| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-08 Medicare Program Integrity | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 852** | **Date: December 21, 2018** |
| | **Change Request 10931** |

**SUBJECT: Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update chapter 12 of Pub. 100-08.

**EFFECTIVE DATE: January 24, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 24, 2019**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | Table of Contents/Chapter 12 |
| R | 12.1/The Comprehensive Error Rate Testing (CERT) Program |
| R | 12.2/MAC Communication with the CERT Program |
| R | 12.3/Overview of the CERT Process |
| R | 12.4/CERT Process Requirements |
| R | 12.4/12.4.1/Providing Sample Information to the CERT Review Contractor |
| R | 12.4/12.4.2/Providing Review Information to the CERT Review Contractor |
| R | 12.4/12.4.2/12.4.2.1/MAC Responsibility After Workload Transition |
| R | 12.4/12.4.3/Providing Feedback Information to the CERT Review Contractor |
| R | 12.43/12.4.3/12.4.3.1/Disputing a CERT Decision |
| R | 12.5/Handling Overpayments and Underpayments Resulting from the CERT Findings |
| R | 12.6/Handling Appeals Resulting from CERT-Initiated Denials |
| R | 12.6/12.6.1/CERT Appeal Results |
| N | 12.7/Annual Certification of CERT Information |
| R | 12.8/Disseminating CERT Information |
| R | 12.9/Annual Improper Payment Reduction Strategy (IPRS) |
| R | 12.10/Additional Documentation Requests (ADRs) |
| N | 12.10/12.10.1/Fraud Investigations |
| N | 12.10/12.10.2/No Response to Additional Documentation Requests |
| N | 12.10/12.10.3/Insufficient Response to Additional Documentation Requests |
| R | 12.11/Late Documentation Received by the CERT Review Contractor |
| R | 12.12/Voluntary Refunds |
| R | 12.13/Administrative Relief to Damaged Areas from a Disaster |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC

Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## IV. ATTACHMENTS:

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 852 | Date: December 21, 2018 | Change Request: 10931 |
|---|---|---|---|

**SUBJECT: Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)**

**EFFECTIVE DATE: January 24, 2019**
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**IMPLEMENTATION DATE: January 24, 2019**

## I. GENERAL INFORMATION

**A. Background:** The CERT review contractor reviews the most current version of the claim that finalized before the date of the transaction file. These instructions provide the MACs with guidance on entering feedback and payment adjustment information for the CERT program for claims that are canceled/replaced after the date of the CERT transaction file.

In instances where the MAC has knowledge that a provider or supplier is part of a fraud investigation, the MAC may contact the CERT review contractor. The CERT review contractor will cease contact with the provider or supplier.

The CERT review of power mobility devices and ambulance prior authorization model claims entails a full review. The instructions in Pub. 100-08, Chapter 12 of the Medicare Program Integrity Manual on limiting the CERT review to the elements that were not part of the prior authorization review are no longer applicable.

This CR will do the following:

- Add MAC instructions for claims that are canceled after the date of the CERT transaction file.
- Reformat the instructions on the annual certification of CERT information into a separate section of the chapter. The MACs may submit the certification to CMS as instructed in the MAC statement of work deliverable schedule.
- Add MAC instructions on notifying the CERT review contractor of fraud investigations.
- Remove the section on the CERT program treatment of power mobility device and repetitive scheduled non-emergent ambulance transport claims in the prior authorization model.
- Reformat the section numbers of the chapter.
- Update the language throughout for consistency among the sections.

