowledge of the system to obtain. Another key item to consider is the need for staff to have necessary access to medical record(s), including any separate radiation oncology-specific medical records that may be housed and maintained separately from a larger electronic health record.

Other findings and tips highlight ongoing issues identified routinely in medical record reviews: a lack of physician signatures or signatures that fail to meet the requirements. If a signature is illegible, an attestation or signature log can be submitted with the original approval to assist; however, many times this documentation is lacking. Documentation is not just the responsibility of the staff answering medical record requests. Signature requirements are something that all physicians should be familiar with and evaluated on to ensure compliance, because the lack of or incompleteness of a signature, no matter how complete the documentation of the service may be, can render the service improper.

Additional information about signature requirements can be found on the Centers for Medicare & Medicaid Services website, as well as Code of Federal Regulations Title 21, Part 11, Electronic Records; Electronic Signatures, Subpart B, Electronic Records, Sec, 11.50, Signature Manifestations, which states the following:[4]

(a) Signed electronic records shall contain information associated with the signing that clearly indicates all of the following:

(1) The printed name of the signer;

(2) The date and time when the signature was executed; and

(3) The meaning (such as review, approval, responsibility, or authorship) associated with the signature.

(b) The items *identified in paragraphs (a)(1), (a)(2), and (a)(3) of this section shall be subject to the same controls as for electronic records and shall be included as part of any human readable form of the electronic record (such as electronic display or printout).*

Other findings in the calendar year 2018 CERT report identify issues with evaluation and management visits for established and subsequent inpatient visits under the specialty of hematology/oncology.[2] Hematology/oncology was listed as 13th out of 13 for improper payments rates for established office visits by provider type and 11th out of 12 for improper payments rates for subsequent hospital visits by provider type.

In light of these findings on improper payment rates, it is increasingly important for providers to closely evaluate all documentation prior to any code or claim submission to ensure that the documentation is complete and appropriate. In addition, ongoing education and review of staff handling requests for medical records in response to denials or payer review is necessary to ensure that preventable errors are not inadvertently identifying specialties as problematic or requiring additional scrutiny.

Tables 1-5, pages 10-11, provide a brief synopsis of the data collected and how the specialties of radiation, medical, and hematology/oncology were valued.

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4. U.S. Food and Drug Administration. CFR—Code of Federal Regulations Title 21. Available online at: accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm. Last accessed April 3, 2019.

Table 1. Improper Payment Rates by Provider Type and Type of Error: Part B[2]

Provider Types Billing to Part B[a]	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Payment by Type of Error				
			No Documentation	Insufficient Documentation	Medical Necessity	Incorrect Coding	Other
Chiropractic	41.0%	388	0.0%	88.3%	7.7%	4.0%	0.0%
Medical oncology	12.7%	112	2.2%	90.0%	0.0%	7.8%	0.0%
Radiation oncology	10.8%	60	0.0%	96.9%	0.5%	2.6%	0.0%
Hematology/oncology	3.0%	355	3.2%	60.5%	1.6%	34.7%	0.0%

[a]Chiropractic had the highest overall improper payment rate; as a comparison, medical oncology was in 18th place, radiation oncology was in 26th place, and hematology/oncology was in 49th place.

Table 2. Improper Payment Rates and Amounts by Provider Type: Part B

Part B Services (BETOS Codes)[a]	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Provider Compliance Improper Payment Rate	Percentage Overall Improper Payments
Internal medicine	1,941	$1,489,011,538	15.7%	9.9%-21.4%	23.1%	4.6%
Medical oncology	112	$268,472,362	12.7%	(6.1%)-31.5%	12.9%	0.8%
Radiation oncology	60	$151,911,093	10.8%	(0.8%)-22.3%	14.3%	0.5%

[a]Improper payments by provider type showing internal medicine with the highest rates, medical oncology providers in 9th place, and radiation oncology providers in 24th place.

Table 3. Improper Payment Rates by Service Type: Part B[2]

Part B Services (BETOS Codes)[a]	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage Overall Improper Payments
Other drugs	79	$1,092,458,318	9.1%	(0.1%)-18.4%	3.4%
Office visits-established	1,461	$1,050,386,680	7.1%	6.0%-8.2%	3.3%
Oncology-radiation therapy	33	$112,699,466	10.3%	(2.2%)-22.7%	0.3%
Chemotherapy	156	$64,081,928	2.1%	(0.3%)-4.5%	0.2%
Oncology-other	280	$10,490,824	4.2%	(1.5%)-10.0%	0.0%

[a]Radiation therapy was 20th on the list of Projected Improper Payment Rates by Service Type: Part B. As reference, other drugs and office vistis-established were listed as first and second, respectively; chemotherapy was 29th and oncology-other was 51st.

Table 4. Improper Payment Rates for Office Visits-Established by Provider Type[2]

Office Visits-Established	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage Overall Improper Payments
Internal medicine	1,941	$1,489,011,538	15.7%	9.9%-21.4%	4.6%
Radiation oncology	60	$151,911,093	10.8%	(0.8%)-22.3%	0.5%

[a]Improper payments by provider type showing internal medicine with the highest rates, medical oncology providers in 9th place, and radiation oncology providers in 24th place.

Table 5. Improper Payment Rates for Hospital Visit-Subsequent by Provider Type[2]

Office Visits-Established	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage Overall Improper Payments
Internal medicine	626	$242,034,784	11.5%	9.2%-13.7%	31.6%
Hematology/ oncology	31	$8,988,060	9.3%	1.6%-17.0%	1.2%

[a]Improper payments by provider type showing internal medicine with the highest rates, medical oncology providers in 9th place, and radiation oncology providers in 24th place.