CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION SERVICES

Comprehensive Error Rate Testing (CERT)

Improper Payment Measurement in the Medicare Fee-for-Service (FFS) Program

Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012

- Amended the Improper Payments Information Act of 2002 (IPIA)
- Requires the heads of Federal agencies, including the Department of Health and Human Services (HHS), to annually review programs it administers to improve agency efforts to reduce and recover improper payments

Requirements of IPERIA

- Identify programs that may be susceptible to significant improper payments
- Estimate the amount of improper payments in those programs
- Submit the estimates to Congress
- Report publicly the estimate and actions the Agency is taking to reduce improper payments

Definition of Improper Payments

- Payments that should not have been made or payments made in an incorrect amount
  - Both overpayments & underpayments are considered improper payments
  - Includes:
    - Payments to an ineligible recipient
    - Payments for an ineligible service
    - Duplicate payments
    - Payments for services not received
    - Payments for an incorrect amount

Improper Payment Measurement History

- Office of Inspector General (OIG) Error Rate Measurement
  - 1996-2002:
    - OIG drew a sample of 6,000 claims
    - OIG asked the Durable Medical Equipment Regional Carriers (DMERC), Carriers, Fiscal Intermediaries (FI), and Quality Improvement Organizations (QIO) to review the claims against all coverage, coding, and payment rules
- OIG calculated a single National Claims Payment Error Rate

Improper Payment Measurement History

- Centers for Medicare & Medicaid Services
  - Took over improper payment measurement
    - Transition began in 2001
    - First reported an improper payment rate in November of 2003
  - Current sample size is 50,000 claims
  - Multiple improper payment rates computed:
    - Nationally
    - By Contractor
    - By Service
    - By Provider Type

The CERT Program

The objective of the CERT program is to estimate the accuracy of the Medicare FFS program

The CERT Process

1. Claim Selection
2. Medical Record Requests
3. Review of Claims
4. Assignment of Improper Payment Categories
5. Calculation of the Improper Payment Rate

CERT Claim Selection

- A stratified random sample is chosen by claim type:
  - Part A (excluding acute inpatient hospital services)
  - Part A (acute inpatient hospital services only)
  - Part B
  - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Sample is comprised of claims that were either paid or denied by the Medicare Administrative Contractor (MAC)
- Current sample size is approximately 50,000 claims

CERT Medical Record Requests

- The CERT Documentation contractor requests medical records from the provider or supplier that submitted the claim (several follow-up requests may be made by letter/fax/phone depending on the response/non-response)
- Additional documentation requests are also made to the referring provider who ordered the item or service
- If no documentation is received within 75 days of the initial request, the claim is classified as a “no documentation” claim and counted as an error
- If documentation is received after 75 days of the initial request (late documentation), CERT will still review the claim

CERT Review of Claims

- Medical review professionals perform complex medical review of the submitted documentation to determine whether the claim was paid properly under Medicare coverage, coding, and billing rules
  - Claim reviewers include nurses, medical doctors, and certified coders (PIM Chapter 3, Section 3.3.1.1)
- Medical review professionals assign improper payment categories

Improper Payment Categories

1. No Documentation
2. Insufficient Documentation
3. Medical Necessity
4. Incorrect Coding
5. Other

No Documentation

- the provider or supplier responds that they do not have the requested documentation
- the provider or supplier fails to respond to repeated requests for the medical records

Insufficient Documentation

- the medical documentation submitted is inadequate to support payment for the services billed; or
- 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, such as a physician signature on an order, or a form that is required to be completed in its entirety

Insufficient Documentation Example

- A hospital billed for infusion of a medication provided in the outpatient department. The CERT program received a visit note to support the medical necessity of the medication. However, the physician's **order** and the **administration record for the infusion** were missing.

Insufficient Documentation Example

- A DMEPOS supplier billed for an osteogenic stimulator. The CERT program received progress notes to support that the patient had a fracture. However, the x-ray **reports** to fulfill the documentation requirements in the National Coverage Determination were missing and the Certificate of Medical Necessity was **incomplete**.

Medical Necessity

- the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies

Medical Necessity Example

- The CERT program received **medical records** from two different physicians documenting that a patient who underwent implantation of an AICD had **severe dementia**. The National Coverage Determination (NCD 20.4) specifies that the patient **must not have irreversible brain damage from preexisting cerebral disease**.
- The CERT contractor reviewers made an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.

Incorrect Coding

- The provider or supplier submits medical documentation supporting
  1. a different code than that billed,
  2. that the service was performed by someone other than the billing provider or supplier,
  3. that the billed service was unbundled, or
  4. that a beneficiary was discharged to a site other than the one coded on a claim.

Incorrect Coding Example

- A nephrologist billed for **four visits** for ESRD related services in the month of June 2013. The CERT program received only **one visit** note. The physician's notes for the remaining three visits were missing. Medical reviewers and coders determined that the documentation supported a **code change** from 90960 to 90962 (ESRD related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month).

