Lesson 3: Medicare Claims Review (Audit) Programs

Audited by a payer?

Is your organization under a payer audit? Fight back by appealing unreasonable denials. But first, learn more about how a complex payer audit system works.

Understanding how a payer reviews and makes a payment determination will strengthen your ability to argue and defend your claim upon appeal. The learning objective of this lesson is to help you become familiar with the Medicare Claims Review Program (MCRP). This program monitors inappropriate payments.

What is an "Improper" payment?

These are reimbursements that should not have been made or that were made in incorrect amounts. According to the U.S. Government Accountability Office (GAO), improper payments have been estimated to total almost $1.7 trillion government-wide from fiscal years 2003 through 2019. Auditing and denying claims after the claims have been paid is "big money" for the government.

- For example, the GAO states they identified about $77.6 billion in financial benefits in fiscal year 2020—***a return of about $114 for every $1 invested.***

- They also identified 1,332 other benefits that led to program and operational improvements across the government.

- Most recently, GAO has been evaluating the largest response to a national emergency in US history, the $2.6 trillion COVID-19 response legislation, and making recommendations about how to improve its effectiveness in dealing with public health issues and the economy.

The ***Medicare Fee-for-Service Compliance programs*** prevent, reduce, and measure improper payments in FFS Medicare through medical review. We provide a number of programs to educate and support Medicare providers in understanding and applying Medicare FFS policies while reducing provider burden.

CMS is part of the Department of Health and Human Services. The National CMS website offers information which may also be located on your MAC website as well. For demonstration purposes, we are using the National CMS website (www.cms.gov) for this lesson.

Abbreviations, Acronyms and Terms You Should Know

Before getting started, review these terms first to help you through this lesson:

CERT

- Comprehensive Error Rate Testing

Clinical Denial

- Denial based on review of medical record documentation

Complex Medical Review
- Determine whether a claim was paid appropriately by auditing supporting documentation (medical record)

CPI
- Center for Program Integrity

DME
- Durable Medical Equipment

FFS
- Fee-For-Service (Regular Medicare Program)

GAO
- U.S. Government Accountability Office

Improper Payment
- Payment or reimbursement of a claim that should not have been made by the payer or made in an incorrect amount

LCD
- Local Coverage Determination

MCRP
- Medical Claims Review Program

Medi-Medi
- Medicare-Medicaid data match program

MIC
- Medicaid Integrity Contractor

MR
- Medical Review

MUE
- Medically Unlikely Edit

NCCI
- National Correct Coding Initiative

NCD
- National Coverage Determination

PSC

- Program Safeguard Contractor

SGS
- SafeGuard Services

Technical Denial
- Filing error causing the payer to reject the claim

TPE
- Targeted Probe and Educate

USO
- Unit of Service

ZPIC
- Zone Program Integrity Contractors (Replaced by UPICs)

The Purpose of the MCRP

Medical reviews identify errors through claims analysis and/or medical record review activities. Contractors use this information to help ensure they provide proper Medicare payments (and recover any improper payments if the claim was already paid). Contractors also provide education to help ensure future compliance.

A Medicare contractor may use any relevant information they deem necessary to make a prepayment or post-payment claim review determination. This includes any documentation submitted with the claim or through an additional documentation request.

Who manages Medicare medical review contractors working the MCRP?

CMS' Center for Program Integrity (CPI) oversees Medicare medical review contractors. CPI conducts contractor oversight activities such as:

- Providing broad direction on medical review policy
- Reviewing and approving Medicare contractors' annual medical review strategies
- Facilitating Medicare contractors' implementation of recently enacted Medicare legislation
- Facilitating compliance with current regulations
- Ensuring Medicare contractors' performance of CMS operating instructions
- Conducting continuous monitoring and evaluation of Medicare Contractors' performance in accord with CMS program instructions as well as contractors' strategies and goals
- Providing ongoing feedback and consultation to contractors regarding Medicare program and medical review issues

Claim Review Contractors

Under the authority of the Social Security Act, CMS employs a variety of contractors to process and review claims according to Medicare rules and regulations. The types of contractors you need to learn for this course are listed below along with their basic responsibilities.

