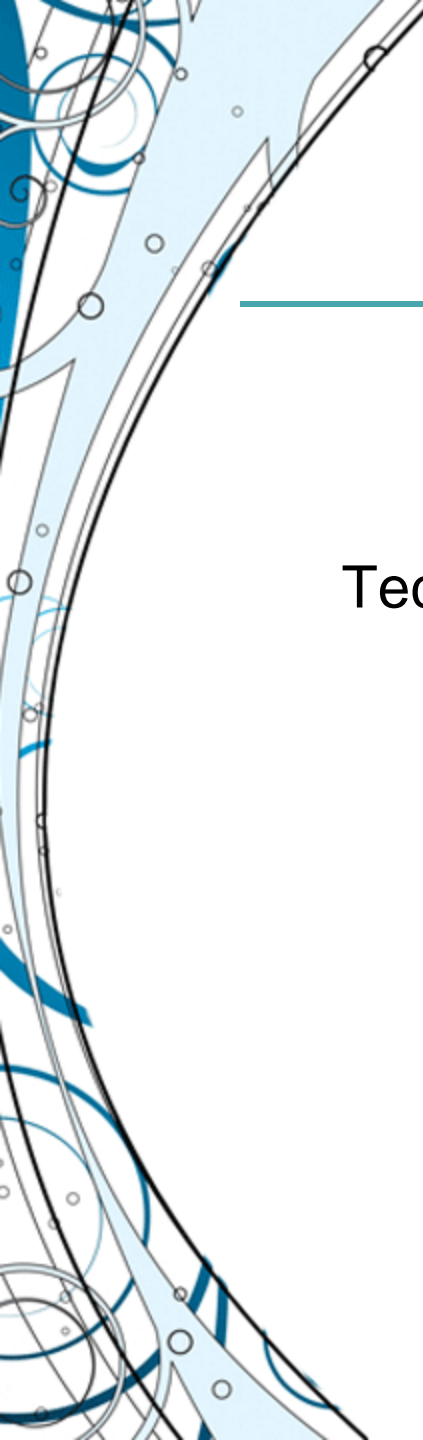




Comprehensive Error Rate Testing (CERT) Program

June 15, 2010



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Agenda

- Requirements for the CERT Program
- What is CERT?
- How is CERT Performed?
- Medical Records Requests
- Responding to CERT Requests
- Documentation
- Benefits of CERT
- Questions?

Background: Improper Payment Information Act of 2002 (IPIA)

IPIA requires all federal agencies to:

- Assess programs for risk of making improper payments
- Estimate and report improper payment amounts annually, for programs at risk
- Take corrective actions to reduce improper payments

Defines “improper payment” as:

- payments that should not have been made, or payments made in an incorrect amount (including overpayments and underpayments)
 - payment to an ineligible recipient,
 - payment for an ineligible service,
 - any duplicate payment,
 - payment for services not received,
 - payments for an incorrect amount.

Executive Order 13520 – Reducing Improper Payments

Issued by the President on November 20, 2009

- Aimed at further intensifying efforts to eliminate payment error, waste, fraud, and abuse in federal programs while continuing to ensure that the right people receive the right payment for the right reason at the right time.

The EO adopts a comprehensive set of policies that include:

- Transparency and public scrutiny of significant payment errors
- Focus on identifying and eliminating the highest improper payments
- Agency accountability for reducing improper payments
- Coordinated federal, state, and local government action in identifying and eliminating improper payments

Executive Order 13520 Supplemental Measures

Measure	What is Being Reviewed	Sample Size	Sample Months	Request Records	Report Findings
Power Wheelchairs	8 HCPCS codes identified	~200 -250	November 2009 through January 2010	Beginning May 2010	Initial report: Sept 2010 Subsequent reports: Semiannually
Short Hospital Stays	inpatient claims for 0 and 1 day length of stay	~200	April 2010 through June 2010	Beginning August 2010	Initial report: March 2011 Subsequent reports: Semiannually
Chiropractic Services	beneficiaries with at least one claim from the same chiro in each month for sample months	all claims with DOS for the prior 12 months for 100 bene's	April 2010 through June 2010	Beginning August 2010	Initial report: March 2011 Subsequent reports: Semiannually
Pressure-reducing Support Surfaces	9 HCPCS codes identified	~270-300	April 2010 through June 2010	Beginning July 2010	Initial report: March 2011 Subsequent reports: Semiannually



Overview of CERT

- What is **CERT**?
- What does **CERT** do?
- How does **CERT** help physicians and other health care providers?
- Is there anyway I will know my claims are being reviewed by **CERT**?
- How can I help lower the claims payment error rate?

