Medicare Program Integrity Manual

Chapter 12 – The Comprehensive Error Rate Testing Program

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(Rev. 13890; Issued: 07-30-26)

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12.1 – The Comprehensive Error Rate Testing (CERT) Program
(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

The Comprehensive Error Rate Testing (CERT) program produces a national Medicare Fee- for-Service (FFS) improper payment rate that is compliant with the Payment Integrity Information Act of 2019 (PIIA) and the implementing guidance in the Office of Management and Budget Circular A-123, Appendix C.

The CERT program evaluates a stratified random sample of Medicare FFS claims to determine if they were paid or denied properly under Medicare coverage, coding, and billing rules. The CERT program considers any payment for a claim that should have been denied or that was made in the wrong amount (including both overpayments and underpayments) to be an improper payment. The claim can be counted as either a total or a partial improper payment, depending on the error. 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 reflective of all claims processed by the Medicare FFS program during the report period.

The results of the improper payment rate calculation are published annually in the Department of Health and Human Services Agency Financial Report, and the CMS Financial Report. More information about the CERT program is available at https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert.

12.2 – MAC Communication with the CERT Program
(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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

A. CERT Staff

CMS CERT Team
7500 Security Blvd
Baltimore, MD 21244
CERT@cms.hhs.gov

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 MAC shall maintain, review, and update the POC information via the administrative section of the C3HUB. The POC information shall be reviewed and updated quarterly by the MAC and when changes to the POC occur. 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. Additionally, the CERT listserv is used to distribute announcements, meeting agendas, and additional CERT information. MACs may contact the CMS CERT team or CERT review contractor to add an individual to the CERT listserv.

C. CERT Information Sources for MACs

- The CMS CERT website at https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert
- The CERT C3HUB at https://c3hub.certrc.cms.gov/
- The Data Dashboard at https://www.cert.cms.gov/LiveDashMerge/main.php
- Quarterly pre-appeal rate documents that are distributed via secure file transfer
- Final MAC-specific reports that are distributed via secure file transfer
- End of year raw data reports that are distributed via secure file transfer

12.3 – Overview of the CERT Process
(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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

The CERT sampling process begins with the CERT statistical contractor sampling from shared systems claims in the Integrated Data Repository (IDR). The CERT statistical contractor will ensure that the sampling universe only contains one record of each unique claim. The CERT statistical contractor transmits files containing the sampled claims to the CERT review contractor twice monthly.

The CERT review contractor 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) daily. Claims sampled from the IDR are matched and reconciled with this CMSDC universe. The sampled claims are held for a predefined period 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 the CERT review contractor to determine if the claim was paid or denied appropriately based upon Medicare coverage, coding, and billing rules. The CERT program collects additional information from the MACs for each

claim considered to be in error via the feedback process.

12.4 – CERT Process Requirements
(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)

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

12.4.1 – Providing Sample Information to the CERT Review Contractor
(Rev. 13890; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

All data exchanged between the CMS Data Center (CMSDC) 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. MAC virtual data center responses to requests from the CERT program for claim information, shall follow the same instructions.

A. Sampling Universe File

The sampling universe file is the universe of claims from which the sample is selected. The CERT statistical contractor creates the sampling universe file using the IDR, which contains an extract of all valid claims that have entered the claims processing system. Each claim in the sampling universe file is reported only once.

Claim adjustment records are excluded from the sampling universe file to ensure that only one record per claim is available for sampling. This prevents the CERT statistical contractor from selecting the same claim more than once in the sample.

B. 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 data centers shall ensure that the claims universe file contains all claims 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 data centers ensure that each claim included in the universe file is unique.

C. Sampled Claims Transaction File

The shared systems shall create a mechanism for the data centers to receive a sampled claims transaction file from the CMSDC daily. This file will include claims that were sampled by the CERT program.

D. Sampled Claims Resolution File and Claims History Replica File

The shared systems shall create a mechanism for the data centers 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 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 data center shall furnish resolution information for all finalized claims included in the transaction file within five days of receipt of a request from the CERT review contractor. MACs receiving daily transaction files shall respond with resolution files (daily 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 data center 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 because 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.

E. 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 review contractor shall review the most current version of the claim that finalized before the date of the transaction file. The CERT review contractor shall not review any version of the claim that finalized after the date of the transaction file. The CERT review contractor shall use the claim adjudication date in the resolution record to determine when the claim finalized. *If the adjusted/replacement claim is not included in the resolution file, the CERT review contractor reviews the original claim as contained in the resolution file and makes a determination based on the original claim regardless of the claim being cancelled and/or adjusted.*

F. 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 C3HUB. 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 Health Insurance Claim Number (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 entered by the CERT Point of Contact, will not be included 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 C3HUB.

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

G. Provider Address File

In addition to the claim resolution file, each MAC data center 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.

