CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 204	Date: MAY 25, 2007
	Change Request 4120

SUBJECT: Comprehensive Error Rate Testing (CERT) Program Changes

I. SUMMARY OF CHANGES: This change clarifies instructions for the CERT support actions including the resolution process, handling and reporting CERT identified overpayments and underpayments, the CERT decision dispute and disagree process, and the new reporting schedule for Error Rate Reduction Plans.

NEW / REVISED MATERIAL
EFFECTIVE DATE: June 25, 2007
IMPLEMENTATION DATE: June 25, 2007

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/Table of Contents
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D	12/12.3.13/Local Coverage Determination (LCD)/National Coverage Determination (NCD)
D	12/12.4/CERT Review Contractor Review Guidelines

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 204	Date: May 25, 2007	Change Request: 4120

SUBJECT: Comprehensive Error Rate Testing (CERT) Program Changes

Effective Date: June 25, 2007
Implementation Date: June 25, 2007

I. GENERAL INFORMATION

A. Background: This change request revises all sections of the CERT portion of the Program Integrity Manual (PIM). During the claim sampling and review process the CERT program identifies claims that have been overpaid and underpaid by Medicare contractors. The CERT program is required by the oversight agencies to collect and report overpayment information on CERT sampled claims. All sampled claim lines determined to be erroneous by the CERT program are sent to the affiliated contractor through the CERT feedback process. The AC may agree, disagree, or dispute the error determination. This section of the PIM defines the rules for an AC to follow to dispute or disagree with an error determination. After contractors are notified of their error rates, they are required to produce an error rate reduction plan that guides current and future actions to reduce improper payments.

B. Policy: These changes are necessary to continue CERT operations with the participating Medicare contractors.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
4120.1	The contractor shall notify the CERT review contractor of the correct HICN when the contractor identifies a no resolution claim where the HICN on the finalized claim is different from the HICN on the transaction request.	X	X	X	X	X	X						
4120.2	The contractor shall not enter an acceptable no resolution reason code for claims that finalized with a HICN different from the HICN on the transaction request.	X	X	X	X	X	X						
4120.3	The contractor shall complete and submit the CERT feedback file via the claims status Web	X	X	X	X	X	X						DME PSC

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
	site within seven business days of its posting.												
4120.4	The contractor shall complete and submit all lines in a feedback batch immediately preceding a report cut-off date.	X	X	X	X	X	X						DME PSC
4120.5	The contractor shall indicate the disputed line via the feedback process. The due dates for feedback information also apply to disputes.	X	X	X	X	X	X						DME PSC
4120.6	The contractor shall submit written statement, using the appropriate field in the feedback form, to explain a dispute.	X	X	X	X	X	X						DME PSC
4120.7	When a line is marked dispute or disagree, the contractor shall recalculate the final allowed amount as if the CERT decision is accurate and the line is in error.	X	X	X	X	X	X						DME PSC
4120.8	When notified of a CERT identified overpayment or underpayment, the contractor shall adjust the claim to reflect the corrected code and payment amount, and make the appropriate payment or collection actions.	X	X	X	X	X	X						
4120.9	The contractor 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 contractor shall pay the system allowed amount and educate the provider about future billing amounts.	X	X	X	X	X	X						
4120.10	The contractor shall make adjustments on zero dollar errors to reflect a change in the reason for error.	X	X	X	X	X	X						
4120.11	The contractor shall report CERT identified overpayment and underpayment collection information using the CERT payment adjustment section of the CERT claims status Web site.	X	X	X	X	X	X						
4120.12	By the first business day in April and October of the year of the report, the contractor shall report the required payment adjustment information for all CERT identified overpayments and underpayments that have been collected or paid.	X	X	X	X	X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
4120.13	Each CERT participating Medicare contractor shall submit an updated error rate reduction plan within 30 days after the release of the mid-year improper payments report.	X	X	X	X	X	X						DME PSC
4120.14	The DME PSCs are responsible for submitting the Error Rate Reduction Plans for their jurisdiction.		X										DME PSC
4120.15	The DME MAC shall work closely with the PSC to create and maintain the ERRP.		X										DME PSC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Nathan Beck (Nathan.Beck@cms.hhs.gov)
Jill Nicolaisen (Jill.Nicolaisen@cms.hhs.gov)
Post-Implementation Contact(s): Nathan Beck (Nathan.Beck@cms.hhs.gov)
Jill Nicolaisen (Jill.Nicolaisen@cms.hhs.gov)

VI. FUNDING

A. *For TITLE XVIII Contractors,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Program Integrity Manual

Chapter 12 – *The* Comprehensive Error Rate Testing *Program*

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12.3 – *The Comprehensive Error Rate Testing (CERT) Program*
(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