What does CERT mean and who administers CERT?

Comprehensive

Error

Rate

Testing

CERT is administered by one of the Program Safeguard Contractors (PSCs)



What does CERT do?

CERT - generally produces:

- National paid claim error rate
- Contractor paid claim error rates
 - Along with a Medicare Contractor's claims resolution error rate and provider compliance error rate
- Benefit Category paid claim error rates
- Provider Specific paid claim error rates
- MAC error rates



CERT

National Error Rate Calculations

- The building block of the national rate is the individual error rate at the contractor/MAC level.
- Historically, for each Part A, Part B and DME MAC contractor, an error rate is calculated based on approximately 2,000 claims per year.
- The error rate, and its standard error, is calculated.
- Sample size varied from 120,000 – 144,000
- For A/B MACs - 2,000 Part B, 1800 Part A with 300 inpatient hospital claims per A/B MAC
- For DME MACs – 2,000 Claims per DME MAC

National Error Rate Calculations

Within a provider type, such as DME, the contractor-specific error rates are aggregated into a provider type (DME) for improper payment estimation.

- The rates are “weighted” by the proportion of DME Medicare payments represented by each DME MAC over the period of inference (year).
- The standard error is a function of weighted aggregation of the individual contractor’s variances.



National Paid Claims Error Rate

Part A/RHHI, Part B and DME MAC Error rates are aggregated into a CERT Error Rate.

- The weights are the proportion of total Medicare Part A, B and DME MAC expenditures represented by each.
- The standard error of the CERT Error Rate is based on a weighted aggregation of the individual component variances in the error rate computation.



