

# Medicare Review Contractors

7/30/2024

**Closed Captioning:** *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

# Today's Presenters

- Provider Outreach and Education Consultants
  - Laura Brown, CPC
  - Lori Langevin





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# Objective

To educate the provider community on the different Medicare review contractors and to understand the provider's role in the Medicare review process.



# Agenda

- Medicare Review Contractors
  - [Supplemental Medical Review Contractor](#)
  - [Unified Program Integrity Contractor](#)
  - [Recovery Auditors](#)
  - [Medicare Administrative Contractors](#)
  - [Comprehensive Error Rate Testing](#)
- [Prepare for a Medicare Audit/Review](#)
- [Resources](#)

# Medicare Review Contractors

- Several initiatives to prevent or identify improper payments before CMS processes a claim, and to identify and recover improper payments after paying a claim
- The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all providers types
- [CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 1](#)

# Supplemental Medical Review Contractor

# SMRC - Mission

- Perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs. The focus of the reviews may include but are not limited to issues identified by CMS internal data analysis, the CERT program, professional organizations and other Federal agencies, such as the OIG/GAO and comparative billing reports.



# SMRC - Contact Information

- Noridian Healthcare Solutions, LLC is the SMRC under contract with CMS
- The SMRC contact center is available
  - Monday–Friday
  - 8:30 a.m.–6:00 p.m. ET/ 7:30 a.m.–5:00 p.m. CT
  - Telephone: 833-860-4133
  - [Noridian SMRC website](#)

# SMRC Process

- Identify provider noncompliance with coverage, coding, billing, and payment policies through the research and analysis of data related to assigned task (e.g., profiling of providers, services or beneficiary utilization)
- As directed by CMS
  - Perform medical review
  - Perform extrapolation
- Notify the individual billing entities of review findings identified and make appropriate recommendations for POE and UPIC referrals

# Role of SMRC

- Serving as a readily available source of medical information to provide guidance in questionable claims review situations
- Providing the clinical expertise and judgment to develop LCDs and internal MR guidelines
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse
- Providing clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse
- Serving as a readily available source of medical information to provide guidance in questionable situations

# Role of MAC

- MACs may initiate claim adjustments and/or overpayment recoupment actions through the standard overpayment recovery process

# Unified Program Integrity Contractor

# UPIIC – Mission

- To help address fraud, waste and abuse by performing Medicare data analysis and comprehensive problem identification and research to identify potentially fraudulent Medicare providers and coordination of benefit integrity activities among MACs in the region, and dissemination of relevant benefit integrity information to the respective MACs

# Jurisdiction K – Safeguard Services, LLC

- UPIC Northeastern
- [Safeguard Services, LLC](#)
- States in UPIC Northeastern
  - Pennsylvania, **New York**, Delaware, Maryland, D.C., New Jersey, **Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut**

# Jurisdiction 6 – CoventBridge Group

- UPIC Midwestern
- [CoventBridge Group](#)
- States in UPIC Midwestern
  - **Minnesota**, Missouri, **Illinois**, Indiana, Iowa, Kansas, Kentucky, Michigan, Nebraska, Ohio, **Wisconsin**



# UPIC Process

- Perform data analysis
- Request medical records and documentation
- Conduct interviews
- Conduct onsite visits
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold payments
- Refer cases to law enforcement

# Role of UPIC

- Investigate instances of suspected fraud, waste and abuse
- Develop investigations early, and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid
- Identify any improper payments that are to be recouped by MACs

# Role of MAC

- Claim processing, including paying providers/suppliers
- Provider outreach and education
- Recouping monies lost to the Medicare Trust Fund
  - The UPICs identify these situations and refer them to the MACs for the recoupment
- Medical review not for benefit integrity purposes
- Complaint screening
- The MAC will refer to the UPIC if fraud is suspected
- Claims appeals of UPIC decisions
- Claim payment determination and claims pricing
- Auditing provider cost reports

# Recovery Auditors

# RA Program - Mission

- To identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments

# RA Region 1 - Jurisdiction K

# RA Region 2 - Jurisdiction 6

- Performant Recovery, Inc.
  - [Website](#)
  - Email - [Info@PerformantRAC.com](mailto:Info@PerformantRAC.com)
  - Telephone: 866-201-0580
- Please visit their website for
  - Issues under review
  - Forms and sample documents
  - FAQs
  - Review provider contact Information for accuracy