**B. Policy:** This CR does not involve any legislative or regulatory policy.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 10931.1 | The MACs feedback shall reflect the CERT decision, when the CERT sampled claim is canceled/replaced after the transaction file date. | X | X | X | X | | | | | |
| 10931.2 | The MACs shall not enter the appeal information in the Claims Status Website (CSW), when the CERT sampled claim is canceled/replaced after the transaction file date. | X | X | X | X | | | | | |
| 10931.2.1 | When the MAC is unable to enter an appeal on the CSW because the claim was canceled/replaced after the transaction fie date, the MAC should send documentation to | X | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | the CERT review contractor for further consideration. | | | | | | | | | |
| 10931.3 | The MAC should enter that the claim was canceled/replaced after the transaction file date and no payment or collection occurred for the payment adjustment information in the CSW, when the CERT sampled claim is canceled after the transaction file date. | X | X | X | X | | | | | |
| 10931.3.1 | When the CERT reviewed claim was canceled after the transaction file date, the MAC shall not pay or collect the amount in error, as the claim has already been canceled. | X | X | X | X | | | | | |
| 10931.4 | The MAC shall not use a CERT review decision | X | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | from a claim that is canceled/replaced after the date of the transaction file on an adjustment claim. | | | | | | | | | |
| 10931.5 | The MAC shall confirm that feedback has been completed before entering an appeal on the CSW. | X | X | X | X | | | | | |
| 10931.6 | The MAC submission of the certification that all required information has been completely and accurately entered on the CSW shall be submitted to CMS as instructed in the MAC statement of work deliverable schedule. | X | X | X | X | | | | | |
| 10931.7 | MACs should contact the CERT review contractor's medical records manager to request a cease in | X | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | provider or supplier contact because the provider or supplier is part of an ongoing investigation. | | | | | | | | | |
| 10931.7.1 | The MAC shall provide written confirmation of the request to cease making provider or supplier contact. | X | X | X | X | | | | | |
| 10931.8 | MACs should submit any additional documentation received from the provider or supplier to the CERT review contractor for consideration as late documentation. | X | X | X | X | | | | | |
| 10931.9 | MACs should obtain a list of claims impacted by administrative relief in the Claims Status Section of the CSW. | X | X | X | X | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
| --- | --- |

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Jill Garver, jill.garver@cms.hhs.gov (`)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

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

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***(Rev. 852, Issued: 12-21-18)***

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## 12.*1* – The Comprehensive Error Rate Testing (CERT) Program

***(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

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, *as* amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA), the* Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012*, 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 considered to be 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 www.cms.hhs.gov/cert.

## *12.2* – MAC Communication with the CERT Program

***(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.

**A. CERT Staff**

CMS CERT Team
7500 Security Blvd
Baltimore, MD 21244
*Mail Stop C3-02-16*
*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 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 t*he CMS CERT team or CERT review contractor to add an individual to the CERT listserv.

**A. CERT Information Sources for MACs**

- The CMS CERT *w*ebsite at www.cms.hhs.gov/cert.
- *The CERT public website at https://certprovider.admedcorp.com/*
- The CERT Claims Status *w*ebsite contains sampled claims information; a calendar of events; the CERT Manual; and the feedback, payment adjustment, and appeals tracking systems.

## *12.3* – Overview of the CERT Process

***(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.

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 *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 MAC*s* 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. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

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*. 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 data centers shall ensure that the claims universe file contains all claims except *home health agency request for anticipated payment* 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 shall ensure that each claim included in the universe file is unique and may only be selected on the day it enters the system.

### *B.* 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 on a daily basis. This file will include claims that were sampled from the daily claims universe files.

### *C.* 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 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 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 (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 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 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.

### *D.* 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.

***E.*** **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 Claims Status *w*ebsite *(CSW)*. 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 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 *CSW*.

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* O*ffice of* I*nspector* G*eneral* upon request.

***F.*** **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. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

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. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

**A. Requests for Feedback Information**

- Feedback is the mechanism by which the CERT *r*eview *c*ontractor notifies MACs of decisions where the CERT *r*eview *c*ontractor 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 *CSW*. Each MAC shall complete the required fields for each claim listed on the feedback section of the *CSW*. Feedback batch posting dates are listed on the *CSW* 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 *r*ecalculated *a*llowed *a*mount 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 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. A*n 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 *seven* 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*, via email,* 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.

***C. Claims that are canceled/replaced 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 after the date of the transaction file are not applicable to the CERT program reporting.*

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

- *Feedback shall reflect the CERT decision.*
- *Appeal information shall not be entered in the CSW.*
- *For the payment adjustment information in the CSW, the MAC may enter that the claim was canceled/replaced 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 after the date of the transaction file on an adjustment claim.*

### 12.4.3.1 – Disputing a CERT Decision

*(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)*

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 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 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 claims 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.

## *12.5* – Handling Overpayments and Underpayments Resulting *f*rom the CERT Findings

*(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.

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 Claim Status *w*ebsite (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. *When the CERT reviewed claim was canceled after the transaction file date, the MAC shall not pay or collect the amount in error, as the claim has already been canceled (see 12.3.3.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 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 *CERT* MAC *f*eedback *c*oordinator.

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 CSW. The list is updated each time the CSW is refreshed. The MAC shall report CERT identified overpayment and underpayment collection information using the CERT payment adjustment section of the CSW. A multiple collection feature is available on the 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 CSW to report collection or payment information throughout the year and enter information on an ongoing basis.