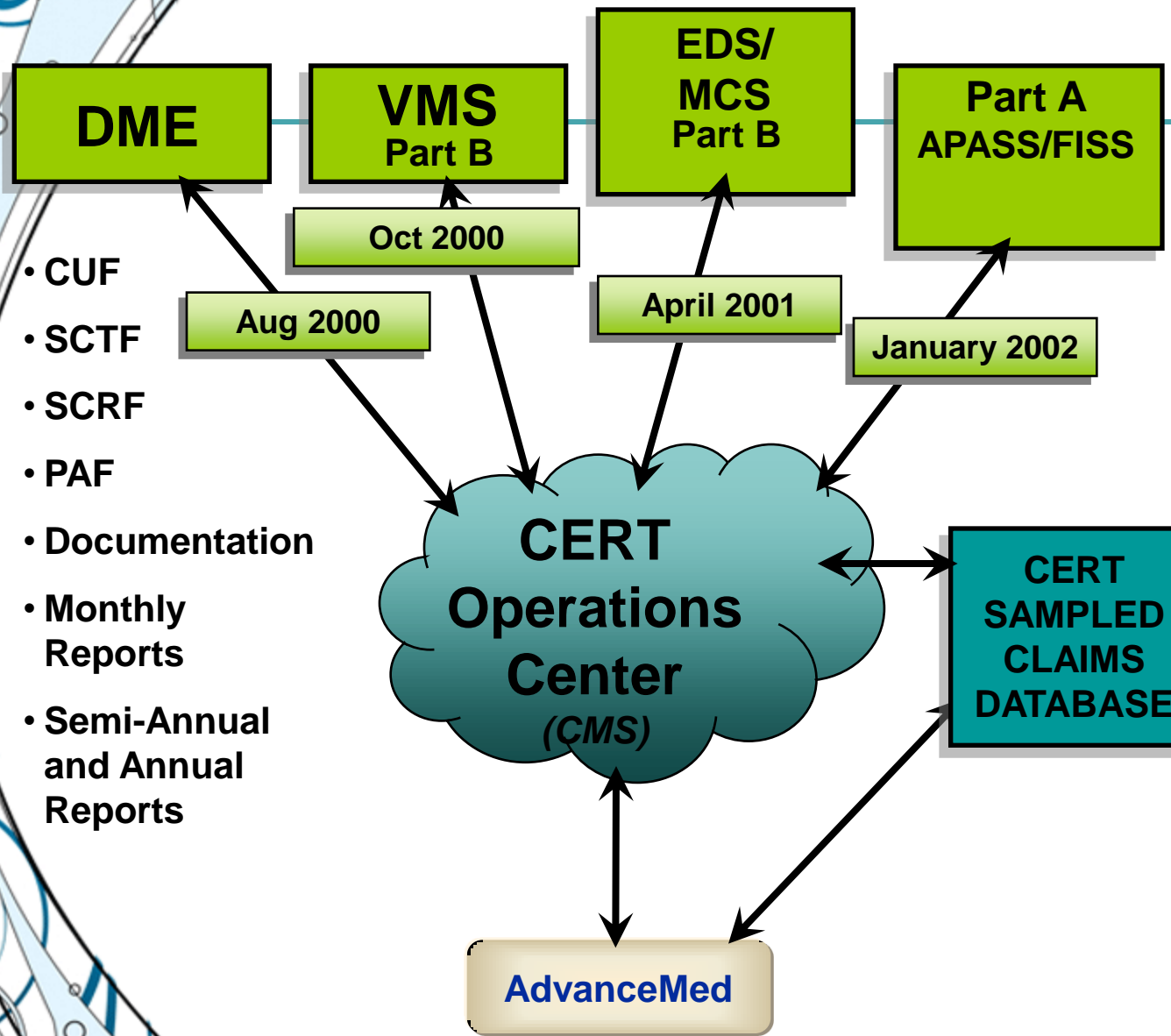
National Paid Claims Error Rate

- CERT sample is drawn for all claims submitted over a 12 month period (fiscal year)
- CERT uses a submitted claim as the sampling unit
- Sample is based on random sample using a skip interval. The OIG used a beneficiary as the sampling unit
- Sample is based on random sample using a skip interval. Random start changes monthly

CERT Implementation

Schedule

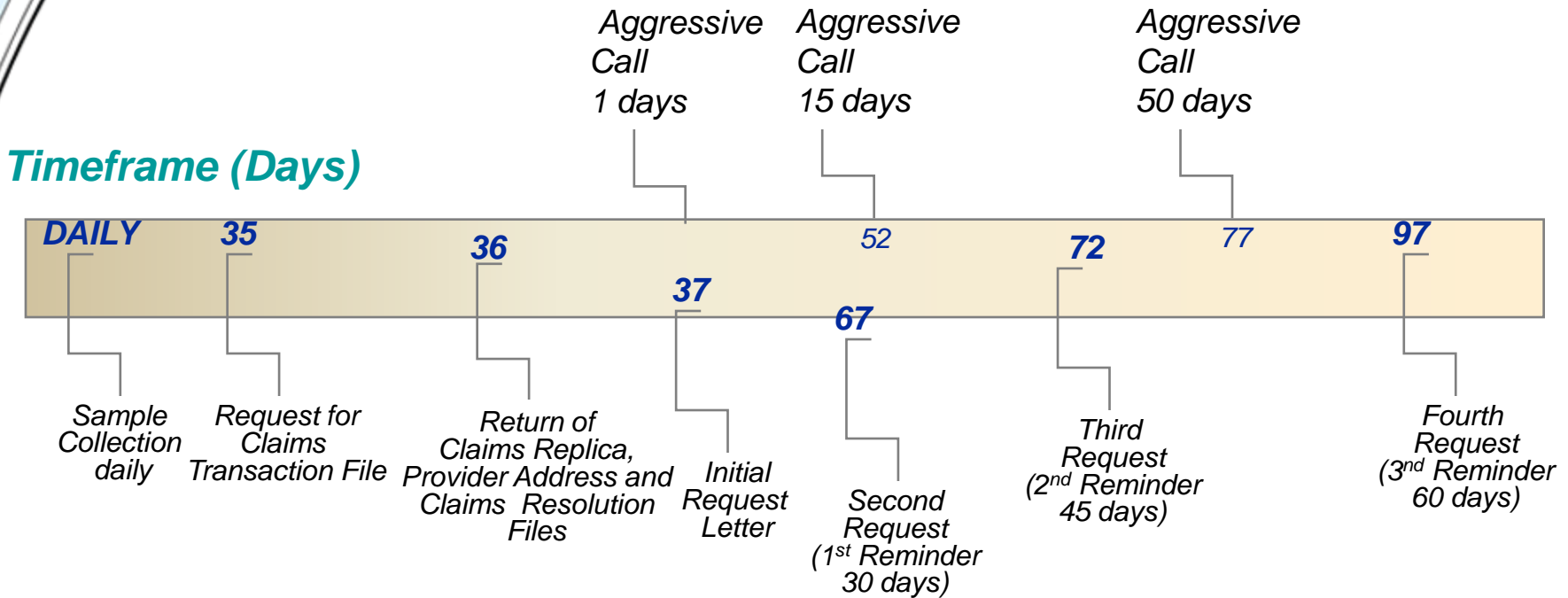
Phase	System	Implementation Date	Official Sampling Month
I. DME	VMS	8/14/2000	10/2000
II. Part B	VMS	10/31/2000	1/2001
III. Part B	EDS/MCS	4/1/2001	7/2001
IV. Part A	APASS/FISS	1/1/2002	4/1/2002
V. Miscellaneous	HPBSS/Verizon	Staggered from 4/1/2002	8/1/2002
VI. Inpatient claims – DRG and LTC	FISS	October 1, 2008	10/1/2008