12.4.2 – Providing Review Information to the CERT Review Contractor
(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)

The MAC shall indicate, in the resolution file, if the claim lines were subject to manual medical review or not.

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 10 percent of sampled claims. Each MAC shall provide the requested information to the CERT review contractor within 10 business days of the request.

12.4.2.1 – MAC Responsibility After Workload Transition
(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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.

12.4.3 – Providing Feedback Information to the CERT Review Contractor

(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

A. Requests for Feedback Information

- Feedback is the mechanism by which the CERT review contractor notifies MACs of CERT review decisions. 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. Daily, the CERT review contractor posts a description of errors it has found for each claim on the C3HUB.

- The MAC shall correctly enter the "Recalculated Allowed Amount" in MAC feedback for all claims where the CERT review contractor disagreed with the MAC decision in adjudicating the claim.

- 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.

    - When co-insurance or a deductible was applied to a claim/line resulting in no payment to the provider, the MAC should enter the "Recalculated Allowed Amount" equal to the allowed amount before the deductible and/or co-insurance was applied. An entry of zero in the recalculated allowed amount results in payment error equal to the deductible or co-insurance applied.

- Each MAC shall submit feedback information for all lines within 30 days of the date posted to C3HUB unless the MAC is actively working with the provider to obtain additional documentation for CERT review. Each MAC shall complete all the lines in the feedback process prior to the cut-off date for the report period. If the feedback is not submitted by the end of the cut-off date for a report period, the lines will be counted as full payment errors. Deadlines for completing feedback are listed on the C3HUB under calendar of events which can be accessed from the

main MAC Central page.

- A MAC may contact the CERT review contractor MAC feedback coordinator, via the collaboration feature on the C3HUB, to request clarification about the results of a CERT review.

B. Repricing

The MAC shall calculate the corrected allowed 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 the 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.

C. Claims that are canceled/replaced on or after the date of the transaction file

The CERT review contractor shall review the most current version of the claim that finalized before the date of the transaction file. Any cancelations, adjustments, or other actions that occur on or after the date of the transaction file are not applicable to the CERT program reporting.

If the claim is canceled/replaced on or after the transaction file date:

- Feedback shall reflect the CERT decision.
- Appeal information shall not be entered in the C3HUB.

For the payment adjustment information in the C3HUB, the MAC may enter that the claim was canceled/replaced on or after the transaction file date and no payment or collection occurred. The MAC shall not use a CERT review decision from a claim that is canceled/replaced on or after the date of the transaction file on an adjustment claim.

12.4.3.1 – Disputing a CERT Decision

(Rev.13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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 C3HUB via the feedback process in accordance with this section. Using the appropriate field in the C3HUB, the MAC shall enter a detailed 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 the claim will be removed from feedback. The CERT review contractor will conduct a re- review of the disputed claim

and issue a new comment via C3HUB. 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 via the C3HUB feedback entry. The MAC must provide a detailed rationale, via the appropriate field in the C3HUB, as to why the claim remains in dispute. The CMS dispute panel shall use Medicare coverage, coding, and billing rules in effect for the billed date of service, 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 C3HUB. The CMS dispute panel decision will appear as a new reviewer comment, and the claim will appear in the new feedback posting.

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

When an appeal has been entered for a disputed claim, the MAC shall notify the CERT review contractor immediately via the C3HUB Appeal Data Entry page to halt the dispute process.

12.5 – Handling Overpayments and Underpayments Resulting from the CERT Findings

(Rev. 13890; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

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 C3HUB. 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. When the CERT reviewed claim was canceled on or after the transaction file date, the MAC shall not pay or collect the amount in error, as the claim has already been canceled (see 12.*4*.3.C). 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 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 CERT 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 adjust 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 C3HUB. The list is updated each time the C3HUB is refreshed. The MAC shall report CERT identified overpayment and underpayment collection information using the CERT payment adjustment section of the C3HUB. A multiple collection feature is available on the C3HUB for cases where the collection is received in installments.

In accordance with the CERT Review Schedule (available on the C3HUB), the MAC shall report the required payment adjustment information for all CERT identified overpayments and underpayments that have been collected or paid for the current report period unless otherwise directed. The deadline for completing payment adjustment information is listed on the C3HUB under calendar of events which can be accessed from the main MAC central page. In general, the MAC should access the payment adjustment section of the C3HUB to report collection or payment information throughout the year and enter information on an ongoing basis.

12.6 – Handling Appeals Resulting from CERT-Initiated Denials

(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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 C3HUB, when a CERT review decision is appealed. The MAC shall confirm that feedback has been completed

before entering an appeal on the C3HUB. No further review shall be conducted by the CERT review contractor after the MAC has entered an appeal on the C3HUB. This includes instances in which additional documentation is received to support the claim. For instances where an appeal is dismissed or canceled, the claim is placed back into the normal CERT review process.

