Comprehensive Error Rate Testing (CERT): Cardiac Procedures Checklist

Document Description	
All documentation to support all codes billed	
Anesthesia record and/or sedation record	
Diagnostic test results/reports, including imaging reports	
Discharge summary/discharge notes	
Emergency room records	
Evaluation & management/counseling notes	
History and physical (PCP, other physicians related to treatment to support medical necessity of procedure)	
Hospital history and physical	
Implant log	
Intra-operative record	
Medication Administration Records	
Nurse's notes	
Observation orders and progress notes — each day	
Operative reports and procedure notes	
Peri-operative record	
Physician orders or intent to order for the dates of service billed	
Physician/nonphysician practitioner (NPP) progress notes	
Plan of care (may be part of evaluation)	
Psychosocial evaluation, if applicable	
Recovery room record	
Reevaluations, when they have been performed	
Any Advanced Beneficiary Notice of Noncoverage (ABN) issued to the beneficiary for each date of service and each specific service an ABN was issued	
For electronic health records, send a copy of the electronic signature policy and procedures that describe how notes and orders are signed and dated	
The following records from outside offices should be obtained prior to submitting medical records for review to Medicare Contractors if relevant to the procedure	
Clinic/office notes	
Consultation reports (OP or IP)	
NCD 20.32 DRG 266/267 The patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals. The heart team concept embodies collaboration and dedication across medical specialties to offer optimal patient-centered care. **The heart team includes the following:** ✓ **Cardiac surgeon and an interventional cardiologist experienced in the care and treatment of aortic stenosis who have:**	

✓ **Independently examined the patient face-to-face, evaluated the patient's suitability for surgical aortic valve replacement (SAVR), TAVR or medical or palliative therapy.** ✓ **Documented and made available to the other heart team members the rationale for their clinical judgment.** ✓ Providers from other physician groups as well as advanced patient practitioners, nurses, research personnel and administrators. The heart team's interventional cardiologist(s) and cardiac surgeon(s) **must jointly participate** in the intra-operative technical aspects of TAVR.	
Shared Decision Making (SDM) Requirements Met **Medicare providers must document SDM encounters in medical records, prior to implanting Left Atrial Appendage Closures (LAACs) and or Implantable Automatic Defibrillators (ICDs). SDM integrates the use of evidence-based decision tools**, which often include treatment pictograms to characterize benefits and harms. This helps patients better understand treatment options and choose the most desirable treatment course. • SDM occurred prior to LAAC or ICD implantation • Benefits and harms discussed with the patient • Any necessary calculations related to risk scoring • The name of the evidence based SDM tool(s) used to aid the patient in better understanding treatment options and choosing the treatment course • The best rationale to seek a non-pharmacologic alternative to warfarin, considering the safety and effectiveness of the device compared to anticoagulation • The result of the evidence based SDM tool, after the provider informs the patient of the risks of LAAC or ICD implantation and any reasonable alternative management strategies	
The name of the tool used and score total must be contained within the medical record documentation submitted.	
NCD 20.34 DRG 274 A formal shared decision-making interaction with an **independent, non-interventional physician — physician other than implanter, like a primary care physician (PCP), non-interventional cardiologist, or neurologist** using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC interaction must be documented in the medical record.	
NCD 20.4 DRG 226/227 A formal shared decision-making interaction with physician or qualified nonphysician practitioner, like a physician assistant, nurse practitioner, or clinical nurse specialist using an evidence-based decision tool on ICDs prior to initial ICD implantation must be documented. The shared decision-making encounter may occur at a separate visit.	
BEFORE YOU SEND. Check for signatures on office/progress notes or other medical record documentation. If the signature(s) are missing or illegible, send a completed signature attestation (find a sample attestation at https://c3hub.certrc.cms.gov/). If the signature(s) are illegible, you may also send a signature log.	

For additional cardiovascular services resources see:

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Beneficiary Engagement and Incentives Models: Shared Decision-Making Model

DRG 266 and DRG 267: Endovascular Cardiac Valve Replacement

Closing the Gap: Left Atrial Appendage Closure Module

DRG 226 and 227 Cardiac Defibrillator Implant without Cardiac Catheterization with/without MCC

American College of Cardiology (ACC) Cardiosmart's AF Treatment Options

Colorado Program for Patient Centered Decisions

National Institute for Clinical Excellence (NICE) Patient Decision Aid on AF Treatment Options

SPARC — Stroke Prevention in Atrial Fibrillation Risk Tool

Implantable Defibrillators Decision Memo

Percutaneous Left Atrial Appendage (LAA) Closure Therapy Decision Memo

CMS IOM PUB 100-03 Chapter 1 §20 (Cardiovascular System)

Collaborative Patient Care is a Provider Partnership Fact Sheet MLN909340