Medicare Program Integrity Manual
Chapter 12 – The Comprehensive Error Rate Testing Program

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(Rev. 774, 03-02-18)

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12.3 - The Comprehensive Error Rate Testing (CERT) Program
(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

The Comprehensive Error Rate Testing (CERT) program produces a national Medicare Fee-for-Service (FFS) improper payment rate that is compliant with the Improper Payments Information Act (IPIA) of 2002, most recently amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012. To meet this objective, the CERT review contractor evaluates a random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or a partial improper payment, depending on the category of error at issue. The CERT program considers any claim that was paid when it should have been denied or that should have been paid at another amount (including both overpayments and underpayments) to be an improper payment. The findings can be projected to the entire universe of Medicare FFS claims because the CERT program ensures a statistically valid random sample. Therefore, the improper payment rate calculated from this sample is considered to be reflective of all of the paid claims in the Medicare FFS program during the year.

The results of the improper payment rate calculation are published annually in the Health and Human Services (HHS) Agency Financial Report, and the CMS Financial Report. More information about the CERT program is available at www.cms.hhs.gov/cert.

12.3.1 - MAC Communication with the CERT Program
(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

A. CERT Staff

CMS CERT Team
Mail Stop C3-09-27
7500 Security Blvd
Baltimore, MD 21244

B. MAC CERT Points of Contact (POCs)

Each MAC shall provide the CERT review contractor with the name, phone number, address, fax number, and email address of a general point of contact (POC) and an information technology (IT) POC. The CERT review contractor will contact the IT POC to handle issues involving the exchange of electronic data. The CERT review contractor will contact the general POC to handle issues related to medical review decisions, payment adjustments, appeals, and other CERT-related issues. The CERT listserv is used to distribute announcements, meeting agendas, and additional CERT information. The

CMS CERT team or CERT review contractor may be contacted to add an individual to the CERT listserv.

C. CERT Information Sources for MACs

- The CMS CERT public Website at www.cms.hhs.gov/cert.

- The CERT Claims Status Website contains sampled claims information; a calendar of events; the CERT Manual; and the feedback, payment adjustment, and appeals tracking systems.

12.3.2 - Overview of the CERT Process

(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

The CERT process begins when claims that have entered the claims processing system are extracted to create a claims universe file. This file is transmitted to the CMS Data Center (CMSDC) on a daily basis. A random sample from the claims universe file is selected for inclusion in the CERT sample. The sampled claims are held for a predefined period of time to allow the claim to be processed and paid by the MAC. After this waiting period, the sample information is sent to the MAC as a sampled claim transaction file. The MAC returns specific information about each claim to the CERT review contractor using the sampled claims resolution file, claims history replica file, and the provider address file formats.

The CERT program uses the information obtained from the MAC to request documentation from the provider who submitted the sampled claim. The claim and the supporting documentation are reviewed by CERT program reviewers who determine if the claim was submitted and paid appropriately based upon Medicare coverage, coding and billing rules. The CERT program collects additional information from the MAC for each claim considered to be in error via the feedback process.

12.3.3 – CERT Process Requirements

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

12.3.3.1 - Providing Sample Information to the CERT Review Contractor

(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

All data exchanged between the CMSDC datacenter and the MAC virtual datacenters shall be in an electronic format via NDM CONNECT:DIRECT.

The MAC virtual data centers shall submit a daily file containing information on claims entered during the day, in the formats specified in instructions available to a MAC CERT Point of Contact (see Section 12.3.1 B). MAC virtual data center responses to requests from the CERT program for claim information, shall follow the same instructions.

Claims Universe File

The shared systems will create a mechanism for the MAC virtual data centers to be able to create the claims universe file, which will be transmitted daily to the CMSDC. The file will be processed through a sampling module residing on the server at CMSDC. The datacenters shall ensure that the claims universe file contains all claims except HHA RAP claims and adjustments that have entered the shared claims processing system. Canceled claims are included in the claims universe file because the decision to cancel the claim has not been made by the time the claims universe file is submitted. The datacenters shall ensure that each claim included in the universe file is unique and may only be selected on the day it enters the system.