The CMS developed the CERT program to produce a national *Medicare fee-for-service error rate compliant with the Improper Payments Information Act. CERT randomly selects a sample of Medicare FFS claims, requests medical records from providers who submitted the claims, and reviews the claims and medical records for compliance with Medicare coverage, coding, and billing rules. The results of the reviews are published in an annual report. More information about the CERT program and the annual report are available at www.cms.hhs.gov/cert.*

For the purpose of this section of the manual, the term "affiliated contractor" (AC) shall refer to carriers, *durable medical equipment regional carriers (DMERC), and fiscal intermediaries (FI). The term MAC shall refer to all Part A/Part B, durable medical equipment (DME), and regional home health intermediary (RHHI) Medicare administrative contractors. The term DME PSC shall be used to refer to all Program Safeguard Contractor (PSC) task orders associated with DME jurisdictions.*

12.3.1 - *Contractor Communication with the CERT Program*
(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

A. CERT Staff

CMS CERT Team *mail stop C3-02-16* *7500 Security Blvd* *Baltimore, MD 21244*	AdvanceMed CERT Review Contractor 1530 E. Parham Road Richmond, Virginia 23228 Phone: (804) 264-1778	Livanta CERT Documentation Contractor Suite 9 9090 Junction Drive Annapolis Junction, MD 20701 Phone: (301) 957-2380

B. AC/*MAC/DME PSC* CERT Points of Contact (POC)

Each AC/MAC/PSC shall provide the CERT contractor with the name, phone number, address, fax number, and email address of *a general* point of contact (POC), and an IT POC. The CERT contractor will contact the IT POC to handle issues involving the exchange of electronic data. *The CERT contractor will contact the general POC to handle medical review decisions, payment adjustments, appeals, and other non-technical CERT related issues. In addition to the two POC listed above, contractors may provide the names and email address of additional POC for the CERT listserv. The listserv is used to distribute announcements, meeting agendas, and additional CERT information.*

C. *CERT Information Sources for CERT Participating Contractors*

- *The CERT public Web site at www.cms.hhs.gov/cert*
- *The CERT Confidential Web site provides access to FAQ, the CERT Manual, Error Rate Reduction Plans, and error rate data.*

- *The CERT Claims Status Web site contains sampled claims information, the feedback system, payment adjustment system, the appeals tracking system, and a calendar of events*

12.3.2 - Overview of the CERT Process

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

The CERT process begins at the AC*/MAC* processing site where claims that have entered the claims processing system are extracted to create a claims universe file. This file is transmitted each day to the *CMS Datacenter. A random sample of the claims submitted 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. Then the sample information is returned to the AC/MAC as the sampled claim transaction file. The AC/MAC returns specific information about each claim to the CERT 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 AC/MAC to request documentation from the provider who submitted the sampled claim. The claim and the supporting documentation are reviewed by CERT program clinicians who determine if the claim was submitted and paid appropriately. The CERT program collects additional information from the contractor for each claim considered to be in error via the feedback process.

12.3.3 – *CERT Process* Requirements

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

12.3.3.1 - Providing Sample Information to the CERT Contractor

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

The AC/MAC datacenters shall submit a daily file, containing information on claims entered during the day, to the CERT contractor via CONNECT:Direct. The *AC/MAC datacenters shall submit the requested information for claims identified in the sample in an electronic format.*

Requests for claim information will be transmitted in the format specified in the sampled claims transaction file section of exhibits *36.1* and *36.2*. The *AC/MAC datacenter* response *shall* be made using NDM and the formats provided for the sampled claims resolution file in exhibit *36.1* and *36.2*.

All cost and workloads associated with §12.3.3.1 activities shall be allocated to the PM CERT Support code (12901). In the case of the DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

A. Claims Universe File

The standard systems will create a mechanism for the datacenters 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. *Datacenters shall* ensure that the claims universe file contains all claims except HHA RAP claims, adjustments, and inpatient hospital PPS claims that have entered the standard claims processing system. *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*.

B. Sampled Claims Transaction File, Sampled Claims Resolution File and Claims History Replica File

The standard systems shall create a mechanism for the data centers to be able to periodically receive a sampled claims transaction file from the CMSDC. *The estimated claim volume is 2000 claims per CERT cluster per year.* This file will include claims that were sampled from the daily claims universe files. The standard systems *shall* create a mechanism for the data centers to be able to match the sampled claims transaction file against the standard system claims history file to create a sampled claims resolution file and a claims history replica file. The claims history replica file is a dump of the standard system claims history file in the standard 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 AC/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 contractor. Contractors receiving daily transaction files shall respond with daily resolution files. 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 AC/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 standard system as a result of adjustments, replicates, or other actions taken by the AC. The sampled claims transaction file will always contain the claim control number of the original claim.