- CUF
- SCTF
- SCRF
- PAF
- Documentation
- Monthly Reports
- Semi-Annual and Annual Reports

- CUF
Claims Universe File
- SCTF
Sampled Claims Transaction File
- SCRF
Sampled Claims Resolution File
- CHRF
Claims History Replica File
- PAF
Provider Address File

CERT Time Frame Beginning with Claims sampled on or after 10-1-06



3 calls and 75 days to respond



How does CERT help physicians and other health care providers?

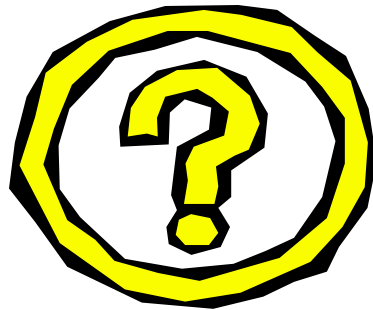
- A “pre-pay” sample but post-pay review
- Providers will not be subject to random pre-pay reviews
- For the improper payment error rate – **Under-coded claims** or **improperly denied claims** are as important as improperly paid claims

Other CERT Benefits

- Contractor Provider Outreach and Education teams are responsible for CERT education.
- Claims Payment Error Rate WILL IMPROVE
 - “Pay the claim right the first time”
- Clear and Consistent Standards for Medical Review
 - CMS wants contractors applying the same review standards

CERT Medical Review

- Many Medical Review Specialists
 - Variety of coding expertise and clinical background
 - Certified coders /Interqual used for screening inpatient claims
 - Lead MRS managers
- 2 Full-time Medical Directors
- Customer Service Area
 - Available 8:00 AM Eastern Time until 5:00 PM Eastern Time



Is there any way I will know my claims are being reviewed by **CERT**?



Documentation Myths

“Because of HIPAA, I cannot respond to this request without authorization from the beneficiary.”

"The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits disclosure of personal health information to carry out treatment, payment or health care operations. When Medicare beneficiaries enroll in the program, they are informed of Medicare's use of their personal health information to carry out health care operations. AdvanceMed performs health care operations as a business associate of CMS with respect to the HIPAA Privacy Rule. Providing the requested documentation does not violate the minimum necessary provision of the HIPAA Privacy Rule and does not require beneficiary authorization."

HIPAA- CMS Business Associates



CMS

COVERED BY MEDICARE & MEDICAID SERVICES



- Medicare Administrative Contractors
- Carriers
- Fiscal Intermediaries

Documentation Myths and other CERT Myths

- Information requested by CERT should go to CMS Central Office
- Information requested by CERT should go to the local Medicare Contractor or MAC
- DME supplier generated information is enough to support medical necessity
- Medical records do not need authentication
- Payment for inpatient hospital medical record copies
- Appeal the claim to the CERT Review Medical Contractor



CERT Operation Center Address CERT Documentation Contractor

CERT Documentation Office
Attn CID #: 333333
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

Submitting Documentation to the CERT Contractor



Instructions for Submitting

Requested Medical Records/Documentation

The preferred method for receipt of medical records/documentation is via FAX to:

(240) 568-6222

CERT Documentation Contractor accepts imaged records: TIF, PDF



CENTERS FOR MEDICARE & MEDICAID SERVICES

RE: CERT - SECOND REQUEST FOR MEDICAL RECORDS

Provider #: 000000
CID #: 000000
MEDICAL CENTER
100 MAPLE ST
ANYVILLE, NY 10000-0001

Due Date: xx/xx/2006

Dear Doctor/Medicare Provider:

This is a second request made by the CERT Documentation Contractor to obtain medical records/documentation to perform a review under a federally mandated program to monitor and improve the accuracy of Medicare payments to physicians and other providers. This request for medical records is the result of a random selection of billing records. The original request was sent to you on xx/xx/06 and your response was needed by xx/xx/06.