Sampled Claims Transaction File

The shared systems shall create a mechanism for the datacenters to receive a sampled claims transaction file from the CMS DC on a daily basis. This file will include claims that were sampled from the daily claims universe files.

Sampled Claims Resolution File and Claims History Replica File

The shared systems shall create a mechanism for the datacenters to match the sampled claims transaction file against the shared system claims history file to create a sampled claims resolution file and a claims history replica file. The claims history replica file is comprised of the claims history data file in the shared system format. These files shall be transmitted at the same time to the CMSDC. The resolution file is input to the CERT claim resolution process and the claims history replica file is added to the Claims History Replica database.

The MAC datacenter shall furnish resolution information for all finalized claims included in the transaction file within 5 days of receipt of a request from the CERT review contractor. MACs receiving daily transaction files shall respond with resolution files (on a daily basis for Part A and DME, weekly for Part B). Resolution information on claims that have not finalized by the initial request shall be included at the first opportunity immediately after the claim has finalized.

The MAC datacenter shall provide the sampled claims resolution file(s) and the claims history replica file(s) for each iteration of the claim when the claim number changes within the shared system as a result of adjustments, replicates, or other actions taken by the MAC. The sampled claims transaction file will always contain the claim control number of the original claim.

Claims with Multiple Versions

In many cases, after a provider submits a claim, a contractor or shared system or provider will submit an "adjustment claim," "split claim," or a "replicate claim." An initial claim can have multiple adjustments or iterations made to it. When the sampled claim has been adjusted or otherwise has multiple versions linked to the sampled claim in the MAC claim processing system, the resolution file contains a separate record for each version of the claim. The CERT RC shall review the most current version of the claim that finalized before the date of the transaction file. The CERT RC shall NOT review any version of the claim that finalized after the date of the transaction file. The CERT RC shall use the claim adjudication date in the resolution record to determine when the claim finalized.

No Resolution Claims

If a claim identified on the transaction file is not found on the shared system claims history file, no record should be created for that claim. These are called no-resolution claims. Each MAC shall take all necessary steps to minimize the number of no-resolution claims it submits to the CERT review contractor each year. The MAC may obtain a list of no-resolution claims for a given time period on either the Status Summary of Sample Claims page or the All Sampled Claims page of the CERT Claims Status Website. If the MAC receives a request for a claim for which the shared system is not able to produce a resolution file, the MAC shall research the claim to determine why a resolution record was not produced.

When the MAC identifies a no-resolution claim where the HICN on the finalized claim is different from the HICN on the transaction request, the MAC shall notify the CERT review contractor of the correct HICN. The MAC shall not enter an acceptable no-resolution reason code for claims that finalized with a HICN different from the HICN on the transaction request.

No-resolution claims with acceptable no-resolution reasons (which are available to a CERT Point of Contact (see Section 12.3.1 B) will not be in the no-resolution rate. Should the MAC discover that one or more no-resolution claims has an acceptable reason, the MAC shall enter the appropriate acceptable no- resolution reason code on the CERT Claim Status Website.

The MAC shall keep documentation on file that supports the acceptable no-resolution reason. The MAC shall make this documentation available to CMS or OIG upon request.

Provider Address File

In addition to the claim resolution file, each MAC datacenter shall transmit the provider address file containing the names; known addresses; and telephone numbers of all the

billing, attending, ordering/referring, and performing/rendering providers for all the claims on the resolution file. Each unique provider and address combination shall be included only once on each provider address file.

12.3.3.2 - Providing Review Information to the CERT Review Contractor

(Rev. 504, Issued: 02-05-14, Effective: 03-06-14, Implementation: 03-06-14)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

The MAC shall indicate, in the resolution file, which claim lines were subject to complex manual medical review or routine manual medical review.

Upon request from CMS or the CERT review contractor, the MAC shall provide all applicable materials used by the MAC to make a payment decision on a CERT sampled claim. Normally, additional material is required on less than ten percent of sampled claims. Each MAC shall provide the requested information to the CERT review contractor within 10 business days of the request.