The MAC shall not enter an appeal in the C3HUB for a claim that was canceled on or after the transaction file date. When the MAC is not able to enter an appeal on the C3HUB because the claim was canceled on or after the transaction file date, the MAC may send documentation to the CERT review contractor for further consideration.

Medical records for the appealed CERT claim may be obtained by contacting the CERT appeals coordinator via the appeals page on the C3HUB. The MAC shall enter all available information for MAC feedback and appeals for CERT sampled claims by the cut-off date listed on the C3HUB calendar. Appeal determinations entered into the C3HUB by the specified due date will be reflected in the report.

12.6.1 – CERT Appeal Results

(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

All CERT appeals must be expedited, and data must be corrected and finalized to ensure its inclusion in the final national and contractor level calculations.

- 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 "Appeal Recalculated Allowed Amount" is not the paid amount. The "Appeal Recalculated Allowed Amount" is the amount paid to the provider (or beneficiary) plus any deductible applied to this claim plus the co-insurance amount.

- If co-insurance or a 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 to the deductible or co-insurance applied.

For example, if a $1,100 deductible is applied to a claim resulting in $0 claim paid amount, the allowed amount of $1,100 should be entered as the recalculated allowed amount. Payment errors are calculated by subtracting the recalculated amount from the final allowed amount. If the claim paid amount of $0 was entered as the recalculated amount a payment error of $1,100 would be calculated.

- The contractor shall access the C3HUB and correct any incorrect entries.

12.7 –Annual Certification of CERT Information

(Rev. 12642; Issued: 05-16-24; Effective: 06-17-24; Implementation: 06-17-24)

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

Annually, by September 30th, 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 C3HUB. The MAC's Certifying Official (for example, President, Senior VP, or Contract Project Manager) shall sign the certification and submit it to CMS as instructed in the MAC statement of work deliverable schedule.

Certification statements shall include the following:

- MAC Name
- Contractor/Jurisdiction Number
- Date certification submitted to CMS: [MM/DD/CCYY]
- Fiscal Year [include the appropriate year]
- Name of MAC Certifying Official
- Title of MAC Certifying Official
- A statement certifying the completeness and accuracy of the information entered in the C3HUB

12.8 – Disseminating CERT Information

(Rev. 10567; Issued: 01-20-21; Effective: 01-18-21; Implementation: 01-29-21)

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 C3HUB.

12.9 – Annual Improper Payment Reduction Strategy (IPRS)

(Rev. 12959; Issued: 11-14-24; Effective:12-17-24; Implementation: 12-17-24)

See Pub 100-08 Medicare Program Integrity Manual, Chapter 7, section 7.1 for specific instructions on the IPRS.

12.10 –Additional Documentation Requests (ADRs)

(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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

A. General

The CERT review contractor sends the ADR to the billing provider/supplier. If the CERT review contractor determines that documentation is missing or insufficient to make a determination on a claim, a subsequent ADR may be sent to the billing provider/supplier, the ordering/referring provider, or a third-party, as appropriate.

B. ADR Letters

When requesting medical records from providers, suppliers, and third parties, the CERT review contractor uses CMS approved ADR letters. The CERT review contractor sends ADRs in Spanish to providers in Puerto Rico and upon request to providers in other regions.

12.10.1 – *No Response to ADR*

(Rev. 13890; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If documentation is not received within 60 days of the first ADR, the claim is a no documentation error with error code 99. Error code 99 claims are posted to the C3HUB on the 61st day from the date the first ADR was sent and will appear in the next MAC feedback posting.

For claims with error code 99, the MACs may proceed at their discretion by doing one of the following:

i. 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. The MACs should not complete feedback while they are working with the provider to obtain documentation and/or the CERT review contractor is reviewing the claim;

ii. Complete MAC feedback in accordance with section 12.4.3 of this chapter and collect the overpayment immediately in accordance with section 12.5 of this chapter; or

Regardless of the option selected above, the MAC must complete feedback at least 30 days prior to the deadline to submit late documentation posted on the C3HUB.

The MAC shall not contact any provider or supplier selected for CERT review until 30 days after the first CERT ADR has been reported on the C3HUB. The MAC may contact the third party and encourage them to send the needed medical record documentation to the CERT review contractor. When contacting providers or suppliers, the MAC shall remind them to include the cover sheet included with the CERT request or the CERT

claim identification number at the top of the medical record. The MAC can download a cover sheet from the C3HUB if needed.

12.10.2 – *Insufficient Response to ADRs*
(Rev. 13890; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If the documentation submitted is inadequate to support payment for the service/item billed, or if the CERT review contractor could not conclude that the billed service/item was provided, was provided at the level billed, and/or was medically necessary, the claim is an insufficient documentation error with error code 21 assigned.