Your response is required even if records for the sampled beneficiary dates of service cannot be provided. In accordance with 42 U.S.C. § 1320C-5 (a) (3) and § 1833 of the Social Security Act, as a Medicare provider, you must provide documentation and medical records to the CERT contractor upon request to support claims for Medicare services. It is your responsibility to obtain additional supporting documentation from a third party (hospital, nursing home, etc.), as necessary. Providing medical records of Medicare patients to the Comprehensive Error Rate Testing (CERT) contractor is within the scope of compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The purpose of the CERT program is to determine the national, contractor specific, service type and provider type paid claim error rates. We are requesting medical record documentation regarding the claim identified on the enclosed Medical Records/Documentation Pull List. A bar coded cover sheet is included in this packet with a control number that corresponds to the record on the Medical Records/Documentation Pull List. CHIRO_TEXT

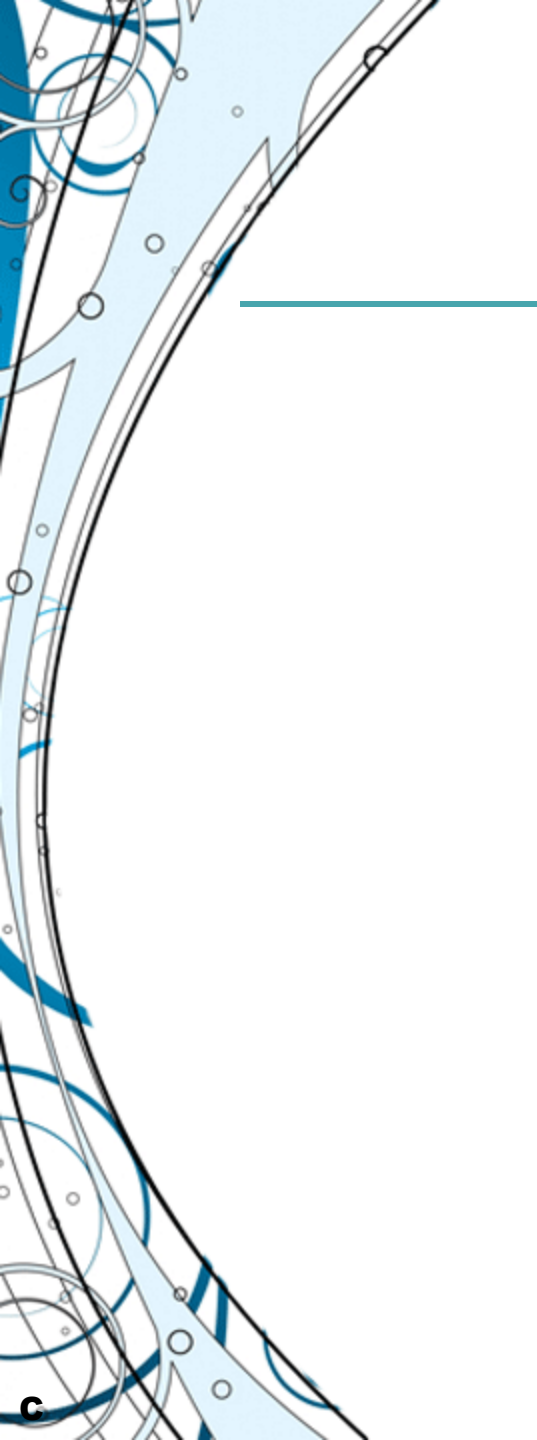
In order to expedite the receipt and processing of your medical records/documentation, please submit no later than xx/xx/2006 including the bar coded cover sheet. Should you require additional time or if you are unsure about what documentation needs to be submitted to fully comply with this request, please call the CERT Documentation Office at (301) 957-2380.

Thank you for your cooperation and prompt attention in this matter.

Sincerely yours,

Douglas Crouch
Program Director
CERT Documentation Contractor
Enclosures





Instructions for Submitting Requested Medical Records/Documentation

The preferred method for receipt of medical records/documentation is via FAX to:

(240) 568-6222

Your cooperation in FAXING the specified documents as soon as possible is greatly appreciated. Should you require additional time to fill this request for medical records/documentation, please call the CDC Documentation Office at (301) 957-2380 to get an extension to the due date.

