



CENTERS FOR MEDICARE & MEDICAID SERVICES

1) RE: CERT– **TECH STOP** REQUEST FOR MEDICAL RECORDS

2) Provider #: **0000000**

3) CID #: **#####**

4) Due Date: **MM/DD/YY**

**BILLING PROVIDER/PRACTICE NAME
ADDRESS
CITY, STATE XXXX-XXXX**

Your group practice/provider name & address is customarily taken from the submitted Medicare Part B sampled claim.

Verify it for accuracy and whether still valid.

Dear Doctor/Medicare Provider:

A request for medical records/documentation was previously sent to you on you under a federally mandated program to monitor and improve the **accuracy of Medicare payments** to physicians and other providers. The CERT Documentation Contractor received the requested documentation to support the claim for CID # **#####** and we thank you for your response. However, additional information is needed to complete the review on this claim.

Your response is required even if records for the sampled beneficiary dates of service cannot be provided. In accordance with 42 U.S.C. § 1320C-5 (a) (3) and § 1833 of the Social Security Act, as a Medicare provider, you must provide documentation and medical records to the CERT contractor upon request to support claims for Medicare services. It is your responsibility to obtain additional supporting documentation from a third party (hospital, nursing home, etc.), as necessary. Providing medical records of Medicare patients to the Comprehensive Error Rate Testing (CERT) contractor is within the scope of compliance with the Health Insurance Portability and Accountability Act (HIPAA).

This request for medical records is the result of an initial review of the documentation submitted and the following identifying items are further required or missing:

Need a copy of the glucose test results for MM/DD/YY. Not included in records previously received.

Specifics of what is needed will be on this page and **repeated** again on the bar coded page.

When returning the additional documentation, please check off the items on the **bar coded cover sheet as these are the specified document(s) needed for the identified claim.**

In order to expedite the receipt and processing of your medical records/documentation, **please submit them no later than MM/DD/YY, including the bar coded cover sheet.** If you have questions regarding this request for additional information, please call the CERT Documentation Office at (301) 957-2380.

Thank you for your cooperation and prompt attention in this matter.

Sincerely yours,

Douglas Crouch
Program Director
CERT Documentation Contractor
Enclosures



Instructions for Submitting Requested Medical Records/Documentation

The **preferred** method for receipt of medical records/documentation is via **FAX** to:

(240) 568-6222

CDC FAX Number

Your cooperation in FAXING the specified documents as soon as possible is greatly appreciated. Should you require additional time to fill this request for medical records/documentation, **please call the CDC Documentation Office at (301) 957-2380 to get an extension to the due date.**

Please adhere to the following directions when **faxing**:

1. Send the **specific documents listed on the Bar Coded Cover Sheet** to support the services of each claim identified on the Medical Records/Documentation Pull List.
2. Place the bar coded cover sheet in front of the medical records/documentation being submitted for review. Submit multiple records with the corresponding Bar Coded Cover Sheet as separator pages.
3. Please make sure all pages are complete, legible, and include both sides and page edges where applicable.

If unable to FAX document, please contact CERT Documentation Office at (301) 957-2380.

Call CDC if problems arise while faxing.

Please adhere to the following directions if you are **mailing** the requested letters:

1. Send the specific records listed on the Bar Coded Cover Sheet to support the services on the claim identified on the Medical Records/Documentation Pull List.
2. Photocopy each record. Please make sure all copies are complete and legible; include both sides of each page, including page edges.
3. Place the bar coded cover sheet in front of the medical records/documentation being submitted for review. Submit multiple records with the corresponding Bar Coded Cover Sheet as separator pages. Mail medical record documentation to:

**CERT Documentation Office
Attn CID #: #####
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701**

CDC Mailing Address

We are not authorized to reimburse providers/suppliers for the cost of claims/medical records duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT Documentation Office.

If the requested information is not received within this time period, CERT CDC will assume the services on the claim were not rendered. Your local Medicare contractor will pursue overpayment recoupment for these undocumented services.

Page 3 Summary

- The above directions for faxing or mailing information to the CDC are essentially identical. Always be sure to include the **bar coded sheet** and the **CID #**.
- The CDC will not pay for in house or outsourced copying of requested records. Don't send them bills or invoices.
- To obtain the appropriate documentation, you should refer to both the **Bar Coded Sheet** (lists needed records), and the **Medical Records/Documentation Pull List** (shows the specific codes and rendering provider's #).