This is a list of CMS Contractors Retained to Audit Your Claims:

- CERT: Comprehensive Error Rate Testing (CERT) Contractors
- MAC: Medicare Administrative Contractors (MACs)
- RAC: Medicare FFS Recovery Auditors
- SMRC: Supplemental Medical Review Contractor (SMRC)
- UPIC: Unified Program Integrity Contractors (UPICs)

About Each MCRP Contractor

Medicare Administrative Contractors (MACs)

- A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.

Unified Program Integrity Contractors (UPICs)

- UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPIC's perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), and the Medicare-Medicaid data match program (Medi-Medi).

- The UPIC contractors operate in five (5) separate geographical jurisdictions in the United States and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.

    - One example is *SafeGuard Services* or SGS. The SGS teams perform comprehensive problem identification, innovative data analysis, investigation, and research to identify potentially fraudulent Medicare providers, refer resulting cases to law enforcement, and pursue administrative actions to reduce, deter, and prevent fraud, waste, and abuse in the Medicare and Medicaid programs.

***Supplemental Medical Review Contractor* (SMRC)**

- The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements. The focus of the medical reviews may include vulnerabilities identified by CMS data analysis, the

Comprehensive Error Rate Testing (CERT) program, professional organizations, and Federal oversight agencies. At the request of CMS, the SMRC may also carry out other special projects to protect the Medicare Trust Fund.

Comprehensive Error Rate Testing (CERT) Contractors

- Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules. The fiscal year (FY) 2020 Medicare FFS estimated improper payment rate is 6.27 percent, representing $25.74 billion in improper payments, compared to the FY 2019 estimated improper payment rate of 7.25 percent representing $28.91 billion in improper payments ***Click Here*** and scroll down to view the most current improper payment rates by claim type.

Medicare FFS Recovery Auditors (aka "RAC")

- The Medicare Fee for Service (FFS) Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

Review Contractor Directory – CMS' Interactive Map

The Review Contractor Directory - Interactive Map allows you to access state-specific CMS contractor contact information. You may receive correspondence from one or several of these contractors in your state. They may request medical records from you, as they perform business on behalf of CMS. You can use this website to access their contact information including emails, phone numbers and websites. ***Click Here to go to the Map*** and then answer the following questions:

SELF REVIEW QUESTIONS

1. The CMS Division Responsible for SMRC Contractors throughout all of the United States is _____.

2. _____ serves as the focal point for Fraud, Waste and Abuse oversight for the Medicare Advantage and Prescription Drug Plans for all 50 states. It also performs oversight of the PPI MEDIC and the Part D RAC.

3. When you use the interactive map, this company is the Recovery Audit Contractor for New York State for both Medicare and National DME/HHH.

4. When looking at the RAC contractors for Texas, what do you find?

5. _____ is the UPIC for the State of Florida.

Categories of Denials

The Medicare Claims Review Program or "MCRP" involves both Technical and Clinical categories of denials performed by CMS contractors. It is a complex system, perfect to use as a teaching example! There are two categories of denials:

1. **Technical Denial & Rejections**
   - This topic has been covered in previous lessons, but let's review again!
     - A technical denial is an error made when filing the claim, such as lack of appropriate coordination of benefits and filing to secondary insurance first. When a critical error gets through the scrubber, the insurance payer software may reject the claim due an error. Correcting these types of errors quickly and refiling the claim typically results in payment. These claims often "fall through the cracks" and can be suspended. Lack of tending to rejected claims can cause huge revenue loss for your organization

2. **Clinical Denial**
   - A clinical denial is the denial of payment by an insurance payor on the basis of medical necessity, length of stay or level of care. Special review of documentation, payer guidelines and often appealing the claim is required to obtain payment.
     - When a payer sends an RFI (Request for Information), the payer is auditing the claim data against medical record documentation.
     - Untimely response to the RFI will result in a denial.
     - Sending inappropriate or the wrong information to the payer will result in a denial.
     - These types of denials can potentially trigger a larger audit, probe, abuse or fraud investigation of your organization.

