



Comprehensive Error Rate Testing (CERT) Program



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

Improper Payments Statutory Requirements & Implementing Guidance

- Requires federal agencies to annually review programs they administer in order to reduce and recover improper payments
- Each agency must:
 - Identify programs that may be susceptible to significant improper payments
 - Estimate the amount of improper payments in those programs
 - Report the estimates to Congress and the public
 - Describe the actions the agency is taking to reduce improper payments in those programs

Statutory Requirements:

- Payment Integrity Information Act (PIIA) of 2019

Implementing Guidance:

- Office of Management and Budget (OMB) A-123, Appendix C

What is an Improper Payment?

- 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

While all payments stemming from fraud are considered improper payments, not all improper payments constitute fraud.

The improper payment rate is a measure of compliance with and adherence to federal rules and requirements and should not be viewed primarily as expenses that should not have occurred in the first place.

CERT Program

The CERT program measures payment compliance with Medicare FFS program federal rules, regulations, and requirements

Methodology: Sample

- Approximately 37,500* claims submitted July 1–June 30 are reviewed annually against Medicare FFS program payment requirements

Claims Submitted	Improper Payment Rate Reported
July 1, 2020- June 30, 2021	Fiscal Year (FY) 2022
July 1, 2021- June 30, 2022	FY 2023
July 1, 2022- June 30, 2023	FY 2024

- Includes claims that were paid or denied by the Medicare Administrative Contractor (MAC)

*FY2024 sample size = 50,000 claims

Methodology: A/B rebilling adjustment factor

- The CERT program calculates the Part A to B rebilling adjustment factor by selecting a random sub-sample of Part A inpatient claims and repricing the individual services provided under Part B
- Accounts for the impact of rebilling of denied Part A inpatient claims for allowable Part B services
- Because the repricing process is not applied to all of the Part A inpatient claims selected by the CERT program, the Part A to B rebilling adjustment factor is only applied to the high-level calculations (i.e., the overall, Part A Total, and Part A Hospital Inpatient Prospective Payment System (IPPS) improper payment rates)

The CERT program methodology remains unchanged since 2012

The CERT Process

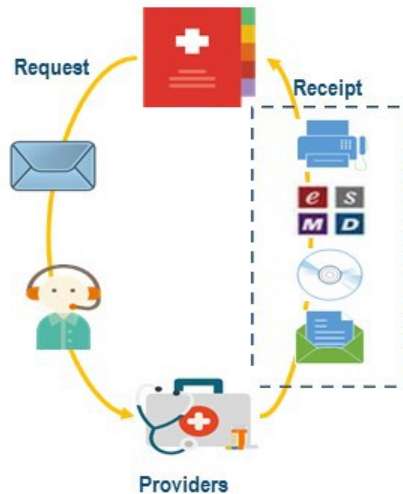
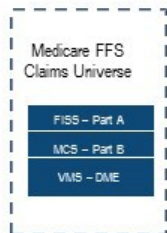
Claim
Selection

Medical
Records

Medical
Review

Calculation of
the Improper
Payment Rate

Reporting



$$\hat{t}_e^{di} = \sum_{k=1}^a \frac{N_k}{n_k} \sum_{j=1}^{n_k^d} e_{kj} = \sum_{k=1}^a W_k \sum_{j=1}^{n_k^d} e_{kj}$$

$$\hat{t}_p^{di} = \sum_{k=1}^a \frac{N_k}{n_k} \sum_{j=1}^{n_k^d} p_{kj} = \sum_{k=1}^a W_k \sum_{j=1}^{n_k^d} p_{kj}$$



Effectuation of appeals
Finalization of expenditure data
Cutoff Date: Mid-Oct. of year
reporting



Claim Selection

- A stratified random sample is chosen by claim type:
 - Part A (Hospital IPPS)
 - Part A (excluding Hospital IPPS)
 - Part B
 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Medical Record Requests

- Medical records are requested from the billing provider or supplier for the claim
- Subsequent 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
 - However, CERT will still review documentation received after 75* days as long as it's before the end of the report period deadline

Starting with report year 2026, errors will be assigned to claims if documentation is not received within **60 days.*

Review of Claims

- Medical review professionals perform medical record review of the submitted documentation to determine whether the claim was paid or denied properly under Medicare coverage, coding, and billing rules
 - Claim reviewers include nurses, medical doctors, and certified coders
- Medical review professionals assign improper payment error categories

Improper Payment Error Categories, Definitions, and Examples

Insufficient Documentation	The documentation is insufficient to determine whether the claim was payable. This occurs when: • Medical documentation submitted is inadequate to support payment • It could not be concluded that the billed services were actually provided, were provided at the level billed, and/or were medically necessary • A specific documentation element, that is required as a condition of payment, is missing	A lab provider billed for a complete blood count (CBC) test. The CERT program received the CBC test results, however, the order/intent to order for the test were missing.
Medical Necessity	Medical documentation supports: • Services billed were not medically necessary based upon Medicare coverage and payment policies	A provider billed for an inpatient rehabilitation facility (IRF) stay. There was not a reasonable expectation that the beneficiary was able to benefit from an intensive rehabilitation program because she was completely independent.
Incorrect Coding	Medical documentation supports: • A different code than what was billed • The service was performed by someone other than the billing provider • The billed service was unbundled • The beneficiary was discharged to a site other than the one coded on the claim	A provider billed for Healthcare Common Procedure Coding System (HCPCS) code 99214. The submitted documentation did not meet the requirements for 99214 but met the requirements for 99213.
No Documentation	The provider or supplier fails to respond to repeated requests for the medical records	A supplier billed for diabetic testing supplies. The provider did not submit any medical records to support the claim.
Other	An improper payment that does not fit into any of the other error categories	A DMEPOS supplier billed for an upper limb orthosis, which the CMS Pricing, Data Analysis and Coding (PDAC) contractor determined was classified as exercise equipment. Exercise equipment is not covered by Medicare.

Review of Claims

- The CERT program notifies the MACs of improper payments identified through the CERT process
 - The MACs repay underpayments and recoup overpayments
- Providers, suppliers, and beneficiaries have the right to appeal any improper payment determination made by the CERT program
- Final appeal decisions are reflected in the calculation of the Medicare FFS improper payment rate
- The improper payment rate reported in the Health and Human Services (HHS) Agency Financial Report (AFR) incorporates the most recent payment information as of the report period deadline

Calculation of the Improper Payment Rate

- After the reviews are completed, the improper payment rate is calculated
- Each MAC's contribution to the overall improper payment rate is proportional to their share of total Medicare payments
- Using statistical weighting, the findings from the sample are projected to the total universe of Medicare FFS claims submitted during the report period
- Uses a statistically valid improper payment sampling and estimation methodology plan
 - Required by PIIA as implemented by OMB A-123, Appendix C
 - Minimum of 95 percent confidence interval of plus or minus 3 percent

Improper Payment Reporting

- Department of Health and Human Services (HHS) Agency Financial Report (AFR)
 - <https://www.hhs.gov/afr/>
 - CMS reports corrective actions for Medicare FFS improper payments in this report
- Medicare Fee-for-Service Improper Payments Reports
 - <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html>
- Payment Accuracy website
 - <https://paymentaccuracy.gov/>

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