# RA Process

- Issue selected for review
- CMS approves issue
- RA requests claims
- RA reviews documentation (complex review) or claim (automated review) and makes determination
- If an error is found, a file is sent to the claims processing MAC to be adjusted for over or underpayment

# Time Frames

- RA has 30 calendar days to complete the review and send a decision letter
- RA may look back up to three years from the claim paid date to review claims
- RA will forward the adjustment to the MAC 30 days after the initial findings letter or after a **discussion period** has been completed



# Role of RA

- Review claims on a postpayment basis using the same Medicare policies as MACs
  - NCDs
  - LCDs and
  - CMS manuals/regulations
- To ensure accuracy, RA is required to employ nurses, therapists, certified coders and a contractor medical director

# Role of MAC

- After a RA post pay review, an electronic file of claims to be adjusted is sent to claims processing contractor
  - Marked as RA adjustments in claims processing system
- Electronic reports are sent to RA on daily basis to notify them that an adjustment has been processed

# Provider Demand Letter

- Identify RA demand letter
  - Right corner will contain letter number that begins with “R” For example: R-1234567
  - The first paragraph says: “This finding was a result of a Recovery Audit Program review.”
- Review the demand letter sent from the MAC
- Providers need to review their remittance advice
  - If they see a N432 that means an adjustment was done due to a RA review

# Provider Rebuttal

- Request rebuttal
  - Opportunity to provide a statement and accompanying evidence indicating why overpayment action will cause financial hardship and should not take place
    - Not disagreeing with overpayment decision
    - No review of supporting medical documentation will take place
  - Must be submitted by the 15th day from date on demand letter

# Provider Appeal

- Appeal with local MAC
  - Include specific reason why you feel RA determination should be overturned

# Medicare Administrative Contractors

# MAC Medical Review – Mission

- To reduce costs related to improper payments and appeals, therefore reducing provider burden

# MAC Medical Review - Contact Information

- National Government Services
  - [Our website](#)
  - Fax
    - J6: 315-595-4364
    - JK: 315-442-4231



# MAC Medical Review Process

- TPE strategy and the NGS medical review process
  - The purpose is to reduce costs related to improper payments and appeals
    - This will reduce provider burden
  - Providers selected for TPE will receive a notification letter from NGS

# MAC Medical Review - Postpayment

- Postpayment probes
  - MR may conduct postpayment claim reviews
  - A sample of paid claims is selected and a request for medical records is requested from the provider
  - Providers must submit medical records as directed by the medical review notice letter within 45 days of the record request

# Time Frame

- Prepayment decision timeline
  - Claims will suspend
  - Documentation requested via ADR
  - Return documentation – 45 days (recommend 30 days)
    - Claims will deny on day 46 if records not received
  - NGS will make review determinations within 30 calendar days of receiving the provider's requested documentation
  - Detailed results letter
    - One-on-one education

# Role of MAC Medical Review

- TPE notification and ADR letters
  - Notification outlines the TPE process
  - Reason for review
    - Why your facility was selected
    - Procedure code/HCPCS code – short description of what is being reviewed
  - Do not send documentation until you receive an ADR letter
    - Will include a list of specific elements needed to support the service being reviewed

# Responding to TPE ADRs

- NGS recommends responding to ADRs within 30 days
  - CMS allows providers 45 days of the ADR date
- Forward the requested documentation to the correct address
- Send responses separately and attach a copy of the corresponding ADR
- Include all records necessary to support the services for the dates requested
- Do not include unrelated correspondence
- Records must be complete and legible
- NGSConnex allows providers to respond to ADRs electronically
- Ensure services include necessary signatures and credentials of professionals

# Provider Tips

- What can you do?
  - Review all contractor provider publications and LCDs
  - Understand Medicare coverage requirements
  - Ensure office staff and billing vendors are familiar with claim filing requirements
  - Perform self-audits of medical records against billed claims using coverage criteria, LCD and coding guidelines
  - Ensure documentation is legible and demonstrates that the patient's condition warrants the services being reported and billed

# Comprehensive Error Rate Testing

# CERT Mission

- Designed to monitor and improve Medicare payment accuracy, evaluate provider claim submission practices and protect the Medicare Trust Fund



