



MLN Matters®



Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3812

MLN Matters Number: MM3812

Related CR Release Date: May 2, 2005

Related CR Transmittal #: 111

Effective Date: October 3, 2005

Implementation Date: October 3, 2005

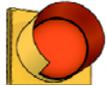
Instructions to Revise the Comprehensive Error Rate Testing (CERT) Shared System Module Including Instructions to Install and Operate the Revised CERT Module for Calculating Fiscal Intermediary (FI) Line Level Error Rates

Note: This article was updated on February 7, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs)

Provider Action Needed



STOP – Impact to You

This article includes information from Change Request (CR) 3812, which revises Medicare systems to capture the claim level covered charge amount into the Medicare Initial Allowed Charge field in time for Medicare FIs computing provider compliance error rates beginning October 3, 2005.



CAUTION – What You Need to Know

The provider compliance error rate is a good indicator of how well Medicare carriers/FIs are educating their provider communities. Currently, carriers, including durable medical equipment regional carriers (DMERCs), are able to compute this error rate. This change will allow FIs to do the same.



GO – What You Need to Do

Providers billing FIs may want to be familiar with how this error rate is computed and understand that Medicare will use these error rates to help focus on areas of improvement in order to reduce claims errors. Providers can help reduce this error rate by carefully following billing instructions from their Medicare

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contractor (carrier or intermediary) and their billing agent and participating in education activities provided by their Medicare contractor.

Background

The Centers for Medicare & Medicaid Services (CMS) believes that strong outcome-oriented performance measures are a good way to 1) assess the degree to which a government program is accomplishing its mission, and 2) identify improvement opportunities. Therefore, CMS established the following programs to monitor the accuracy of the Medicare Fee-for-Service (FFS) program:

- **The Comprehensive Error Rate Testing (CERT) program** – This program calculates the error rates for Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and FIs; and
- **The Hospital Payment Monitoring Program (HPMP)** – This program calculates the error rate for the Quality Improvement Organizations (QIOs).

The national paid claims error rate is a combination of error rates calculated by the CERT contractor and HPMP with each component representing about 50% of the error rate.

For Fiscal Year (FY) 2004, the performance measurement process for the Medicare FFS Program is described in the FY2004 *Improper Medicare Fee-for-Service Payments Report*.

For FY 1996 to 2002, the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates. The OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Carriers/DMERCs/FIs/QIOs erroneously paid). However, CMS has decided to calculate a number of additional rates 1) to better measure the performance of the Carriers/DMERCs/FIs and 2) to gain insight about the causes of errors. These additional rates include:

- **Provider compliance error rate** (which measures how well providers prepared claims for submission), and
- **Contractor-specific paid claims error rates** (which measure how accurately each specific Carrier/DMERC/FI/QIO made claims payment decisions).

For the FY2004 *Improper Medicare Fee-for-Service Payments Report*, CMS calculated the Medicare Fee-for-Service error rate and improper payment estimate using the following OIG-approved methodology:

- A sample of approximately 160,803 claims submitted in calendar year 2003 were randomly selected;
- Medical records were requested from providers that submitted the claims in the sample;
- The claims and medical records were reviewed to see if the claims complied with Medicare coverage, coding, and billing rules;
- Errors were assigned to claims denied or paid incorrectly;
- Providers who did not supply needed documentation were classified as non-responders;
- Non-response claims were treated as errors; and
- Carriers/DMERCs/FIs sent overpayment letters to providers for claims that were overpaid.

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The Provider Compliance Error Rate

One of the rates needed for the *Improper Medicare Fee-for-Service Payments Report* is the **Provider Compliance Error Rate**. This rate is based on how the claims looked when they first arrived at the Carrier/DMERC/FI – before the Carrier/DMERC/FI applied any edits or conducted any reviews. The Provider Compliance Error Rate is a good indicator of how well the Carrier/DMERC/FI is educating the provider community since it measures how well providers prepared claims for submission.

CMS can calculate this rate for carriers and DMERCs because CMS gets information on how claims looked when they arrived at carriers and DMERCs; but CMS cannot calculate this rate for Fiscal Intermediaries (FIs) because CMS does not get information on how claims looked when they arrived at FIs as part of FI reporting. As a result of CR3812, FIs will begin to capture this information on claims they receive.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R111PI.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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