Program Memorandum
Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-02-178 **Date: DECEMBER 27, 2002**

CHANGE REQUEST 2002

SUBJECT: Clarification of the Comprehensive Error Rate Testing (CERT) Program Contractor Resolution Process (CCRP)

Background

The CMS requires that you provide the CERT contractor with feedback for those claims identified on the Monthly CERT Error Review Report – Affiliated Contractor (AC) Feedback Report (the Error Report). Each month, the CERT contractor will send you a description of errors it has found. The CERT point of contact must contact the CERT contractor to discuss decisions with which you do not agree.

Purpose

This Program Memorandum (PM) clarifies instructions with regard to the guidelines and processes for submitting monthly CERT error findings to the CCRP.

Process:

You can only utilize the CCRP for CERT error findings the CERT PSC included on the Error Report (see line items for report code 1 on Attachment 1 for the content) for lines of service that your medical review (MR) staff previously subjected to routine or complex MR. You may not use the CCRP for a line that your MR staff subjected to routine or complex MR only after you discovered the line was included as an error on an Error Report, i.e., you may not use CCRP for a line that MR staff subsequently reviewed after you noted the line as an error that the PSC identified. You cannot employ the CCRP for any other error findings. Therefore, you cannot utilize the CCRP for lines of service that you subjected to automated MR.

You must start the CCRP within 10 business days of the issuance of the Error Report. The CMS will not consider any request to use the CCRP you submit in excess of 10 business days after issuance of the Error Report and will not adjust the error rate to reflect any findings related to the CCRP. You must detail your request for the CCRP on the CERT PSC Contractor Feedback Data Entry Screen (see line items for report code 2 on Attachment 1 for a description of the content of this screen) and return the report to the CERT PSC within the allotted time.

You must return the CERT PSC Contractor Feedback Data Entry Screen within 10 working days of receipt with the final allowed charge fields for line reductions that you do not wish to subject to the CCRP regardless of whether you wish to utilize the CCRP for any other lines.

Your failure to provide the requested documentation to the CERT PSC will result in a documentation error for that line of service and you may not re-submit the line to the CCRP, even where your staff have previously conducted routine or complex MR.

The CERT PSC will provide your CERT PSC Contractor Feedback Data Entry Screen to CMS and will also maintain a tracking database of all such reports you submitted to CMS to include final disposition of error findings submitted to the CCRP. Do not provide that information to other entities; the CMS will handle all requests for copies of those reports.

NOTE: Due to limitations of the Part B standard systems that existed before January 10, 2002, the CERT PSC cannot easily differentiate lines Part B contractors subjected to automated, routine, and/or complex MR before January 10, 2002. For claims you processed on or after that date, CMS expects the CERT PSC to determine the type of review to which you subjected the claim. For Part B contractor claims processed before January 10, 2002, Part B contractors will be responsible for manually identifying whether they subjected lines of service to routine or complex review. The CMS and the CERT PSC will provide Part B contractors with detailed instructions on how to use the CERT PSC Contractor Feedback Data Entry Screen to indicate the type of review Part B contractors performed.

Resolution Guidelines:

If there is disagreement concerning the payment of a claim line, the CERT PSC will forward the file for the line to the CCRP Panel. The CCRP Panel will make best efforts to complete its review and render a determination on the line within 20 working days of their receipt of the disagreement.

The CCRP Panel will receive the following for each line submitted to the CCRP:

- Relevant information from the medical record for the disagreed upon line of service,
- Explanations from the CERT PSC and the AC of their decisions, and
- Specific references to included documentation that the AC or the CERT PSC believes supports their decision.

The CCRP Panel will make a decision based upon all information presented to them.

The CCRP Panel will consist of physician and registered nurse representation from the Center for Medicare Management (CMM), Office of Clinical Standards & Quality (OCSQ), and Program Integrity Group (PI Group). Regional office clinicians may participate in the process if they are available. The panel may request the assistance of policy and coding experts or other clinical specialists. The PI Group will determine panel membership based on the nature of the information the AC submits. A list of all participants will accompany the final report from the panel to the contractors.

Members of the panel will review the file presented without opportunity for the CERT PSC or you to submit additional material. You may make no further appeal.

The CERT PSC will provide final results from the CCRP Panel reviews to you in the CERT Quarterly Error Reconciliation Report (see line items for report code 3 on Attachment 1 for the content); the PSC will include in this report only those lines the CCRP Panel has confirmed to be in error after the CCRP Panel has completed all review of lines you submitted to the CCRP for that quarter.

You will collect overpayments on all lines paid in error included in the Error Report except for errors submitted to the CCRP. You will also collect overpayments on all lines in error included in the CERT Quarterly Error Reconciliation Report. The CMS does not require collection or payment for errors in coding that do not affect the amount originally paid, e.g., a line with an incorrect code is paid, but the corrected code (determined after CERT review) is reimbursable at the same amount as the code in error.

Part A ACs should follow payment and post payment procedures described in MIM, Chapter 8, §§3707 through 3709. Note that §3709.2 requires that you do not attempt recovery action and do not refer the case to CMS when the total overpayment is less than $50. Part B ACs should follow payment and postpayment procedures described in MCM, Part 3, Chapter 7, §7100. Note that §7115 indicates that recovery is not required when the total payment is less than $10.

You should send all reports to:

AdvanceMed
1530 E. Parham Road
Richmond, Va. 23228.

The CERT PSC will send reports to the CERT point of contact.

