CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 560	**Date: December 12, 2014**
	Change Request 8905

SUBJECT: Program Integrity Manual Chapter 12 Revision

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Program Integrity Manual Chapter 12 including 1) references to the Exhibits, 2) the number of disputes allowed and 3) the ERRP process.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 1, 2015

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	12/12.3/The Comprehensive Error Rate Testing (CERT) Program
R	12/12.3.1/MAC Communication with the CERT Program
R	12/12.3.2/Overview of the CERT Process
R	12/12.3.3.1/Providing Sample Information to the CERT Review Contractor
R	12/12.3.3.2.1/MAC Responsibility After Workload Transition
R	12/12.3.3.3/Providing Feedback Information to the CERT Review Contractor
R	12/12.3.3.3.1/Disputing/Disagreeing with a CERT Decision
R	12/12.3.4/Handling Overpayments and Underpayments Resulting From the CERT Findings
R	12/12.3.6/Disseminating CERT Information
R	12/12.3.7/MAC Error Rate Reduction Plan (ERRPs)
R	12/12.3.8/Contacting Non-Responders and Documentation Requests

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 obliged 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: 560	December 12, 2014	Change Request: 8905

SUBJECT: Program Integrity Manual Chapter 12 Revision

EFFECTIVE DATE: January 1, 2015
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IMPLEMENTATION DATE: January 1, 2015

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update Program Integrity Manual Chapter 12 including (1) references to the Exhibits, (2) the number of disputes allowed, and (3) the Error Rate Reduction Plan (ERRP) process.

B. Policy: N/A

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	
8905.1	The Medicare Administrative Contractor (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 Comprehensive Error Rate Testing (CERT) Point of Contact (see Section 12.3.1 B).	X	X	X	X					CERT, VI
8905.1.1	MAC virtual data center responses to requests from the CERT program for claim information shall follow the same instructions.	X	X	X	X					CERT, VI
8905.2	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.	X	X	X	X					CERT
8905.2.1	The assuming MAC shall not have access to the data until the individual workload has transitioned, unless	X	X	X	X					CERT, VI

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	otherwise negotiated with the outgoing MAC.									
8905.3	The MAC shall correct the recalculated final allowed amount if the CERT review contractor or the Centers for Medicaid & Medicare Services (CMS) finds, upon re-review, that the error determination is inaccurate.	X	X	X	X					CERT
8905.4	The MAC shall indicate the disputed claim via the feedback process in accordance with this section.	X	X	X	X					
8905.5	If the CERT review contractor does not overturn the error, the CERT review contractor shall send the disputed claim to the CMS dispute panel that shall complete the review within 30 days of receipt.									CERT
8905.5.1	If supporting evidence for the dispute is missing or lacking, the CMS dispute panel shall uphold the CERT review contractor decision.									CMS
8905.5.1.1	The CMS dispute panel shall review the disputed claim using the medical record and systems information available to the CERT review contractor.									CMS
8905.5.2	The CERT review contractor shall notify the MAC of the result by way of a change in status on the claims status website.									CERT
8905.6	The MAC shall correct the recalculated final allowed amount if the CERT review contractor or CMS finds, upon re-review, that the error determination is inaccurate.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibili
		A/B MAC

		A	B	H H H	
	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): Marissa Malcolm, 410-786-0119 or marissa.malcolm@cms.hhs.gov , Pamela Villanyi, 410-786-1522 or pamela.villanyi@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

12.3 - The Comprehensive Error Rate Testing (CERT) Program

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

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

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

12.3.1 - MAC Communication with the CERT Program

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

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

A. CERT Staff

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

B. MAC CERT Points of Contact (POCs)

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

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

C. CERT Information Sources for MACs

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

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

12.3.2 - Overview of the CERT Process

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

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

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

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

12.3.3.1 - Providing Sample Information to the CERT Review Contractor

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

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

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

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

Claims Universe File

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

Sampled Claims Transaction File

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

Sampled Claims Resolution File and Claims History Replica File

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

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

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

Claims with Multiple Versions

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

No Resolution Claims

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

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

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

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

Provider Address File

In addition to the claim resolution file, each MAC datacenter shall transmit the provider address file containing the names; known addresses; and telephone numbers of all the billing, attending, ordering/referring, and performing/rendering providers for all the claims on the resolution file. Each unique provider and address combination shall be included only once on each provider address file.

12.3.3.2.1 - MAC Responsibility After Workload Transition

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

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.*

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

12.3.3.3 - Providing Feedback Information to the CERT Review Contractor

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

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

A. **Requests for Feedback Information**

- Feedback is the mechanism by which the CERT Review Contractor notifies MACs of decisions where the CERT Review Contractor disagreed with the MAC's decision in adjudicating the claim. It also serves as the mechanism by which the MAC provides the CERT program with corrected pricing, which allows the program to determine the difference between what was allowed on the original claim and the amount that should have been allowed based on the CERT decision. Approximately twice each month, the CERT review contractor posts a description of errors it has found for each MAC on the Claims Status Website. Each MAC shall complete the required fields for each claim listed on the feedback section of the Website. Feedback batch posting dates are listed on the Claims Status Website under calendar of events and on the main feedback page.