12.3.3.2.1 - MAC Responsibility After Workload Transition

(Rev.766, Issued: 02-2-02-18, Effective: 03-02-18, Implementation: 03-02-18)

When the workload transitions from one MAC to another, the MAC that assumes the workload shall follow-up on no documentation claims, MAC feedback, appeals, and all other efforts needed to produce an accurate improper payment rate.

The assuming MAC shall not have access to the data until the individual workload has transitioned, unless otherwise negotiated with the outgoing MAC or approved by CMS.

For CERT reporting purposes, any error will be assigned to the MAC that was responsible for the workload at the time the claim was processed.

12.3.3.3 - Providing Feedback Information to the CERT Review Contractor

(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

A. Requests for Feedback Information

- Feedback is the mechanism by which the CERT Review Contractor notifies MACs of decisions where the CERT Review Contractor disagreed with the MAC's decision in adjudicating the claim. It also serves as the mechanism by which the MAC provides the CERT program with corrected pricing, which

allows the program to determine the difference between what was allowed on the original claim and the amount that should have been allowed based on the CERT decision. Approximately twice each month, the CERT review contractor posts a description of errors it has found for each MAC on the Claims Status Website. Each MAC shall complete the required fields for each claim listed on the feedback section of the Website. Feedback batch posting dates are listed on the Claims Status Website under calendar of events and on the main feedback page.

- The MAC shall correctly enter the Recalculated Allowed Amount in MAC feedback for Change in Status claims.

- The “Recalculated Allowed Amount” is not the paid amount. The Recalculated Allowed Amount is the amount paid to the provider (or beneficiary) PLUS any deductible applied to this claim PLUS the copayment amount.

- If co-insurance or deductible was applied to a claim resulting in no payment to the provider, an entry of zero in the recalculated allowed amount results in payment error equal the deductible or co-insurance applied.

- Each MAC shall submit feedback information for all lines within 7 business days after it is posted. If the feedback is not submitted by the end of the response period, the lines will be counted as full payment errors until further information is received. Uncompleted lines will be returned in the next feedback batch. Each MAC shall complete all of the lines in the feedback process prior to the cut-off date for a report.

- A MAC may contact the CERT MAC feedback coordinator at the CERT review contractor to request a meeting about the results of a CERT review.

B. Repricing

The MAC shall calculate the corrected payment amount for each claim on the feedback report. The MAC shall take special care to report accurate information in the recalculated final allowed amount field. The recalculated final allowed amount is the amount that would be allowed for the line if the claim were paid at the level indicated after CERT review. It includes the paid amount, coinsurance, deductibles, and offsets. When appropriate, the MAC shall report recalculated final allowed amounts as the output from a payment calculator such as the PRICER prospective payment system (PPS). The PRICER PPS automatically adds the outlier payments into this output. Therefore the outlier payment amount in value code 17 should not be added or subtracted from the recalculated final allowed amount.

12.3.3.3.1 – Disputing a CERT Decision

(Rev. 774; Issued: 03-02-18; Effective: 03-19-18; Implementation: 03-19-18)

A dispute may be filed in situations in which the MAC does not agree with the final CERT review contractor decision on a claim. The MAC shall indicate the disputed claim on the CERT Claims Status website (CSW) via the feedback process in accordance with this section. Using the appropriate field in the CSW, the MAC shall enter a statement that explains the rationale for filing the dispute. Once a MAC files a dispute on a claim, they should not enter any feedback information on that claim since it will be removed from the feedback batch. The CERT review contractor will conduct a re-review of the disputed claim and issue a new comment via the CERT CSW. If the MAC does not agree with the re-review decision or new reviewer comment, the MAC has the option to escalate the dispute to CMS in the next feedback cycle. The MAC must provide a detailed rationale, via the appropriate field in the CSW, as to why the claims remains in dispute. The CMS dispute panel shall use the medical record, CERT review contractor comments, and MAC comments/rationales to review the disputed claim. The CERT review contractor shall notify the MAC of the CMS dispute panel final decision by way of the CSW. The CMS dispute panel decision will appear as a new reviewer comment, and the claim will appear in the new feedback/change in status cycle.