Other

- Improper payments that do not fit into any of the other categories
- Examples
  - duplicate payment error
  - non-covered or unallowable service

Other Example

- A DMEPOS supplier billed for an upper limb orthosis. The PDAC determined that is was classified as exercise equipment. Exercise equipment is **non-covered** by Medicare.

Calculation of the Improper Payment Rate

- After the reviews are completed, the Medicare FFS improper payment rate is calculated by the Statistical Contractor

- Using statistical weighting, the findings from the sample are projected to the total universe of Medicare FFS claims submitted during the report period

- It is important to note that the improper payment rate does not measure fraud. It estimates the payments that did not meet Medicare coverage, coding, and billing rules

Corrective Actions

- CMS and MACs analyze improper payment rate data and MACs develop Improper Payment Reduction Strategies to reduce improper payments
- Corrective actions include:
  - Refining improper payment rate measurement processes
  - Improving system edits
  - Updating coverage policies and manuals
  - Conducting provider education efforts
  - Prior authorization projects
  - Risk based provider screening
  - Comparative Billing Reports (CBRs)to specific providers
  - Program for Evaluating Payment Patterns Electronic Report (PEPPERs) to inpatient hospitals

Resources

- CERT Reports and Supplementary Appendices

  https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/

- CERT Provider Website

  https://www.certprovider.com/

- Payment Accuracy Website

  https://paymentaccuracy.gov/

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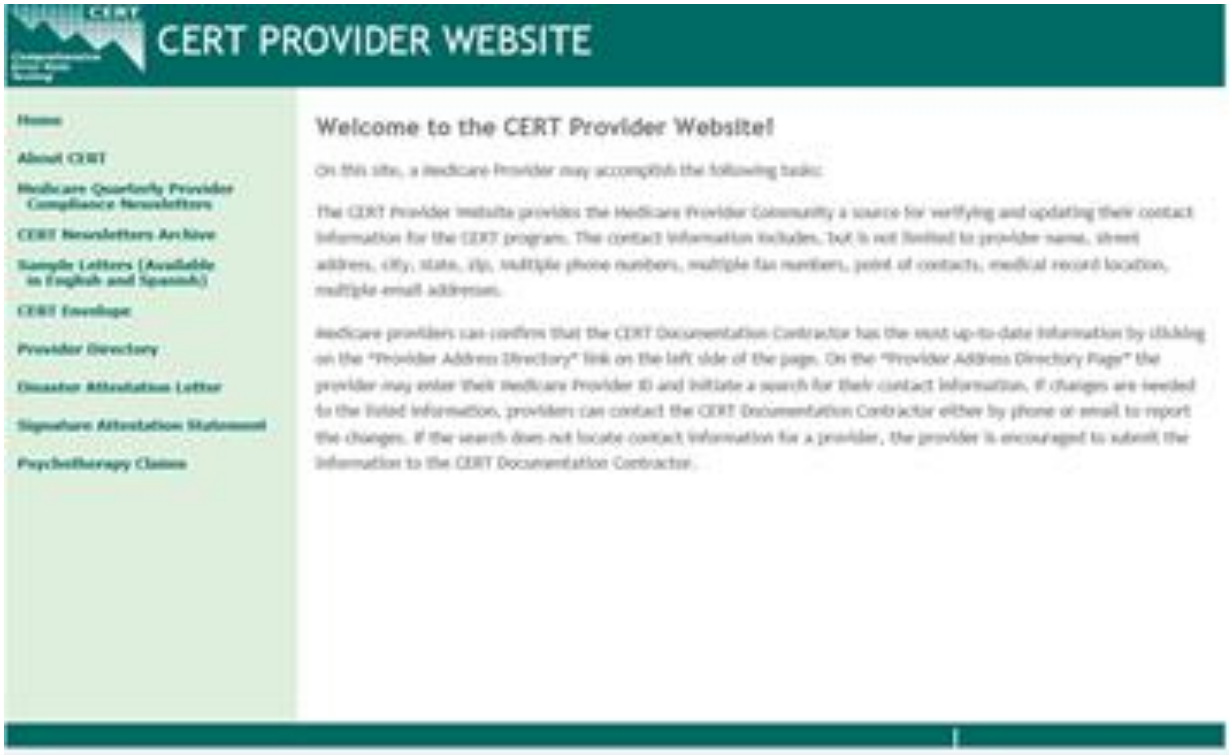
https://www.certprovider.com/



Acronyms

- **AICD** Automatic Implantable Cardioverter Defibrillators
- **CMS** Centers for Medicare & Medicaid Services
- **ESRD** End Stage Renal Disease
- **FFS** Fee-for-Service

CERT Mailbox

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Thank you