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

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

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

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

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

B. Repricing

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

12.3.3.3.1 - Disputing/Disagreeing with a CERT Decision

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

A. Dispute Process

A dispute may be filed in situations in which the MAC does not agree with the final CERT review contractor decision on a particular claim. Each MAC is allowed to file *1* dispute*d claim* per *month on or before the final day of each month*. *The MAC shall indicate the disputed claim via the feedback process in accordance with this section.* The MAC shall submit a written statement, using the appropriate field in the feedback form, to explain the dispute. *If the CERT review contractor does not overturn the error, the CERT review contractor shall send the disputed claim to the* CMS dispute panel *who shall* complete the review within 30 days *of receipt*. If supporting evidence for the dispute is missing or lacking, the CMS dispute panel *shall* uphold the CERT *review contractor* decision. *The CMS dispute panel shall review the disputed claim* using the medical record and systems information available to the CERT review contractor. The CERT review contractor *shall* notify the MAC of the result *by way of a change in status on the claims status website*. Should the MAC elect not to submit a dispute in a given *month*, the unused opportunity does not carry over to the following *month*.

B. Disagree Process

If the MAC does not agree with a CERT decision and the MAC does not choose to dispute the claim, the MAC may mark the line as disagree on the feedback form. The MAC is encouraged to submit the rationalization for a disagree line using the appropriate field in the feedback form. Lines marked as disagree may be reviewed by the CERT review contractor or CMS.

When a line is marked dispute or disagree, the MAC shall recalculate the final allowed amount as if the CERT decision is accurate and the line is in error. *The MAC shall correct the recalculated final allowed amount if the CERT review contractor or CMS* finds*, upon re-review,* that the error determination is inaccurate.

12.3.4 - Handling Overpayments and Underpayments Resulting From the CERT Findings

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

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

The 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 manuals.

The CERT review contractor notifies the MAC when an underpayment or an overpayment is identified via the CERT Claim Status Website. The MAC shall adjust the claim to reflect the corrected code and payment amount, and make the appropriate payment or collection. The MAC shall pay or collect the full amount in error as defined

by the CERT-identified underpayment or overpayment. If shared systems logic limits the payment correction amount to a sum less than the full amount in error, the MAC shall pay the system allowed amount and educate the provider about future billing amounts. The MAC shall not collect overpayments from Medicare beneficiaries.

The MAC shall use the normal claim adjustment procedures published in Pub 100-4 Claims Processing Manual. The MAC shall use the bill type XXH ("CMS") to indicate the adjustment was due to a CERT review.

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

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

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

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

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

12.3.6 – Disseminating CERT Information

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

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

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

12.3.7 – MAC Error Rate Reduction Plan (ERRPs)

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

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

Each MAC that receives MAC-specific improper payment rate data shall develop and submit an Error Rate Reduction Plan (ERRP) 30 days after they receive their MAC specific improper payment rate data. In addition, each MAC shall develop and submit an Error Rate Reduction Plan (ERRP) 30 days after the award of a new MAC contract in accordance with their Statement of Work. The MAC shall describe the corrective actions the MAC plans to take in order to lower the improper payment rate within that jurisdiction, in the ERRP. The MAC shall base the ERRP upon the improper payment data for which the MAC has continuing jurisdiction in the upcoming review period.

The MAC shall include the following in the ERRP:

- Reasons for error in the MAC's jurisdiction
- Corrective actions already in place and new corrective actions planned
- Adjustments the MAC has made or will make to its MR Strategy
- Coordination activities with other components within the MAC
- How the MAC will utilize the CERT findings to develop and implement outreach and education efforts
- Suggestions on how CMS can help reduce the improper payment rate or improve the CERT process

The regional office (RO) medical review (MR) staff shall determine if the MR components of the ERRP are reasonable based upon the MAC's improper payment rate findings. The CMS provider outreach and education (POE) staff shall determine if the POE components of the ERRP are reasonable based upon the MAC's improper payment rate findings.

12.3.8 – Contacting Non-Responders and Documentation Requests

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

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

A. The CERT Claims Status Website

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

B. Contacting Non-Responders

Each MAC may contact those providers who have failed to submit medical records and encourage them to submit the requested records to the CERT review contractor. A MAC shall not contact any provider selected for CERT review until 20 days after the CERT initial request as reported on the Claims Status Website. A MAC may contact third party providers and encourage them to send the needed records to the CERT review contractor.

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

C. Customizing Address

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

D. Additional Documentation Requests

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

E. Request Letters

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