Quality Assurance Function:

On an annual basis, the CCRP Panel will conduct routine quality assurance reviews of the CERT program including review of a random sample of claims with error and non-error findings. The QA findings will be sent to the CERT PSC, AC, and applicable parties (i.e., ROs or CO).

The *effective date* for this PM is December 27, 2002.

The *implementation date* for this PM is December 27, 2002.

These instructions should be implemented within your current operating budget. ACs are to include all costs for the CCRP activity in Activity Code 21100. This PM is contractor specific only.

This PM may be discarded after November 1, 2003

If you have any questions, contact JStewart@cms.hhs.gov **or** TMoore2@cms.hhs.gov

Attachment

ATTACHMENT 1

DATA ITEMS INCLUDED ON CERT REPORTS AND SCREENS

Item #	Item Name	Description	Completed by	Report(s) on which item appears (A)
1	CERT Batch Date	The review date range (Monthly) for the batch of claims that CERT Operation Center that have reviewed and have disagreement on.	CERT PSC	1,2,3
2	File Created On	The date when the data file was created.	CERT PSC	1,2,3
3	Record #	Record number. Sequential record ID.	CERT PSC	1,2,3
4& 5	Contractor Number and Name	The 5 characters contractor ID and full name	CERT PSC	1,2,3
6	Claim Review Date	Date this claim was reviewed by CERT.	CERT PSC	1,2,3
7	CERT Internal Claim	QID is the CERT database key field. This field will be used to link to all CERT related tables.	CERT PSC	1,2,3
8	Line #	Claim line-item number.	CERT PSC	1,2,3
9	Sample Reason	Sample Reason. The sixth position of this field identifies which sample category for this claim. O=Original, V=Verification, T=Technical.	CERT PSC	1,2,3
10	Original	ICN/CCN originally assigned to the claim by the standard system.	CERT PSC	1,2,3
11	HICNUM	Beneficiary's Health Insurance Claim Number	CERT PSC	1,2,3
12	Beneficiary Name	Beneficiary name.	CERT PSC	1,2,3
13	Claim Entry Date	Universe date. Date this claim entered into the standard system.	CERT PSC	1,2,3
14	HCPCS Procedure Code	HCPCS Procedure Code.	CERT PSC	1,2,3
15	HCPCS Modifier	First code identifying special circumstances related to the service.	CERT PSC	1,2,3
16	HCPCS Modifier	Second code identifying special circumstances related to the service.	CERT PSC	1,2,3
17	Submitted Charge	Actual charge submitted by provider or supplies for the service or equipment.	CERT PSC	1,2,3
18	Medi. Initial Allow	Amount Medicare allowed for the service or equipment before any reduction or denial.	CERT PSC	1,2,3
19	Final Allowed Charge	Final amount the Medicare contractor allowed for this service or equipment after any reduction or denial.	CERT PSC	1,2,3
20	Cert Finding Error	Internal sequence of all error code related to this line item.	CERT PSC	1,2,3
21	Error Description	All denial codes related to this line item.	CERT PSC	1,2,3
22	CERT Reviewer Comments	CERT reviewer comments.	CERT PSC	1,2,3
23	Disagree Reason Code *(in Contractor Decision section)*	The code that indicates the reason the Medicare contractor disagrees with the CERT contractor decision. AA = Medically unnecessary service or treatment BB = Service incorrectly downcoded CC = Service incorrectly upcoded DD = Service incorrectly coded EE = Not covered or unallowable service FF = Service provided by someone other than billing provider HH = Duplicate payment II = Unbundling JJ = Other	MEDICARE CONTRACTOR	2,3

		KK = Disagreement with error code (include short narrative in narrative field)		
Item #	Item Name	Description	Completed by	Report on which appears (A)
24	Adjusted Internal Control # *(in Contractor Decision section)*	Adjusted ICN from contractor.	MEDICARE CONTRACTOR	2,3
25	Date *(in Contractor Decision section)*	Date the contractor made the adjustments (system default to current date).	MEDICARE CONTRACTOR	2,3
26	Amount Questioned *(in Contractor Decision section)*	Dollars questioned as a result of CERT recommendation, generally the amount of money to be repaid to Medicare if the adjustment resulted in an overpayment. Preface negative values (underpayments) with a minus sign (-).	CERT PSC	1,2,3
27	Final Amount *(in Contractor Decision section)*	Corrected final amount allowed for this service or equipment after the CERT error condition is applied.	MEDICARE CONTRACTOR	2,3
28	Adj. HCPCS Code *(in Contractor Decision section)*	The adjusted Health Care Procedure System code identifying the service or supply that was rendered, as determined by the CERT independent reviewer (may be blank if no coding errors). The HCPCS code itself is 5 positions long and may include 1st two 2-position modifiers.	CERT PSC	1,2,3
29	Contractor Comments	Concise statement written by the Medicare contractor in response to items listed on the Monthly CERT Error Review Report.	MEDICARE CONTRACTOR	2,3
30	CERT UMBI Rebuttal	Detailed CERT UMBI Manager rebuttal description based on contractor's response	CERT PSC	3
31	Date *(in CERT UMBI Rebuttal section)*	Date the CERT UMBI manager reviewed the claim	CERT PSC	3
32	CMS Panel Decision	Indicates whether the paned agreed with CERT or agreed with the AC	CCRP Panel	3
33	Date reviewed by CMS panel	Date on which the CMS panel made their decision	CCRP Panel	3

Note A: Definition of report codes

1: Monthly CERT Error Review Report -- AC Feedback Report
2: CERT PSC Contractor Feedback Data Entry Screen
3: CERT Quarterly Error Reconciliation Report