If a claim identified on the transaction file is not found on the standard system claims history file, no record should be created for that claim. These are called no-resolution claims. *Each AC/MAC* shall take all necessary steps to minimize the number of no-resolution claims it submits to the CERT contractor each year. *The AC/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 Sample Discards and Errors page of the CERT Claims Status Web site.*

If the AC/MAC receives a request for a claim for which the shared system is not able to produce a resolution file, the AC/MAC shall research the claim to determine why a resolution record was not produced.

When the AC/MAC identifies a no-resolution claim where the HICN on the finalized claim is different from the HICN on the transaction request, the AC/MAC shall notify the CERT review contractor of the correct HICN. The AC/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 (see exhibit 36.8) will not be counted as errors. Should the AC/MAC discover that one or more no-resolution claims has an acceptable reason, the AC/MAC shall enter the appropriate acceptable no-resolution reason code on the CERT Claim Status Web site.

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

C. Provider Address File

In addition to the claim resolution file, each AC/MAC data center shall transmit the *provider address file containing the* names, *all known* addresses, and telephone numbers of *all* the billing providers and attending physicians *for all the claims on the resolution file*. Each *unique* provider *and address combination shall* be included only once on *each* provider address file.

D. Canceling Claims

The chart below describes the circumstances under which a cancelled/voided/deleted claim *is considered* to be an error.

	ACCEPTABLE Reason for Canceling the Claim	**UNACCEPTABLE Reason for Canceling the Claim**	
		AC paid the claim	**AC denied (full or partial)**
BEFORE the AC receives the Transaction File	These claims will be considered to be "OK": - Not a paid claim error - Not a provider error CERT will score as follows: - Paid: $0/$0	These claims will be considered to be all 3 errors: - Is a paid claim error - Is a provider error CERT will score as follows: - Paid: $x/$x - Provider: $x/$x	These claims will be considered to be the following errors: - NOT a paid claim error - Is a provider error CERT will score as follows: - Paid: $0/$0 - Provider: $x/$x

	- Provider: $0/$0		
AFTER the AC receives the Transaction File	CERT Contractor will review the SAMPLED version of the claim and score it according to the finding of the review.	Same as above	Same as above

12.3.3.2 - Providing Review Information to the CERT Contractor

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

Upon request from *CMS or the CERT contractor*, the *AC/MAC/DME PSC shall* provide the CERT contractor with all applicable materials used *by the AC/MAC/DME PSC* to *make a payment decision on* a *CERT* sampled claim. Normally, additional material *is required* on *less than* ten percent of *sampled* claims. Each *AC/MAC/DME PSC shall provide the requested information to the CERT contractor within 10 business days of the request.*

The AC/MAC/DME PSC shall indicate, in the resolution file, which claim lines were subject to complex manual medical review or routine manual medical review.

All cost and workloads associated with §12.3.2 activities shall be allocated to the MIP CERT support code (21901). In the case of a DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.3.3 - Providing Feedback Information to the CERT Contractor

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

Requests for Feedback Information

- Twice each month the CERT contractor will *post* a description of errors it has found *for* each AC/*MAC/DME* PSC *on the Claims Status Web site*. *Each* AC/*MAC/DME* PSC *shall complete the required fields for each claim listed on the* feedback *section of the Web site. Feedback batch posting dates are listed on the Claims Status Web site under calendar of events, and on the main feedback page.*

- Each AC/*MAC/DME* PSC *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. An uncompleted line will be returned in the next feedback batch. Each AC/MAC/DME PSC shall complete all of the lines in the feedback process prior to the cut-off date for a report.*

- *An* AC/*MAC/DME* PSC may *contact the CERT AC feedback coordinator to request a meeting about the results of a CERT review.*

Repricing

The *AC/MAC/DME PSC shall calculate the corrected payment* amount for each claim on the feedback report. *An AC/MAC/DME PSC* 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 AC/MAC/DME PSC* 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*.

All cost and workloads associated with §12.3.3.3 activities shall be allocated to the MIP CERT Support code (21901). In the case of a DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.3.3.1 – Disputing/Disagreeing With a CERT Decision

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

Each CERT cluster is allowed to file one dispute of any claim per quarter. The AC/MAC/DME PSC shall indicate the disputed claim via the feedback process. The due dates for feedback also apply to disputes. The AC/MAC/DME PSC shall submit written statement, using the appropriate field in the feedback form, to explain the dispute. If supporting evidence for the dispute is missing or lacking, the CMS dispute panel will uphold the CERT decision. Using the medical record and systems information available to the CERT contractor, the CMS dispute panel will complete the review within 30 days after the end of the quarter. The CERT contractor will notify the AC/MAC/DME PSC of the result after the CMS panel has made a decision. Should the AC/MAC/DME PSC elect not to submit a dispute in a given quarter, the unused opportunity does not carry over to the following quarter.