Error code 21 claims will be posted under the MAC feedback section of the C3HUB. MACs should reach out to the provider or supplier to submit the requested documentation to the CERT review contractor.

12.10.3 – Insufficient Response to ADRs
(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

If the documentation submitted is inadequate to support payment for the service/item billed, or if the CERT review contractor could not conclude that the billed service/item was provided, was provided at the level billed, and/or was medically necessary, the claim is an insufficient documentation error with error code 21 assigned.

Error code 21 claims will be posted under the MAC feedback section of the C3HUB. MACs should reach out to the provider or supplier to submit the requested documentation to the CERT review contractor.

12.11 – Late Documentation Received by the CERT Review Contractor
(Rev. 13678; Issued: 03-12-26; Effective: 04-13-26; Implementation: 04-13-26)

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

The MACs may submit any additional documentation received from the provider or supplier to the CERT review contractor for consideration as late documentation.

If the CERT review contractor receives late documentation before the review decision is posted on the C3HUB, the CERT review contractor reviews the late documentation and scores the claim appropriately. If the CERT review contractor receives late documentation after the review decision has been posted on the C3HUB, the CERT review contractor checks to see if the MAC has entered an appeal in the C3HUB. If the MAC has entered an appeal for the CERT-initiated denial in the C3HUB, the CERT review contractor does not review the late documentation. If the MAC has not entered an appeal for the CERT-initiated denial in the C3HUB, the CERT review contractor reviews the late documentation and scores the claim appropriately. If the late documentation is received before the cutoff date to receive late documentation for the report (in time to

complete review before the cutoff dates for the report) it is included in that year's improper payment rate calculation.

The MAC shall notify the provider of the change in denial reason. These cases are included in the feedback section of the C3HUB.

12.12 – Voluntary Refunds
(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)

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 or supplier on a CERT sampled claim, the MAC shall process the voluntary refund normally, as instructed in other manuals. If the 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.

12.13 – Administrative Relief to Damaged Areas from a Disaster
(Rev. 12959; Issued: 11-14-24; Effective:12-17-24; Implementation: 12-17-24)

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 the CERT review contractor 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. A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impact a single site only (e.g., water main failure).

A provider or supplier must submit a disaster attestation (available on the CERT public website https://c3hub.certrc.cms.gov/ and upon request) when the documentation requested to support a claim has been wholly or partially destroyed in a disaster. The CERT review contractor shall accept an attestation that no medical records exist due to a

disaster.

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 the Secretary of the Department of Health and Human Services. Please refer to the CMS Emergency Response and Recovery website at https://www.cms.gov/about-cms/what-we-do/emergency-response for information on current and past emergencies.

The CERT review contractor shall apply administrative relief along with flexibilities and waivers related to medical review at the direction of CMS. 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 requests (ADRs) or attempt telephone calls to request medical documentation on claims, as directed by CMS, 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.

- Administrative relief does not include claims that have completed CERT review 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.

- If at any time documentation is received from the provider or supplier for claims impacted by administrative relief, the CERT review contractor will proceed with review.

The MACs may obtain a list of claims impacted by administrative relief in the Claims Status Section on the C3HUB.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R13890PI	07/30/2026	Revisions to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) and Exhibit 46 in the Exhibits Chapter of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)	08/28/2026	14539
R13678PI	03/12/2026	Revisions to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)	04/13/2026	14399
R12959PI	11/22/2024	Revisions to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)	11/22/2024	13842
R12642PI	05/16/2024	Revisions to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual) and Deletions to Exhibit 34 in the Exhibits Chapter of Pub. 100-08	06/17/2024	13602
R10709PI	04/27/2021	Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08	07/28/2021	11488
R10567PI	01/20/2021	Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08	01/29/2021	12112
R905PI	09/27/2019	Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08	12/30/2019	11329
R883PI	05/31/2019	Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub) 100-08 (Medicare Program Integrity Manual)	08/30/2019	11283
R852PI	12/21/2018	Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)	01/24/2019	10931
R800PI	06/15/2018	Comprehensive Error Rate Testing (CERT) Update to Chapter 12 of Publication (Pub.) 100-08	07/17/2018	10778

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
R686PI	11/10/2016	Comprehensive Error Rate Testing (CERT) Program: Medicare Administrative Contractor (MAC) Certifying Official	12/12/2016	9846
R622PI	10/30/2015	Program Integrity Manual Chapter 12 Revision	12/07/2015	9391
R595PI	05/22/2015	Comprehensive Error Rate Testing (CERT) Program Treatment of Power Mobility Device (PMD) and Repetitive Scheduled Non-Emergent Ambulance Transport Claims in the Prior Authorization Model	06/23/2015	9156
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
R012PIM	09/20/2002	Clarification & Manualization of Chapter	N/A	1143

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