Each MAC is allowed to file *two* disputed claim*s* per month on or before the last day of each month. Should the MAC choose not to submit a dispute in a given month, the unused opportunity does not carry over to the following month.

When an appeal has been entered for a disputed claim, the MAC shall notify the CERT review contractor immediately in order to halt the dispute process.

12.3.4 - Handling Overpayments and Underpayments, MAC Feedback, and Appeals Resulting From the CERT Findings

(Rev. 686; Issued: 11-10-16; Effective: 12-12-16; Implementation: 12-12-16)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

The instructions in this section apply only to overpayments and underpayments that result from CERT findings. The MAC shall continue to handle overpayments and underpayments resulting from non-CERT findings as instructed in other CMS manuals.

The CERT review contractor notifies the MAC when an underpayment or an overpayment is identified via the CERT Claim Status Website (CSW). The MAC shall adjust the claim to reflect the corrected code and payment amount, and make the appropriate payment or collection. The MAC shall pay or collect the full amount in error as defined by the CERT-identified underpayment or overpayment. If shared systems logic limits the payment correction amount to a sum less than the full amount in error, the MAC shall pay the system allowed amount and educate the provider about future billing amounts. The MAC shall not collect overpayments from Medicare beneficiaries.

The MAC shall use the normal claim adjustment procedures published in Pub 100-04 Claims Processing Manual. The MAC shall use the bill type XXH ("CMS") to indicate the adjustment was due to a CERT review.

For more information about the reason for the payment adjustment, contact the MAC Feedback Coordinator.

The MACs may temporarily suspend reason codes that prevent the adjustment of a CERT-initiated denial claim that will not process due to the age of the claim. The suspension shall only last long enough for the claim to be adjusted. Example: reason code 36200 was not in effect when the initial claim processed. The CERT review contractor has now reviewed the claim and determined that it should be adjusted. The claim will not process because this edit cannot be overridden.

The MAC shall provide the CERT program with the status and actual amounts of overpayment collections and underpayment payments. An overpayment is considered collected when the overpayment amount has been fully or partially collected, through provider overpayment check, offset or other payment arrangement. An overpayment is also considered collected if the MAC has failed to recoup the overpayment amount from the provider in a specified time, and has referred the debt to treasury or another entity. The overpayment is not considered collected when the claim is adjusted or when only the accounts receivable is set-up. Similarly, an underpayment payment is reported only when the payment is made. The MAC shall make adjustments on zero dollar errors to reflect a change in the reason for error. No actual collection or payment is made, and $0 shall be reported as the payment adjustment.

A list of CERT identified overpayments and underpayments are provided to the MAC via the CERT CSW. The list is updated each time the CERT CSW is refreshed. The MAC shall report CERT identified overpayment and underpayment collection information using the CERT payment adjustment section of the CERT CSW. A multiple collection feature is available on the CERT CSW for cases where the collection is received in installments.

By the first business day in April and October, the MAC shall report the required payment adjustment information for all CERT identified overpayments and underpayments that have been collected or paid unless otherwise directed. The MAC should access the payment adjustment section of the CERT CSW to report collection or payment information throughout the year and enter information on an ongoing basis.

Annually, by October 15th MACs shall submit a certification that all required information (e.g., overpayments and underpayments identified by CERT, MAC feedback, appeals, and recoveries) has been completely and accurately entered on the CERT CSW. The MAC's Certifying Official (for example, President, Senior VP, or Contract Project Manager) shall sign the certification and submit it to CMS via the CERT mailbox at: CERT@cms.hhs.gov.

Certification Elements

Certification statements shall include the following:

- MAC Name

- Contractor/Jurisdiction Number
- Date Report Submitted to CMS: [MM/DD/CCYY]
- Subject: Certification Statement: FY__ [Include the appropriate report year in the Subject line.]
- Name of MAC Certifying Official
- Title of MAC Certifying Official
- A statement certifying the completeness and accuracy of the information entered in the Claims Status Website.