CMS estimates the Medicare FFS improper payment rate through the Comprehensive Error Rate Testing (CERT) program. Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules.

Two Types of Audits and Claims Reviews

Audits or claim reviews are conducted either prepayment or postpayment of the claim. Let's review each one, starting with the PRE-PAYMENT Reviews.

PREPAYMENT CLAIM REVIEW PROGRAMS
National Correct Coding Initiative (NCCI) Edits
Medically Unlikely Edits (MUEs
Medical Review (MR)

National Correct Coding Initiative (NCCI) Edits

Basically, NCCI edits review codes on a claim to determine whether the items can be filed and paid separately or bundled into one code. The claims scrubber software within your practice management system will analyze the codes on the claim and compare the information to the NCCI edits. Items that

should be bundled will be suspended for further review. Your office cannot bill a patient for a service denied due to denied claims based on the NCCI edits.

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The Centers for Medicare & Medicaid Services (CMS) owns the NCCI program and is responsible for all decisions regarding its contents. The CMS annually updates the National Correct Coding Initiative Policy Manual for Medicare Services. The NCCI Policy Manual should be used by Medicare Administrative Contractors (MACs) as a general reference tool that explains the rationale for NCCI edits.

These edits are updated at least quarterly and revised in your practice management system through updates to the software. Information about the National Correct Coding Initiative (NCCI) can be found in the Internet-Only Manual, Publication 100-04, Section 20.9 of Chapter 23 of the Medicare Claims Processing Manual at:

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

When appealing NCCI edit denials, it is important to review the claim to ensure the appropriate modifier has been used. If not, review the documentation and appropriate append the modifier to the line item on the claim and submit your appeal with the documentation.

Modifiers allowed with the National Correct Coding Initiative (NCCI) procedure to procedure (PTP) edits to use under appropriate clinical circumstances to bypass an NCCI PTP edit include:

- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers: 24, 25, 57, 58, 78, 79
- Other modifiers: 27, 59, 91, XE, XS, XP, XU

NOTE: Overuse of such modifiers just to get claims passed through the edits for payment can trigger an audit, probe or investigation.

For more information on the use of modifiers please see the CMS Claims Processing Manual, Publication 100-04, Chapter 12 (PDF) and the NCCI Policy Manual for Medicare Services, Chapter 1, Section E.

Medically Unlikely Edit (MUE)

This audit feature analyzes a claim to determine if the appropriate number of units are being reported per line item. It is a unit of service (USO) edit for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service (DOS). The ideal MUE is the maximum unit of service that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims.

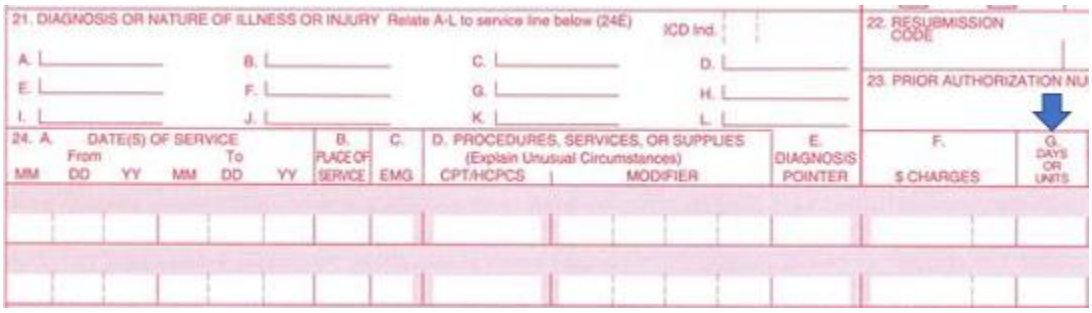
MUEs are designed to reduce errors due to clerical entries and incorrect coding based on criteria such as anatomic considerations, Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and claims data.