Please adhere to the following directions when faxing:

1. Send the specific documents listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
2. Place the bar coded cover sheet in front of the medical records/documentation being submitted for review. Submit multiple records with the corresponding Bar Coded Cover Sheet as separator pages.
3. Please make sure all pages are complete, legible, and include both sides and page edges where applicable.

If unable to FAX document, please contact CERT Documentation Office at (301) 957-2380.

Please adhere to the following directions if you are mailing the requested letters:

1. Send the specific records listed on the Bar Coded Cover Sheet to support the services on the claim identified on the Medical Records/Documentation Pull List.
2. Photocopy each record. Please make sure all copies are complete and legible; include both sides of each page, including page edges.
3. Place the bar coded cover sheet in front of the medical records/documentation being submitted for review. Submit multiple records with the corresponding Bar Coded Cover Sheet as separator pages. Mail medical record documentation to:

CERT Documentation Office
Attn CID #: 000000
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

We are not authorized to reimburse providers/suppliers for the cost of claims/medical records duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT Documentation Office.

If the requested information is not received within this time period, CERT CDC will assume the services on the claim were not rendered. Your local Medicare contractor will pursue overpayment recoupment for these undocumented services.

Medical Record/Claim Attachment Pull-List

Medical Records/Documentation Pull List

Medicare PART B Provider

Provider ID#:	000000	Request Date:	xx/xx/06
Patient Name:	DOE, JOHN	Date of Birth:	xx/xx/26
Service From/To Dates:	xx/xx/06 - xx/xx/06	CERT Claim ID (CID):	000000
HICNUM:	000000000A	Claim Date:	xx/xx/06
Claim Control Number (CCN):	0000000000000000	Performing Provider:	
Address ID:		Bill Type:	0

ICD-9 Codes

Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10
Line Item Date	Revenue Code	Performing Provider	Provider Specialty	Diagnosis Code	HCPCS Code	HCPCS Modifier 1	HCPCS Modifier 2	HCPCS Modifier 3	HCPCS Modifier 4

SAMPLE

CERT Record Request Bar-code Sheet

PLACE THIS SHEET IN FRONT OF THE RECORD
(NO Fax Cover Sheet Needed)

Medicare CERT Documentation Contractor CMS 500-99-0019/0002 PSC CERT

Medicare PART B Provider

Report Date:

xx/xx/06

Claim Control Number:

0000000000000000

Contractor Type:

PART B

Provider Number:

000000

Service From/To:

xx/xx/06 - xx/xx/06

Contractor Number #:

00000

CID Number:

000000

Patient Name:

DOE, JOHN



* C D C O O O O O O *

Letter Sequence:

Second Letter

Universe Date:

xx/xx/06

The documents listed below may be required in support of a medical claim review. Please provide all of the pertinent medical records/documentation listed below and any additional documentation to support the above listed claim for the specified date (s) of service:

Please copy both sides of each page and please DO NOT cut off page edges when copying. Please send the original copy of this bar coded cover sheet with a copy of the medical record documents noted above. The record documents must be with the original cover sheet in order to ensure proper validation of receipt by the CERT Documentation Office. Please fax documentation to: (240) 568-6222. If unable to fax documents, please send information to the address noted below.

CERT Documentation Office
Attn: CID # 000000
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

CERT Documentation Requests

Documentation Request facts:

- Letters now viewable at:
<http://www.certcdc.com/certproviderportal/>
- www.cms.hhs.gov/CERT
- CERT makes additional requests for support of an order or medical necessity of a service.
- CERT may request additional documentation via phone or letter
- Ultimately no response results as documentation error
- We would like our no response rate to be zero

Program Integrity Manual

5.7 – Documentation in the Patient’s Medical Record

For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient’s record. However, neither a physician’s order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

CERT Documentation Keys

- Submitted diagnosis may be insufficient
 - Even if diagnosis is a “covered” diagnosis in LCD/NCD
- Order Forms or Prescription Orders are insufficient
- Medical record **must support** medical necessity
- Medical Record must support ALL requirements of NCDs or LCDs
- NCDs and LCDs can be found at:
 - <http://www.cms.gov/MCD/overview.asp>



Excerpt from November 2009 Medicare FFS Improper Payment Rpt

The following describes the modifications made to the CERT medical review criteria:

