Comprehensive Error Rate Testing (CERT) Frequently Asked Questions (FAQs)

General:

1. **What is the CERT Program?**
   The Centers for Medicare & Medicaid Services (CMS) implemented the CERT program to measure improper payments in the Medicare Fee-for-Service (FFS) program.

   The CERT program selects a stratified random sample of approximately 50,000 claims submitted to Part A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DMACs) during each reporting period. This sample size allows CMS to calculate a national improper payment rate as well as contractor- and service-specific improper payment rates. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample is considered to reflect all claims processed by the Medicare FFS program during the report period.

   CMS. 2015. CERT. *[ONLINE] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html.* [Accessed 7 October 2016].

2. **Why are medical records being requested?**
   The sample of Medicare FFS claims is reviewed by an independent medical review contractor to determine if they were paid or denied properly under Medicare coverage, coding, and billing rules. If these criteria are not met or the provider fails to submit medical records to support the claim billed, the claim is counted as either a total or partial improper payment. This improper payment amount may be recouped (for overpayments) or reimbursed (for underpayments). The last step in the process is the calculation of the Medicare FFS improper payment rate, which is published annually in the Health and Human Services (HHS) Agency Financial Report (AFR).

   CMS. 2015. CERT. *[ONLINE] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html.* [Accessed 7 October 2016].

3. **If I release this information, will I be in violation of the HIPAA regulations?**
   Providing medical records of Medicare beneficiaries to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).

4. **Will you include a release with your medical record request?**
   A release will not be included with the medical record request. When the beneficiary became insured by Medicare, the beneficiary signed a release authorizing Medicare to obtain their medical records at any time.

5. **Do you have the beneficiary's written consent to release medical records?**
   A signed consent form is not required from the beneficiary for the release of medical records. When enrolling in Medicare, the beneficiary signed a release authorizing Medicare to obtain their medical records at any time.

6. **Who pays postage and photocopying costs?**
   The CERT program is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

7. **Where should I send copies of medical records?**
   Copies of medical records can be faxed or mailed to the information below. Please be sure to include the Claim Identification number (CID number) and barcoded cover sheet.

   Fax: 804-261-8100

   Mail:
   Attn: CID XXXXXXX
   CERT Documentation Center
   1510 East Parham Road
   Henrico, VA 23228

   Compact Disc (CD):
   If mailing a CD, it MUST contain only images in TIFF or PDF format. Please be sure that all information is encrypted and protected by a password. Send the password via email to certmail@admedcorp.com

   esMD:
   CERT accepts documentation from providers sent via the Electronic Submission of Medical Documentation (esMD) mechanism. For more information about esMD, see https://www.cms.gov/esMD

8. **If the medical records that are needed to fulfill the CERT request are located at another site or with a third party, can you request the medical records from there?**
   The provider that billed the claim is responsible for maintaining all documentation necessary to support the services billed on the claim. We encourage providers and/or suppliers to work with the third party to obtain the records. We can request the medical records from the third party, if you are able to provide the contact information, however, in the event they do not comply with our request, Medicare may deny the claim or ask for an adjustment to the payment that was made.

9. **The information being requested in the "Additional Documentation" letter was previously submitted in my original response, what should I do?**
   You should look over the response that was sent and compare it to what is being requested. You may respond indicating the information was previously provided and add details as to where this information is located within the record.

   OR

   Contact the CERT Documentation Center at 888-779-7477 and request clarification as to what specifically the reviewers are looking for aside from what has already been sent.

10. **I do not have access to all of the medical records listed on your barcoded sheet. Am I required to submit all of the documentation listed?**
    The documents listed on the barcoded sheet are typical of documents needed to support Medicare payment of the claim. Please provide all of the pertinent medical records/documentation and any additional documentation needed to support the claim.

11. **My claim is for psychotherapy. I think there are special rules that I don't have to submit medical records.**
    You are not required to submit psychotherapy notes. Psychotherapy notes are defined as notes recorded by a mental health professional that 1) document or analyze the contents of a counseling session and 2) are separated from the rest of a medical record (see Final Privacy Rule, 45 CFR, Part 164.501).

    The definition of psychotherapy notes expressly excludes the following information and should be submitted in support of the claim:

    - Medication prescription and monitoring,
    - Counseling session start and stop times,
    - Modalities and frequencies of treatment furnished,
    - Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.

    It is important to note that if a provider has combined information excluded from the definition of psychotherapy notes with a psychotherapy note (e.g., symptoms), it is the responsibility of the provider to extract the information needed to support that a Medicare claim is reasonable and necessary.

    CMS. [ONLINE] Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3457.pdf [Accessed 7 October 2016].

12. I have the medical records you are requesting and all of the beneficiary's information matches, however the spelling of the beneficiary's name is different, what should I do?

Submit the medical records you have along with a copy of the Medicare Card. If there are any issues, you will be contacted by our Quality Control department.

13. If I have requested the medical records from the third party and they are refusing to provide the information, what should I do?

Please contact us to furnish the third party contact information (i.e., contact name, phone, and fax number). We will contact the third party and try to obtain the medical records directly. Please remember, failure to obtain the requested records may result in a payment adjustment from your Medicare Administrative Contractor (MAC).