MUEs are adjudicated either as claim line edits or DOS edits.

- If the MUE is a claim line edit, each line of a claim is adjudicated against the MUE value for the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code on that claim line.
- If the UOS on the claim line exceeds the MUE value, all UOS for that claim line are denied. If the same code is reported on more than one line of a claim by using CPT modifiers, each line of the claim is adjudicated separately against the MUE value of the code on that claim line.

For Medically Unlikely Edits (MUEs) that are adjudicated as claim line edits, each line of a claim is adjudicated separately against the MUE value for the code on that line. The appropriate use of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary UOS in excess of an MUE value.

24.G is the field being audited for MUE compliance:



These edits are updated at least quarterly and revised in your practice management system through updates to the software.

If a provider/supplier, healthcare organization, or other interested party believes that a Medically Unlikely Edit (MUE) value should be modified, CMS directs you to email the CMS NCCI Mailbox at **NCCIPTPMUE@cms.hhs.gov**. The party should include, exact codes, an alternative MUE value, the rationale for the alternative MUE value and any supporting documentation. Please note that NCCI does not accept PHI/PPI and ask that you do not submit supporting documentation with patient information.

Click Here for the CMS Medically Unlikely Edits webpage for more information you may need to determine an appeal approach.

Medical Review (MR)

Medical reviews involve the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing, and medical necessity requirements. As you can note in the table above, Medical Reviews are part of both the pre and post payment programs.

Medical reviews identify errors through claims analysis and/or medical record review activities. Contractors use this information to help ensure they provide proper Medicare payments (and recover any

improper payments if the claim was already paid). Contractors also provide education to help ensure future compliance.

A Medicare contractor may use any relevant information they deem necessary to make a prepayment or post-payment claim review determination. This includes any documentation submitted with the claim or through an additional documentation request.

Medical review activities, such as the ***Targeted Probe and Educate*** program, are based on data analysis and other findings indicative of a potential vulnerability. This might include findings from the Comprehensive Error Rate Testing (CERT) Contractor, the Office of Inspector General (OIG), the Government Accountability Office (GAO), or the Recovery Audit Contractors (RACs).

- ***CMS's Targeted Probe and Educate (TPE) program***
  This program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help. TPE is intended to increase accuracy in very specific areas. MACs use data analysis to identify:

  - providers and suppliers who have high claim error rates or unusual billing practices, and
  - items and services that have high national error rates and are a financial risk to Medicare.

MACs can choose which providers need TPE. Providers whose claims are compliant with Medicare policy won't be chosen for TPE.

Medicare medical review contractors are ***required*** to follow CMS coverage instructions, as well as pertinent coding and billing materials. Coverage criteria may be outlined in statute and/or regulation, and may be further defined in:

- **National Coverage Determinations (NCDs)**
  Medicare coverage is limited to items and services that are *reasonable and necessary* for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).
  - The NCDs are developed by CMS to describe the circumstances for which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs.
  - If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision.
  - NCDs are accessible via the Medicare Coverage Database or the Medicare National Coverage Determination Manual (PDF).

- **Local Coverage Determinations (LCDs)**
  In the absence of a national coverage policy, an item or service may be covered at the discretion of the MACs based on a local coverage determination (LCD) and Article.
  - You need to reference both the Article and LCD for full information about a particular service to understand documentation, coding and medical necessity requirements.

- You can find this information on your MAC website or by going to the Nation CMS Medicare Coverage Database.
- The Medicare Program Integrity Manual (PIM), Chapter 13 reports National CMS guidelines for MACs to use when developing LCDs. ***Click Here*** for more information.
- ***Click Here*** to search for NCDs, LCDs and articles through the Medicare Coverage Database (MCD) Search software.