- **February 23, 2009** - CMS directed the CERT contractor that clinical review judgment cannot override statutory, regulatory, ruling, national coverage decision or local coverage decision provisions and that all documentation and policy requirements must be met before clinical review judgment applies.
- **May 15, 2009** - CMS provided guidance on a variety of issues related to review of durable medical equipment claims. This included guidelines on period of medical necessity documentation requirements, policy requirements added after the original order, and medical necessity requirements for DME accessories, repairs, and maintenance.
- **May 31, 2009** - Based on CMS policy, during the course of a complex medical review, a claim must be denied if the signature on the medical record is absent or illegible. Through their audit, OIG found that CMS contractors were not uniformly applying this policy. Thus, CMS provided guidance to the CERT contractor that claims should be counted as an error if the CERT reviewer could not identify the author of the medical record entry.



Excerpt from November 2009 Medicare FFS Improper Payment Rpt

The more stringent review criteria for review of claims selected for the November 2009 report resulted in increases in the error rates due to:

- Records from the treating physician not submitted or incomplete
In the past, CERT would review available documentation, including physician orders, supplier documentation, and patient billing history and apply clinical review judgment. Now, CERT requires medical records from the treating physician and does not review other available documentation or apply clinical review judgment.
- Missing evidence of the treating physician's intent to order diagnostic tests
In the past, CERT would consider an unsigned requisition or physicians' signatures on test results. Now, CERT requires evidence of the treating physician's intent to order tests, e.g., signed orders, progress notes.
- Medical records from the treating physician did not substantiate what was billed
In the past, CERT would review available documentation, including physician orders, supplier documentation, and patient billing history and apply clinical review judgment. Now, CERT requires medical records from the treating physician and does not review other available documentation or apply clinical review judgment.
- Missing or illegible signatures on medical record documentation
In the past, CERT would apply clinical review judgment in considering medical record entries with missing or illegible signatures.
Now, CERT disallows entries if a signature is missing or illegible.



Excerpt from November 2009 Medicare FFS Improper Payment Rpt - Corrective Actions

- CMS is revising Medicare FFS manuals to clarify requirements for reviewing documentation to promote uniform interpretation of our policies across all medical reviews performed by Medicare contractors.
- CMS is revising Medicare FFS manuals to address the errors related to signature requirements. CMS is currently devising a process whereby providers can attest to their signature if it is illegible or missing in a medical record under review. CMS also plans to conduct provider education related to signature requirements.
- CMS is developing comparative billing reports to help Medicare contractors and providers analyze administrative claims data.



Excerpt from November 2009 Medicare FFS Improper Payment Rpt - Corrective Actions (cont.)

- CMS is undertaking an automated edit demonstration to evaluate the accuracy of several commercial products that purport to deny health care claims that contain Medicare improper payments. The demonstration will determine whether these products are feasible in the Medicare FFS environment and would result in added value to the Medicare FFS program.
- CMS tasked each Carrier, FI, and MAC with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.
- CMS requires the Carriers, FIs, and MACs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce medical necessity and incorrect coding errors.
- CMS increased and refined educational contacts with providers who are billing in error.
- CMS developed and installed new correct coding edits.
- CMS is expanding educational efforts to inform providers of Medicare coverage and coding rules.

Medicare FFS Improper Payments

Table 1a: National Error Rates by Year (Dollars in Billions)

Year	Total Dollars Paid	Overpayments		Underpayments		Overpayments + Underpayments	
		Payment	Rate	Payment	Rate	Improper Payments	Rate
1996	\$168.1	\$23.5	14.0%	\$0.3	0.2%	\$23.8	14.2%
1997	\$177.9	\$20.6	11.6%	\$0.3	0.2%	\$20.9	11.8%
1998	\$177.0	\$13.8	7.8%	\$1.2	0.6%	\$14.9	8.4%
1999	\$168.9	\$14.0	8.3%	\$0.5	0.3%	\$14.5	8.6%
2000	\$174.6	\$14.1	8.1%	\$2.3	1.3%	\$16.4	9.4%
2001	\$191.3	\$14.4	7.5%	\$2.4	1.3%	\$16.8	8.8%
2002	\$212.8	\$15.2	7.1%	\$1.9	0.9%	\$17.1	8.0%
2003	\$199.1	\$20.5	10.3%	\$0.9	0.5%	\$12.7	6.4%
2004	\$213.5	\$20.8	9.7%	\$0.9	0.4%	\$21.7	10.1%
2005	\$234.1	\$11.2	4.8%	\$0.9	0.4%	\$12.1	5.2%
2006	\$246.8	\$9.8	4.0%	\$1.0	0.4%	\$10.8	4.4%
2007	\$276.2	\$9.8	3.6%	\$1.0	0.4%	\$10.8	3.9%
2008	\$288.2	\$9.5	3.3%	\$0.9	0.3%	\$10.4	3.6%
2009	\$308.4	\$23.0	7.5%	\$1.1	0.4%	\$24.1	7.8%

