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Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) Program - The Importance of Complying with Requests for Claim Documentation

Note: This article was revised to include web addresses that conform to the new CMS web site.

Provider Types Affected

Medicare Fee-for-Service (FFS) physicians, providers, and suppliers

Provider Action Needed



STOP – Impact to You

The 2004 national gross paid claims error rate was 10.1 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated CERT contractor. Medicare FFS physicians, providers and suppliers must provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error and you will receive a demand letter requesting refund of payment received for the "erroneous" claim.



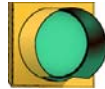
CAUTION – What You Need to Know

During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review contractor (CRC) can verify that billing was proper. Be assured that forwarding specifically requested records to the designated CERT

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contractor does not violate privacy provisions under the Health Insurance Portability and Accountability (HIPAA) law.



GO – What You Need to Do

If you receive a letter from CMS regarding a CERT request for medical documentation, you should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. This special edition article provides an overview of the CERT program and stresses the importance of providing the requested medical documentation for the CERT review.

Background

The Government Performance and Results Act of 1993 established performance measurement standards for Federal agencies. To achieve the goals of this Act, CMS established the Comprehensive Error Rate Testing (CERT) program in November 2003. The purpose of the CERT program is to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

Methodology

The CERT program was originally administered by the Department of Health and Human Services, Office of the Inspector General (OIG) from 1996 - 2002. During this period, the OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Medicare contractors erroneously allowed). Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission). The CMS methodology includes:

- Randomly selecting a sample of claims submitted in a specific calendar year;
- Requesting medical records from providers who submitted the claims;
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules; and

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- When providers fail to submit the requested documentation, treating the claims as errors and sending the providers overpayment letters.

The designated CERT review contractor currently reviews over 140,000 randomly-selected claims and corresponding medical records each year, with a medical review staff that includes physicians and nurses who can use clinical judgment when necessary in reviewing medical records. Their medical review staff has access to national and local policies, contractor processing guidelines and automated edits.

If you fail to submit the requested information in a timely fashion, an "error" is registered against both the Medicare contractor (your Medicare Carrier or Fiscal Intermediary) and you, as the Medicare provider. (At this point, the CERT review contractor has no choice but to register the claim submission as "erroneous" because there is insufficient supporting documentation to determine otherwise.) These errors have a corresponding negative impact on the other error rates that are calculated under the CERT program.

Your Role Is Critical To Improvement

Our research has shown that providers do not comply with the requests for information because:

- They believe it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to send patient records to the designated CERT contractor; or
- They are unaware of the CERT process, and they may not appreciate the importance of cooperating in a timely fashion.

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare claims. Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

If You Receive A Letter From CMS Regarding A CERT Medical Review...

- Don't ignore it! Respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. The letter will provide a clearly defined list of the documentation required and where to submit the information.
- Include any additional material that you believe supports the service(s) billed to the Medicare program.

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- Make sure your address files and telephone numbers that are on file with your carrier or fiscal intermediary are accurate to ensure that CERT documentation requests are received and allow time for you to respond timely.
- Remember that physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.

Additional Information

In an effort to assist Medicare physicians, providers and suppliers with CERT compliance, we have several resources available to explain the CERT process and how your responsiveness is in everyone's best interest.

- CERT webpage (<http://www.cms.hhs.gov/cert>)
- CERT Newsletters (<http://www.certprovider.org/newsletters.aspx>)
- A designated telephone number for Medicare physicians, providers and suppliers for general information and questions regarding the CERT initiative — (804) 864-9940.

In addition, we are preparing a series of Fact Sheets, Frequently-Asked Questions, and future MLN Matters articles to provide further guidance regarding the CERT process.

Remember

Review can result in identification of overpayments as well as underpayments.

If CERT changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor.

It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare Program.

Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

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