If the AC/MAC/DME PSC does not agree with a CERT decision, and the AC/MAC/DME PSC does not choose to dispute the claim, the AC/MAC/DME PSC may mark the line as disagree on the feedback form. The AC/MAC/DME PSC 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 contractor or CMS.

When a line is marked dispute or disagree, the AC/MAC/DME PSC shall recalculate the final allowed amount as if the CERT decision is accurate and the line is in error. If the CMS panel finds that the error determination is inaccurate, the recalculated amount will be corrected.

All cost and workloads associated with §12.3.3.3.1 activities shall be allocated to the MIP CERT support code (21901). In the case of the DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.4 - Handling Overpayments and Underpayments Resulting From CERT Findings

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

The instructions in this section apply only to overpayments and underpayments that result from CERT findings. The AC/*MAC* shall continue to handle overpayments and underpayments resulting from non-CERT findings as instructed in other manuals.

The CERT program notifies the AC/MAC when an underpayment or an overpayment is identified. The AC/MAC shall adjust the claim to reflect the corrected code and payment amount, and make the appropriate payment or collection. The AC/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 AC/MAC shall pay the system allowed amount and educate the provider about future billing amounts. The AC/MAC shall not collect overpayments from Medicare beneficiaries.

The AC/MAC shall use the normal claim adjustment procedures published in Pub 100-4 Claims Processing Manual. An FI/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 Claims Status Web site Coordinator.

Contractors 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 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 AC/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 AC/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 AC/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 contractor via the CERT claims status Web site. The list is updated each time the claims status Web site is refreshed. The AC/MAC shall report CERT identified overpayment and underpayment collection information using the CERT payment adjustment section of the CERT claims status Web site. A multiple collection feature is available on the Web site for cases where the collection is received in installments.

By the first business day in April and October, the AC/MAC shall report the required payment adjustment information for all CERT identified overpayments and underpayments that have been collected or paid (e.g., May 2007 report claims = April 2, 2007 due date). The AC/MAC may access the payment adjustment Web site to report collection or payment information anytime throughout the year.

All cost and workloads associated with §12.3.4 activities shall be allocated to the PM CERT Support code (12901). In the case of the DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.5 - Handling Appeals Resulting From CERT Initiated Denials

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

Each AC/MAC shall process appeals stemming from *a CERT initiated denial*. *The AC/MAC shall ensure that the appeal is handled appropriately as described in other CMS manuals.*

Each AC/MAC shall notify the CERT contractor, using the claims status Web site, when a CERT sampled claim is appealed. Medical records for the appealed CERT claim may be obtained by contacting the CERT appeals coordinator via the appeals page on the Claims Status Web site. Each AC/MAC shall enter all available information for appealed CERT sampled claims by the cut-off date listed on the CERT claims status Web site calendar. Appeal determinations entered into the CERT appeals tracking system by the specified due date will be reflected in the report.

All cost and workloads associated with §12.3.5 activities shall be allocated to the PM CERT support code (12901). In the case of the DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.8 – *Disseminating* CERT Information

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

Sharing CERT Information with the Provider Community

Each AC/MAC shall disseminate information concerning the CERT program to the provider community. *Each AC/MAC shall educate the provider community about the CERT program and the importance of responding to CERT requests for medical documentation. An AC/MAC may disclose the review status and the result of a review to the provider. The AC/MAC can obtain the review information from the Claims Status Web site.*

Sharing CERT Information with *Other Medicare Contractors*

Each AC/MAC/DME PSC shall share relevant CERT information with other Medicare contractors with whom they have a working relationship.

All costs and workloads associated with §12.3.8 activities shall be allocated to the MIP CERT Support code (21901). In the case of a DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.9 – *Error Rate Reduction Plan (ERRP)*

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

Every November, CMS *publishes a report on Medicare fee-for-service improper payments. The report includes national, contractor-type, and contractor-specific error rates. Each CERT participating Medicare contractor responsible for a jurisdiction that received a contractor-specific error rate shall develop and submit an Error Rate Reduction Plan. The ERRP shall describe the corrective actions the AC/MAC/DME PSC plans* to take in order to lower the paid claims error rate and provider compliance error rate. *The Initial ERRP is due 30 days after the release of the annual (November) improper payments report.*

After the release of the mid-year improper payments report, each CERT participating Medicare contractor shall submit an updated plan informing CMS of the progress on the error rate reduction actions described in the initial plan. Any changes to the plan should be made directly to the body of the plan in database and then summarized in the revision history portion of the ERRP. The ERRP Update is due 30 days after the release of the mid-year (May) improper payments report.