## *12.6* – Handling Appeals Resulting *f*rom CERT-Initiated Denials

***(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.

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 Claims Status *w*ebsite (CSW), when a CERT *review decision* is appealed. *The MAC shall confirm that feedback has been completed before entering an appeal on the CSW.* No further review shall be conducted by the CERT review contractor after the MAC has entered an appeal on the CSW. This includes instances in which additional documentation is received to support the claim.

*The MAC shall not enter an appeal in the CSW for a claim that was canceled after the transaction file date. When the MAC is not able to enter an appeal on the CSW because the claim was canceled 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 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 CSW calendar. Appeal determinations entered into the CERT appeals tracking system by the specified due date will be reflected in the report.

## *12.6.1* – CERT Appeal Results

***(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

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 *c*orrected *c*ontractor *recalculated final allowed charge* is the *f*inal *a*llowed *c*harge (or the *g*ross *a*llowed *c*harge for Part A).

- 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 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 *CSW* and correct any incorrect entries.

## *12.7 –Annual Certification of CERT Information*

***(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.*

*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 Claims Status website (CSW). 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 CSW*

## *12.8* – Disseminating CERT Information

***(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.

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 *w*ebsite.

## *12.9* – Annual Improper Payment Reduction Strategy (IPRS)

***(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.

The annual IPRS is a problem-focused, outcome-based operational plan developed by the 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 *Medical Review (MR), CERT, and Provider Outreach and Education* Business Function Leads and the Regional Office Technical Monitor MR staff.

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

## *12.10* –Additional Documentation Requests (ADR*s*)

***(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.

***A. General***

The CERT review contractor sends the additional documentation request (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. Additional Documentation Request Letters***

*When requesting medical records from providers, suppliers, and third-parties, the CERT review contractor uses CMS approved ADR letters, found at https://certprovider.admedcorp.com/. The CERT review contractor sends ADRs in Spanish to providers in Puerto Rico and upon request to providers in other regions.*

### *12.10.1 – Fraud Investigations*

***(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

*A MAC may contact the CERT review contractor's medical records manager to request a cease in provider or supplier contact because the provider or supplier is part of an ongoing investigation. In such cases, the MAC is responsible for providing written confirmation of the request to cease making provider or supplier contact. These requests require CMS approval.*

### *12.10.2 – No Response to Additional Documentation Requests*

***(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

If *documentation is not* received *within* 75 days *of the first ADR*, the *claim is a no documentation* error *with e*rror *c*ode 99. *Error code 99* claims are posted to the Claims Status website (CSW) on the 76th day from the date the first *ADR* was sent *and* will appear in the next MAC feedback batch.

For claims with *e*rror *c*ode 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 allow feedback to roll over as long as 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 12.3.3 of this chapter and collect the overpayment immediately in accordance with section 12.4 of this chapter; or

iii. Collect the overpayment within 10 business days of the deadline for entering final MAC feedback.

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 CSW. The MAC may contact the third-party and encourage them to send the needed medical record documentation to the CERT review contractor. When contacting provider*s* or supplier*s*, the MAC shall remind them to include the barcoded 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 barcoded cover sheet from the CSW if needed.

### *12.10.3 – Insufficient Response to Additional Documentation Requests*
***(Rev. 852; Issued: 12-21-18; Effective: 1-24-19; Implementation: 1-24-19)***

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 actually provided, was provided at the level billed, and/or was medically necessary*, the claim is an insufficient documentation error with e*rror *c*ode 21.

*Error code 21 c*laims will be posted under the MAC feedback section of the CSW. 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. 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.

*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 Claims Status website (CSW), the CERT review contractor review*s* the late documentation and score*s* the claim appropriately. If the CERT review contractor receives late documentation after the *review decision* has been posted on the CSW, the CERT review contractor check*s* to see if *the MAC has entered an appeal in the CSW*. If *the MAC has entered an appeal for the CERT-initiated denial in the CSW*, 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 CSW*, the CERT review contractor review*s* the late documentation and score*s* the claim appropriately. If the late documentation is received in time to complete review before the cutoff date 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 listed on the change in status section of the CSW.

## *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 *f*rom *a* Disaster
***(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.

**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 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 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 requests (ADR*s*), 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*s*, 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 no documentation error* 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 MACs may obtain a list of claims impacted by administrative relief in the Claims Status Section* on the Claim Status website.