November 2009 Report Improper Payments

Table 1b: Error Rates and Projected Improper Payments by Contractor Type (Dollars in Billions)

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier/MAC	\$78.7	\$7.6	9.7%	\$0.1	0.2%	\$7.8	9.9%
DME MAC	\$10.4	\$5.4	51.9%	\$0	0.0%	\$5.4	51.9%
FI/MAC - Non-Inpatient	\$108.2	\$4	3.7%	\$0.2	0.2%	\$4.2	3.9%
FI/MAC - Inpatient	\$111.2	\$6.1	5.5%	\$0.8	0.7%	\$6.8	6.1%
All Medicare FFS	\$308.4	\$23	7.5%	\$1	0.4%	\$24.1	7.8%

Medicare FFS Improper Payments

Table 1c: Summary of Error Rates by Category

Type Of Error	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross	Gross	Gross	Gross
No Documentation Errors	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%	0.6%	0.2%	0.1%
Insufficient Documentation Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%	0.4%	0.6%	1.9%
Medically Unnecessary Errors	5.1%	4.2%	3.9%	2.6%	2.9%	2.7%	3.6%	1.1%	1.6%	1.6%	1.4%	1.3%	1.4%	4.0%
Incorrect Coding Errors	1.2%	1.7%	1.3%	1.3%	1.0%	1.1%	0.9%	0.7%	1.2%	1.5%	1.6%	1.5%	1.3%	1.6%
Other Errors	1.1%	0.5%	0.7%	0.9%	0.4%	0.2%	0.0%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
IMPROPER PAYMENTS	13.8%	11.4%	7.1%	8.0%	6.8%	6.3%	6.3%	9.8%	10.1%	5.2%	4.4%	3.9%	3.6%	7.8%
CORRECT PAYMENTS	86.2%	88.6%	92.9%	92.0%	93.2%	93.7%	93.7%	90.2%	89.9%	94.8%	95.6%	96.1%	96.4%	92.2%

(5)

Medicare FFS Improper Payments

Table 1d: Type of Error Comparison for 2008 and 2009

Type of Error	Nov 2008 Report	2009 Report				
	Total	Total	Carrier/ MAC	DME MAC	FI/MAC Non Inpatient	FI/MAC Inpatient
No Documentation Errors	0.2%	0.1%	0.1%	0.0%	0.0%	0.0%
Insufficient Documentation Errors	0.6%	1.9%	1.2%	0.0%	0.5%	0.2%
Medically Unnecessary Errors	1.4%	4.0%	0.5%	1.7%	0.5%	1.3%
Incorrect Coding Errors	1.3%	1.6%	0.7%	0.0%	0.0%	0.6%
Other Errors	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
Improper Payments	3.6%	7.8%	2.5%	1.7%	1.4%	2.2%

MAC Medical Review CERT versus Traditional PI



Balancing Priorities

Balancing Medical Review MAC versus CERT

Traditional Medical Review Functions

- PCA – focused reviews
- Look for outliers
- Provider outreach & education
- Provider or group of providers
- Micro

CERT

- Random sample of all providers
- What are the payment errors for your average provider?
- Provider outreach & education
- Population based
- Macro



Major Issues Affecting all Claim Types

- Medical records versus attestations
- Physician order must be present
- Physician authentication
- Billed service covered by a NCD or LCD must meet all aspects of coverage
- Linking a billed service to a covered ICD-9 code does not guarantee payment on post payment review
- Medical records from the ordering physicians are critical to support medical necessity when the billing entity is not the ordering physician, e.g., DME, clinical diagnostic tests.

References

- CERT Contractor Customer Service:
 - 888.779.7477 or 301.957.2380
- www.certprovider.org (Disaster Attestation)

Website references:

- Internet Only Manual (IOM) – 100-8, Ch. 4 section 26.1
- Program Integrity Manual (PIM) 100-8, Ch. 5 section 5.7
- **CMS CERT:** www.cms.gov/cert/
- **Reports:** www.cms.gov/CERT/CR/list.asp#TopOfPage

Questions???