The report releases will be publicized through the CERT listserv, the CERT conference call, and the CERT public Web site.

The initial ERRP and the ERRP update shall follow the format required by the ERRP data entry system. The ERRP will describe:

- Reasons for error in the contractor's jurisdiction
- *Corrective actions already in place and new corrective actions planned for the future*
- Adjustments the AC*/MAC/DME PSC* has made or will make to its MR Strategy

- Coordination activities with other components within AC*//MAC/DME PSC*
- *How the AC/MAC will utilize the CERT findings to develop and implement outreach and education efforts*
- Suggestions on how CMS can help reduce the error rate or improve the CERT process

Each DME PSC is responsible for submitting and updating the Error Rate Reduction Plans for their jurisdictions. The DME MAC shall work closely with the PSC to create and maintain the ERRP, especially the sections where the PSC has no authority.

The CMS business function experts (BFEs), who have the responsibility of monitoring the contractor submitting the ERRP, will receive an e-mail notification of the ERRP submission from the CERT confidential Web site. The RO Divisions of Medicare Financial Management and the BFE will determine if the ERRP is a reasonable response to the contractor's error rate. RO Divisions of Medicare Financial Management will approve the entire plan after sufficiently consulting all appropriate functional areas. The approval shall take place through the RO review function in the ERRP data entry system.

All costs and workloads associated with §12.3.9 activities shall be allocated to the MIP CERT support code (21901). In the case of a DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

12.3.10 – Contacting Non-Responders

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

All costs and workloads associated with §12.3.10 activities shall be allocated to the MIP CERT support code (21901). In the case of the DME PSC, the costs and workloads associated with these tasks shall be reported in CMS ART.

A. The CERT Claims Status Web site

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 AC*/MAC/DME PSC* has the requested information, the AC*/MAC/DME PSC* may submit the documentation to the CERT contractor.

B. Contacting Non-Responders

*Each AC/MAC/DME PSC may contact all providers who have failed to submit medical records and encourage them to submit the requested records to the CERT contractor. An AC/MAC/DME PSC s*hall not contact any provider selected for CERT review until 20 days after the CERT initial request *as reported on the Claims Status Web site*. *An AC/MAC/DME PSC* may contact third party providers and encourage them to send the needed records to the CERT contractor.

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

C. Tech-Stops

An AC/MAC/DME PSC may contact providers when a claim is tech stopped. Tech stop claims can be found on the Tech Stop portion of the Claims Status Web site.

D. Customizing Address

Each AC/MAC/DME PSC shall verify the address of providers that had claims selected for CERT review. Should the AC/full PSC determine that the address in the Claim Status Web site is wrong or could be improved the AC shall notify the CERT contractor using the provider address modification tool on the CERT documentation contractor's *Web site*.

E. Requesting Spanish Letters

Spanish versions of all documentation request letters are available by contacting the CERT documentation contractor.

12.3.11 - Late Documentation Received by the CERT Contractor

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

If documentation is not received *within 75 days of the initial request the claim is scored as a no-documentation error.*

If the CERT contractor receives late documentation before the *claim is posted on the feedback Web site*, the CERT contractor *will review the late documentation and score the case appropriately.*

If the CERT contractor receives late documentation after the claim has been posted on the feedback Web site *but before the cut-off date for the report*, the CERT contractor will check the *appeals section of the Claims Status Web site* to see if the provider has appealed the denial. If the provider appealed the CERT-initiated denial, the CERT contractor will not review the late documentation. If the provider *did not appeal the denial*, the CERT contractor *will review the late documentation and score the case appropriately.*

In either case the AC/MAC/DME PSC shall notify the provider of the change in denial reason. These cases are listed on the change in status section of the claims status Web site.

12.3.12 - Voluntary Refunds

(Rev. 204, Issued: 05-25-07; Effective/Implementation Date: 06-25-07)

If the *AC/MAC* receives a voluntary refund from a provider on a *CERT sampled* claim. The *AC/MAC* shall process the *voluntary refund normally, as instructed in other manuals. If an AC/MAC processes the voluntary refund of a CERT sampled claim after receiving the transaction file for the claim in question*, the *AC/MAC* shall complete the feedback file as though the voluntary refund had not been received.