12.3.5 - Handling Appeals Resulting From CERT Initiated Denials

(Rev. 686; Issued: 11-10-16; Effective: 12-12-16; Implementation: 12-12-16)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

The MAC shall process appeals stemming from a CERT-initiated denial. The MAC shall ensure that the appeal is handled appropriately as instructed in other CMS manuals.

The MAC shall notify the CERT review contractor, using the CERT Claims Status Website (CSW), when a CERT sampled claim is appealed. No further review shall be conducted by the CERT review contractor after the MAC has entered an appeal on the CERT CSW. This includes instances in which additional documentation is received to support the claim. Medical records for the appealed CERT claim may be obtained by contacting the CERT appeals coordinator via the appeals page on the CERT CSW. The MAC shall enter all available information for MAC feedback and appeals for CERT sampled claims by the cut-off date listed on the CERT CSW calendar. Appeal determinations entered into the CERT appeals tracking system by the specified due date will be reflected in the report.

12.3.5.1 – CERT Appeal Results

(Rev. 504, Issued: 02-05-14, Effective: 03-06-14, Implementation: 03-06-14)

It is essential that all CERT appeals be expedited and that data be corrected and finalized in order to ensure its inclusion in the final national and contractor level calculations.

- In order to finalize an appeal, the MAC shall enter the "Date Appeal Process Finalized". The MAC shall enter the date for each level of appeal.

- The "Corrected Contractor Recalc Final Allowed Chg" is not the paid amount. The "Corrected Contractor Recalc Final Allowed Chg" is the Final Allowed Charge (or the Gross Allowed Charge for Part A).

- If co-insurance or deductible was applied to a claim resulting in no payment to the provider, an entry of zero in the recalculated allowed amount results in payment error equal the deductible or co-insurance applied.

- For example, if $1,100 deductible is applied to a claim resulting in 0 claim paid amount, an entry of zero in the recalculated allowed amount results in a payment error of $1,100.

- The contractor SHALL access the claim status website and correct any incorrect entries.

12.3.6 – Disseminating CERT Information

(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

Each MAC shall disseminate information concerning the CERT program to the provider community. Each MAC shall educate the provider community about the CERT program and the importance of responding to CERT requests for medical documentation. A MAC shall disclose the review status and the result of a review to the provider upon request. The MAC shall obtain the review information from the Claims Status Website.

12.3.7 – Annual Improper Payment Reduction Strategy (IPRS)

(Rev. 622, Issued: 10-30-15, Effective: 12-07-15, Implementation: 12-07-15)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

The annual Improper Payment Reduction Strategy (IPRS) is a problem-focused, outcome-based operational plan developed by the Medicare Administrative Contractor (MAC) that identifies risks to the Medicare Trust Fund and describes the improper payment interventions to be implemented to ensure proper payments and address the risks. The IPRS addresses both provider- and service-specific vulnerabilities and includes a prioritization of the problems based on data analysis findings and the availability of resources.

The MAC shall submit an IPRS as directed by the Statement of Work and Contracting Officer's Representative (COR). The current IPRS shall be updated or revised as required by the COR after review by the Business Function Leads (BFLs) (MR, CERT and POE) and the Regional Office (RO) Technical Monitor (TM) MR staff.

See Pub 100-08 Chapter 7, Section 7.1 for specific instructions on the IPRS.

12.3.8 – Contacting Non-Responders and Documentation Requests

(Rev. 691, Issued: 12-16-16 Effective: 01-19-17, Implementation: 01-19-17)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

A. The CERT Claims Status Website

Cases where requested documentation has not been received will be posted on the Outstanding Documentation section of the CERT Claims Status Website (CSW). If the MAC has the requested information, the MAC may submit the documentation to the CERT review contractor.

B. Contacting Non-Responders

The CERT Review Contractor posts Error Code 99 to the CERT CSW on the 76th day from the date the first request letter was sent.