- **CMS' Manuals**: CMS manuals (such as the Benefit Policy, Claims Processing, and Program Integrity Manuals) provide further interpretative medical review guidance for medical review activities. Review the section below which provides details and how to access the Internet Only Manuals (IOM).

CMS Online Manuals

Medicare Publishes Guidelines for Review Contractors Online

The Online Manual System is used by CMS program components, partners, contractors, and State Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. We have access to this information too! Because this information is public, CMS expects health care providers to utilize this information.

In 2003, CMS transformed the CMS Program Manuals into a web user-friendly presentation and renamed it the *CMS Online Manual System*. The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. Information in these manuals can be used to help you choose wording in an appeal letter.

Locate the following documents on the CMS website and remember, these documents can be updated frequently.

Step 1: Go to www.cms.gov.

Step 2: Click on the "Regulations & Guidance" tab on the main webpage tool bar.

Step 3: Save this page as a "favorite" for future reference on your computer.

Step 4: Under the column labeled "Guidance" locate and click on "Manuals" which takes you to the Manuals webpage.

Step 5: In the left column under "Manuals" choose "Internet-Only Manuals (IOMs)" which brings you to a list of hyperlinks taking you to publications.

Step 6: Locate and choose the *Medicare Claims Processing Manual* which is listed as publication **100-04** and also the *Program Integrity Manual* **100-08**.

Publication #	Title
100	Introduction
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual
100-03	Medicare National Coverage Determinations (NCD) Manual
100-04	Medicare Claims Processing Manual
100-05	Medicare Secondary Payer Manual
100-06	Medicare Financial Management Manual
100-07	State Operations Manual
100-08	Medicare Program Integrity Manual
100-09	Medicare Contractor Beneficiary and Provider Communications Manual

See Chapter 12 and other Chapters which may related to services billed by your organization

See Chapter 3 "Verifying Potential Errors and Taking Corrective Actions

We highly recommend downloading and saving the information below as practice and to become familiar with the manual, chapters and content.

Medicare Claims Processing Manual

- Chapter 12 – Physician/Nonphysician Practitioners

- Locate at least one other chapter applicable to the type of claims filed by your organization (laboratory services, ambulance, FQHC, Indian Health Services, Ambulatory Surgical Centers, etc.)

Program Integrity Manual
Section 3.3.2 – Medical Review Guidance

Postpayment Claim Review Programs

POSTPAYMENT CLAIM REVIEW PROGRAMS
Comprehensive Error Rate Testing (CERT) Program
Recovery Audit Program
Medical Review (MR)

Comprehensive Error Rate Testing (CERT) Program

CERT contractors perform a *complex* medical review of the claim and the supporting documentation to determine whether the claim was paid appropriately according to Medicare coverage, payment, coding, and billing rules. CMS calculates a national Medicare FFS improper payment rate and improper payment rates by service type to accurately measure the performance of the MACs and gain insight into the causes of errors. CMS publishes the results of these reviews annually. The Medicare FFS Improper Payment Rate is a good indicator of how claim errors in the Medicare FFS Program impact the Medicare Trust Fund. CERT errors are listed by the following categories:

Type of Error	Description
No Documentation	Provider or supplier fails to respond to repeated requests for the medical records or they do not have the requested documentation.
Insufficient Documentation	Submitted medical documentation is inadequate to support payment for the services billed; 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; or a specific documentation element that is required as a condition of payment is missing (for example, a physician signature on an order).
Medical Necessity	There is adequate documentation in the medical records to make the informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.

Incorrect Coding	Provider or supplier submits medical documentation supporting: • A different code than was billed • The service was performed by someone other than the billing provider or supplier • The billed service was unbundled • A beneficiary was discharged to a site other than the one coded on a claim
Other	When a claim error does not fit in any other category (for example, duplicate payment error, non-covered, or unallowable service).

Watch this 4-minute CMS video and answer the questions below.