Medical Records/Documentation Pull List

Medicare Part B Provider
 Provider ID#: Billing Provider 0000000 Request Date: MM/DD/YY
 Patient Name: LAST, FIRST NAME Date of Birth: MM/DD/YY
 Service From/To Dates: MM/DD/YY – MM/DD/YY CERT Claim ID (CID): #####
 HICNUM: XXXXXXXXX X Claim Date*: MM/DD/YY
 Claim Control Number (CCN): 00##### Performing Provider:
 Address ID: Bill Type: 0

ICD-9 Codes

Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*The **Claim Date** is NOT the date of service. It is an “entry” date. This date represents the day when processing of your submitted claim first began at Palmetto GBA OH/WV. (Please see **Service From/To Dates** above for date(s) of service.)

Line Item Date	Revenue Code	Performing Provider	Provider Specialty	Diagnosis Code	HCPCS Code	HCPCS Modifier 1	HCPCS Modifier 2	HCPCS Modifier 3	HCPCS Modifier 4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fields are blank in TECH STOP letter.

Request Letter HINTS

- Only the providers’ Medicare Part B numbers will be shown. No actual names and designations are currently given. **Be careful** to obtain the correct records for the specific CCN listed above, especially **IF multiple providers from your practice performed services** for the patient during the same time frames outlined in the letter. This is particularly true for inpatient hospital care.
- Not a violation of HIPAA to send records. NO SIGNED RELEASE NEEDED. Notify your staff and medical records department of this.
EXCEPTION: Psychotherapy where counseling session note contains *confidential exchanges* between the therapist and patient. However, psychiatric records, which are social/medical/administrative in nature, don’t require special authorization, e.g., medication checks.
- **Participation in this review is not optional.** No response = no records = overpayment, and Palmetto GBA OH/WV must request a refund from your practice. You would have the same appeal rights with Palmetto GBA as in any other situation; however, this could be an unnecessary, time-consuming process.

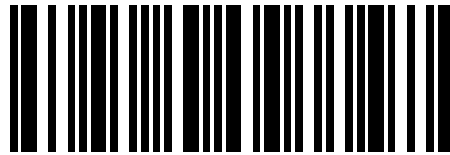
PLACE THIS SHEET IN FRONT OF THE RECORD
(NO Fax Cover Sheet Needed)

Medicare CERT Documentation Contractor
CMS 500-99-0019/0002 PSC CERT

Medicare Part B Provider

Report Date:

Claim Control Number: 00##### Contractor Type: Part B
Provider Number: 0000000 (Billing Provider) Service From/To: MM/DD/YY – MM/DD/YY
Contractor Number #: 00883 (Palmetto GBA OH/WV) CID Number: #####



BAR CODE
Unique to each CID #

* C D C # # # # # *

CID #
Unique to each sampled claim and records

Letter Sequence:

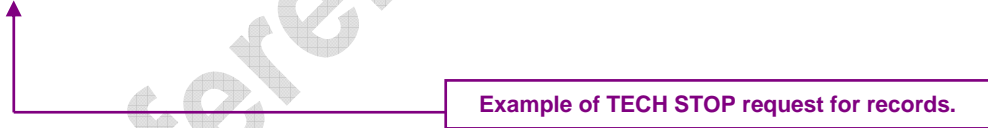
Tech Stop Letter

Universe Date*:

MM/DD/YY

The documents listed below may be required in support of a medical claim review. Please provide all of the pertinent medical records/documentation listed below and any additional documentation to support the above listed claim for the specified date(s) of service:

Need a copy of the glucose test results for MM/DD/YY. Not included in records previously received.



Please copy both sides of each page and please DO NOT cut off page edges when copying. **Please send the original copy of this bar coded cover sheet with a copy of the medical record documents noted above.** The record documents must be with the original cover sheet in order to ensure proper validation of receipt by the CERT Documentation Office. Please fax documentation to: (240) 568-6222. If unable to fax documents, please send information to the address noted below.

CERT Documentation Office
Attn: CID #####
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

*The **Universe Date = Claim Date** (see page 4) and is **NOT** the date of service. It is an “entry” date. This date represents the day when processing of your submitted claim first began at Palmetto GBA OH/WV. (Please see **Service From/To Dates** above for date(s) of service.)