14. What is a Signature Attestation Statement?

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a handwritten or an electronic signature. Stamped signatures are not acceptable.

- If the signature is illegible, CMS medical review entities shall consider evidence in a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, CMS medical review entities shall disregard the order during the review of the claim. The order must be signed at the time of the order. Providers may not submit an attestation when the signature is missing from an order.
- If the signature is missing from any other medical documentation, CMS medical review entities shall accept a signature attestation from the author of the medical record entry.
- For a list of exceptions to signature requirements, please refer to the Medicare Program Integrity Manual (PUB 100-08), Chapter 3, Section 3.3.2.4.

In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

CMS. 2010. *CMS Manual System*. [ONLINE] Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf [Accessed 7 October 2016].

15. What is an ABN?

Advance Beneficiary Notice (ABN) is issued to Medicare beneficiaries to notify the beneficiary he/she will be financially responsible if Medicare does not pay for the services provided. The beneficiary must sign the ABN before services are performed.

16. **For short (less than 24 - 48 hour stay) inpatient hospital stays, is a discharge summary required as part of the documentation?**
    A discharge summary is not required when a beneficiary is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary.

17. **What is a Contractor ID?**
    The contractor ID is the 5 digit identifying number belonging to the entity responsible for processing claims in your geographic location.

18. **What is your website?**
    http://www.certprovider.com

19. **What company or organization do you work for?**
    We are the CERT Review Contractor contracted by CMS.

20. **What are the consequences if errors are found?**
    The CERT program notifies the MACs of improper payments identified through the CERT process. The MACs then reimburse underpayments and recoup overpayments. Contact your MAC to see what your next step should be.

21. **What is the procedure if there is an overpayment?**
    The MACs recoup overpayments. Contact your MAC to see what your next step should be.

Documentation from Referring/Ordering Providers:

1. **Referring/Ordering Provider: Why am I receiving this request**?
   You are receiving this request because you were listed on this claim as the ordering/referring provider. The information listed in bold specifies what is needed from your office.

2. **Referring Provider: Why is this request addressed to a facility other than my own?**
   You are receiving this request because you were listed on this claim as the referring provider. This claim was billed by the facility listed on the letter. The information listed in bold specifies what is needed from your office.

3. **Referring Provider: I did not see this patient on the date of service that is listed on your request.**
   The dates of service specified on the request are the dates when the billing provider treated this patient. You may/should have documentation on or prior to the date of service listed.

4. **Referring Provider: This is my NPI number; however, I have never treated this patient.**
   If you are certain that you have never treated this patient and you have no other offices where this patient could have been seen, please submit a signed statement to confirm this.

5. **Referring Provider: This is my NPI number; however, I only own the practice. I have never treated this patient; another physician that practices at my office treated this patient. How should I respond to this request?**
   You are receiving this request because your NPI number was listed on a claim as the referring provider. The information listed in bold specifies what is needed from your office. Please provide what is being requested along with a statement in writing clarifying your affiliation with the physician that actually treated the patient for the specified services.

Submitting Documentation:

1. **Can I send in my medical records on a USB flash drive?**
   No, the only acceptable methods of submitting medical records are:
   - Paper copy via mail
   - CD/Disc using PDF or TIFF files (do not imbed images in proprietary software) via mail
   - Fax
   - esMD

2. **What should I do if the copy of medical records we have on file is not clearly legible?**
   Try to obtain a legible copy from where the original is located before sending to the CERT Documentation Center.

3. **Who do I contact if I have questions regarding what documentation is being requested?**
   Please contact the CERT Documentation Center at 888-779-7477 if you have any questions about the request letter and/or the items listed on it.

4. **What should I do if there was an error in billing on the claim that is now being audited by CERT?**
   Send the CERT Documentation Center a response stating that there was a billing error and contact your MAC to see what your next step should be.

5. **Who is responsible for obtaining medical records from a third party?**
   The billing provider is responsible for obtaining medical records from the third party to substantiate the claim that was billed.

6. **Why am I receiving a request for Additional Documentation with a date of service that I do not have/did not bill for?**
   After reviewing the initial documentation received, a clinical professional determined that additional documentation is needed for the review. That supporting documentation could be prior and/or after the "billed" date of service to substantiate the claim that was billed.

7. **We utilize a copy service for our release of information. How should these requests be handled by the copy service?**
   All providers must review the request before submitting them to their copy services. The necessary documentation may not necessarily be on the date of service listed on the request. Supporting documentation may be prior to and/or after the "billed" date of service.

8. **Who should I send an invoice to for the copying of medical records?**
   The CERT program is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

9. **What do I do if I receive another request after I have already submitted the records?**
   Please contact the CERT Documentation Center at 888-779-7477 to determine if the proper records have been received. Please do not resend the records without confirming with the CERT Documentation Center.

10. **The MAC and CERT are requesting the same records. Do I still need to send the records to both entities?**
    If the MAC has indicated that they are requesting records in support of a CERT audit, you may notify them after you have provided the records to CERT. If the MAC has not indicated the purpose of the request, please submit records to both the MAC and CERT.