Provider Minute Video: The Importance of Proper Documentation

Find out how it affects items/services, claim payment, and medical review in the Provider Minute*: The Importance of Proper Documentation* 4-minute video. Learn about:

- How proper documentation supports medical necessity
- Top five documentation errors
- How to submit documentation for a *Comprehensive Error Rate Testing* review
- How your Medicare Administrative Contractor can help

Click Here to go to the CMS webpage which provides a link to this video.

SELF REVIEW QUESTIONS (VIDEO)

6. "CERT" is the acronym for the _____ program.

7. Consequences of improper documentation can result in:

8. What is the first tip given in the video when responding to a CERT request for documentation?

9. What is the second records request tip when responding to a CERT request for documentation?

10. What is the last tip provided in the video when responding to a CERT request for documentation?

11. Documentation should answer these questions:

12. What documents are referenced for additional information about documentation and authentication of records?

The Recovery Audit Program

Most hospitals and clinics are familiar with the "RAC" or Recovery Audit Contractor program – now referred to as the "Recovery Audit Program" by CMS.

RAC's review claims on a post-payment basis by auditing past Medicare FFS claim data for potential overpayments or underpayments, reviewing medical records when necessary to make appropriate determinations. When performing these reviews, Recovery Auditors follow Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions, and the respective MAC's Local Coverage Determinations (LCDs). Recovery Auditors do not develop or apply their own coverage, payment, or billing policies.

In general, Recovery Auditors do not review a claim previously reviewed by another entity. Recovery Auditors analyze claim data using their proprietary software to identify claims that clearly or likely contain improper payments.

The chart below summarizes the types of pre- and post-review programs under Medicare:

PREPAYMENT CLAIM REVIEW PROGRAMS	POSTPAYMENT CLAIM REVIEW PROGRAMS
National Correct Coding Initiative (NCCI) Edits	Comprehensive Error Rate Testing (CERT) Program
Medically Unlikely Edits (MUEs	Recovery Audit Program
Medical Review (MR)	Medical Review (MR)

ANSWERS TO SELF REVIEW QUESTIONS

1. The CMS Division Responsible for SMRC Contractors throughout all of the United States is _____.

   - **Noridian Healthcare Solutions, LLC**

2. _____ serves as the focal point for Fraud, Waste and Abuse oversight for the Medicare Advantage and Prescription Drug Plans for all 50 states. It also performs oversight of the PPI MEDIC and the Part D RAC.

   - **Division of Prescription Drug Audits (DPDA)**

3. When you use the interactive map, this company is the Recovery Audit Contractor for New York State for both Medicare and National DME/HHH.

    - **Performant Recovery**

4. When looking at the RAC contractors for Texas, what do you find?

    - **Region 2 Medicare RAC: Cotiviti, LLC**
    - **Region 5 National DME/HHH: Performant Recovery**

5. _____ is the UPIC for the State of Florida.

    - **SafeGuard Services (SGS)**

6. "CERT" is the acronym for the _____ program.

    - **Comprehensive Error Rate Testing**

7. Consequences of improper documentation can result in:

    - **Loss of financial revenue**
        - **Causes having to appeal to get paid**

    - **Patient Care Errors**

8. What is the first tip given in the video when responding to a CERT request for documentation?

    - **The first tip is to send ALL associated documentation supporting the item or service billed**
        - **This may mean sending documentation from a previous visit to demonstrate an order or medical necessity, lab test results and information in other parts of the patient's chart.**

9. What is the second records request tip when responding to a CERT request for documentation?

    - **Respond timely. Send documentation by the deadline in the request**

10. What is the last tip provided in the video when responding to a CERT request for documentation?

    - **Review the documentation**

11. Documentation should answer these questions:

- Answer the Who, What, When, Why and How to verify the service performed for medical necessity

12. What documents are referenced for additional information about documentation and authentication of records?

    - **Complying with Medical Record Documentation Requirements**
    - **Complying with Medicare Signature Requirements**