In response to the display of Error Code 99 on the CERT CSW, the MAC may proceed at their discretion by doing one of the following:

1. Contact those providers who have failed to submit medical records and encourage them to submit the requested records to the CERT review contractor for review;

2. Collect the overpayment immediately in accordance with PIM 12.3.4.; or

3. Collect the overpayment within 10 business days of the deadline for entering, on the CERT CSW, AC feedback and change in status information to be included in the report (i.e., the annual/November report).

A MAC shall not contact any provider selected for CERT review until 20 days after the CERT initial request has been reported on the CERT CSW. A MAC may contact third party providers and encourage them to send the needed records to the CERT review contractor.

When contacting the provider, the MAC shall request the provider to include the barcode sheet or the CERT claim identification number at the top of the medical record.

C. Customizing Address

Each MAC shall verify the address of providers that had claims selected for CERT review. Should the MAC determine that the address in the CERT CSW is inaccurate, the MAC shall notify the CERT documentation contractor using the provider address modification tool on the CERT Provider website.

D. Additional Documentation Requests

A MAC may contact providers when an additional documentation request (ADR) is issued. ADR claims can be found on the CERT CSW.

E. Request Letters

When requesting medical records from providers, the CERT documentation contractor shall use the CMS-approved request letters, found at www.certdoc.org for MACs and at www.CERTprovider.com for all providers and suppliers. The CERT documentation contractor shall send the request letter in Spanish to providers in Puerto Rico and upon request to providers in other regions.

12.3.9 - Late Documentation Received by the CERT Review Contractor

(Rev.766, Issued: 02-2-02-18, Effective: 03-02-18, Implementation: 03-02-18)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

If documentation is not received within 75 days of the initial request, the claim is scored as a no-documentation error.

If the CERT review contractor receives late documentation before the claim is posted on the Claims Status website (CSW), the CERT review contractor will review the late documentation and score the claim appropriately. If the CERT review contractor receives late documentation after the claim has been posted on the CSW, the CERT review contractor will check the appeals section of the CSW to see if the provider has appealed the denial. If the provider appealed the CERT-initiated denial, the CERT review contractor will not review the late documentation. If the provider did not appeal the CERT-initiated denial, the CERT review contractor will review the late documentation and score the claim appropriately. If the late documentation is received in time to complete review before the cutoff date for the report, it will be included in that year's improper payment rate calculation.

The MAC shall notify the provider of the change in denial reason. These cases are listed on the change in status section of the CSW.

12.3.10 - Voluntary Refunds

(Rev. 504, Issued: 02-05-14, Effective: 03-06-14, Implementation: 03-06-14)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

If the MAC receives a voluntary refund from a provider on a CERT sampled claim, the MAC shall process the voluntary refund normally, as instructed in other manuals. If a MAC processes the voluntary refund of a CERT sampled claim after receiving the transaction file for the claim in question, the MAC shall complete the feedback file as though the voluntary refund had not been received.

12.3.11 - CERT Program Treatment of Power Mobility Device (PMD) and Repetitive Scheduled Non-Emergent Ambulance Transport Claims in the Prior Authorization Model

(Rev. 595, Issued: 05-22-15, Effective: 06-23-15, Implementation: 06-23-15)

The following information describes how the CERT program shall handle PMD and Repetitive Scheduled Non-Emergent Ambulance Transport (herein, ambulance) prior authorization model claims that are selected as part of the CERT sample. This instruction does not apply to any claim that has been prior authorized as part of any other alternate payment model or any claim that has been subject to prepayment review.

The CERT review of PMD and ambulance prior authorization model claims shall be limited to those elements that were not part of the prior authorization review (e.g., delivery slip, transport record). Documentation that was reviewed as part of the prior authorization process will not be requested or reviewed by the CERT program. The CERT program shall issue an abbreviated additional documentation request (ADR) letter to the billing provider or supplier for the post-prior authorization documentation elements only. The CERT program shall review the requested documentation and a claim determination will be made. If an error is found in the review of the post-prior authorization documentation the CERT program shall score this as an error and the overpayment will be recouped.

This instruction is effective for claims sampled on and after July 1, 2015.

12.3.12 - Administrative Relief to Damaged Areas From A Disaster

(Rev.766, Issued: 02-2-02-18, Effective: 03-02-18, Implementation: 03-02-18)

This section applies to Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) as indicated.

A. General

In the event of a disaster, the CERT program shall grant temporary administrative relief to any affected providers and suppliers. The administrative relief available to the CERT program is discussed below.

B. Definition of a Disaster

A disaster is defined as any natural or man-made catastrophe (e.g., hurricane, tornado, earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, explosion, etc.) which causes damage of sufficient severity and magnitude to partially or completely destroy medical records and associated documentation that could be requested by CERT in the course of medical review, interrupt normal mail service (including US Postal delivery, overnight parcel delivery services, etc.), and/or otherwise significantly limit the provider or supplier’s daily operations.

C. Administrative Relief

Once a disaster has been declared, CMS will notify the CERT review contractor to grant temporary administrative relief to those providers or suppliers in areas that have been declared a disaster by CMS (refer to the CMS Emergency Response and Recovery website) and the Federal Emergency Management Agency (FEMA).

The administrative relief is to be granted to affected providers and suppliers in accordance with the following guidelines:

- The CERT review contractor shall not send any additional documentation request (ADR) letters, attempt telephone calls to request medical documentation, or finalize review decisions on claims for at least 30 calendar days to providers and suppliers affected by the disaster as determined by locations listed on the CMS Emergency Response and Recovery website or as determined by CMS. This administrative relief starts on the date the disaster is effective.

- The CERT review contractor shall not send any ADR letters, attempt telephone contact to request medical documentation, or finalize medical review decisions on claims for at least 60 calendar days to providers and suppliers affected by the disaster as determined by locations that fall within the FEMA designated disaster areas. The administrative relief starts on the date the disaster is declared.

- Administrative relief does not include claims that have completed CERT review or assigned an error code 99 as a non-response claim before the administrative relief began.

- Administrative relief is applied to entities when the physical location or mailing address of the provider or supplier is in the area impacted by the disaster.

The claims from impacted areas will not display on the CERT Claim Status website (CSW). A provider or supplier must submit a disaster attestation (available on the CERT Public website and upon request) when the documentation requested to support a claim has been wholly or partially destroyed in a disaster. CERT shall accept an attestation that no medical records exist due to a disaster.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R774PI	03/02/2018	Comprehensive Error Rate Testing (CERT) Program Dispute Process	03/19/2018	10485
R766PI	02/02/2018	Comprehensive Error Rate Testing (CERT) Updates to Chapter 12 of Pub. 100-08	03/02/2018	10442
R743PI	09/08/2017	Comprehensive Error Rate Testing (CERT) Program Dispute Process	10/10/2017	10242
R691PI	12/16/2016	Contacting Non-Responders and Documentation Requests	01/19/2016	9856
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R622PI	10/30/2015	Program Integrity Manual Chapter 12 Revision	12/07/2015	9391
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R560PI	12/12/2014	Program Integrity Manual Chapter 12 Revisions	01/01/2015	8905
R504PI	02/05/2014	Revision to Chapter 12 of the Medicare Program Integrity Manual - The Comprehensive Error Rate Testing Program	03/06/2014	8591
R240PI	02/08/2008	Review the Fiscal Intermediary Shared System (FISS) to Include All 11x Claims in the Nightly Universe Files Generated for the Comprehensive Error Rate Testing (CERT) Program	04/07/2008	5915
R204PI	05/25/2007	Comprehensive Error Rate Testing (CERT) Program Changes	06/25/2007	4120
R115PI	07/22/2005	PIM Revision – CERT Support Actions	08/22/2005	3786
R077PI	05/28/2004	Comprehensive Error Rate Testing (CERT) Requirements	06/28/2004	3229
R071PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R067PI	02/27/2004	Comprehensive Error Rate Testing (CERT) Requirements	03/12/2004	2976
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