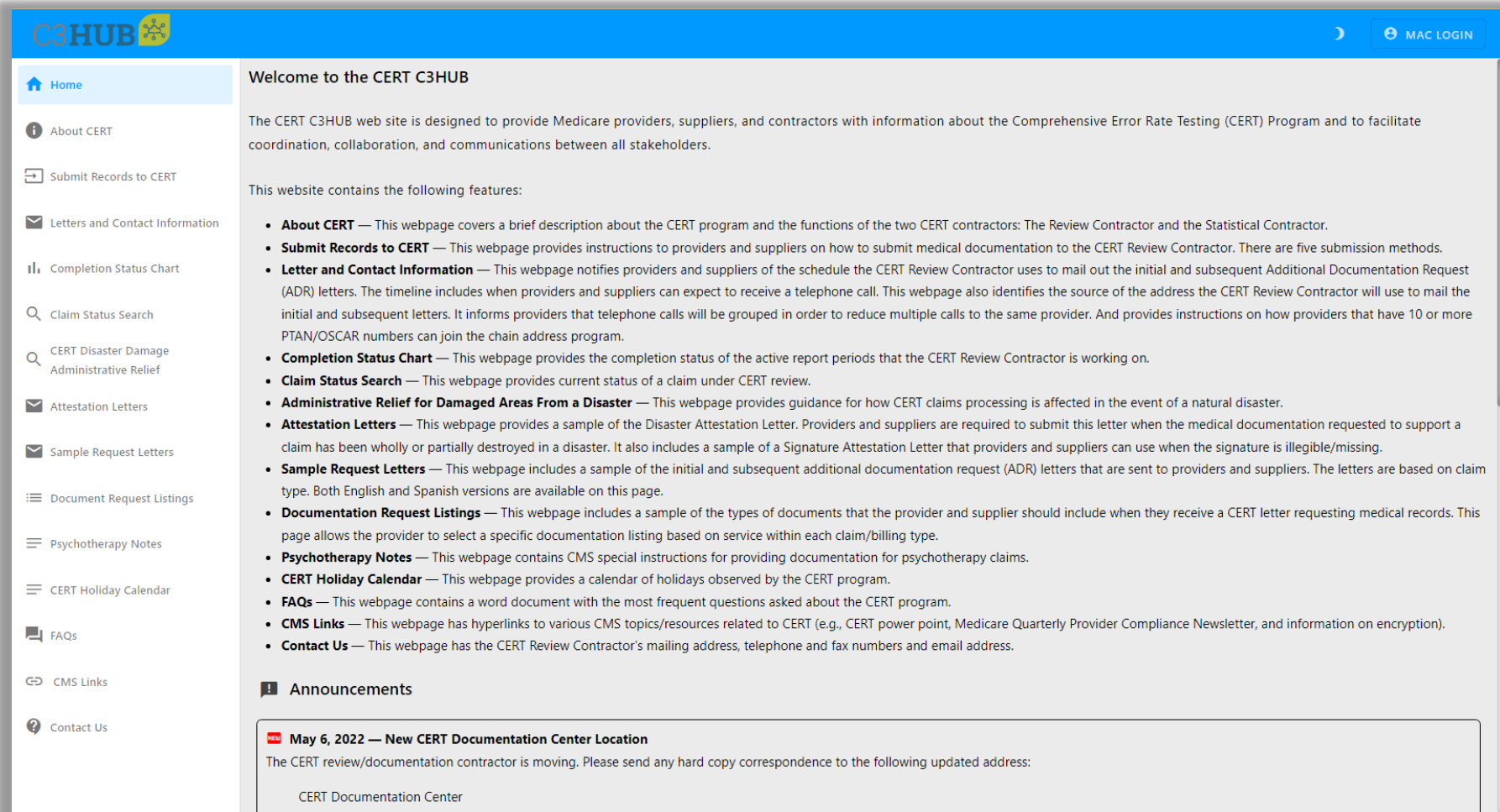
# CERT Contact Information

- Website: [CERT C3HUB](#)
- Mail:
  - CERT Documentation Center  
8701 Park Central Drive, Suite 400-A  
Richmond, Virginia 23227
- Fax: 804-261-8100
- Telephone: 443-663-2699 or Toll Free 888-779-7477
- Email: [certprovider@empower.ai](mailto:certprovider@empower.ai) (general questions)
- Email: [certmail@empower.ai](mailto:certmail@empower.ai) (medical records and passwords)
  - Include barcoded coversheet with CID number with medical record submissions

# CERT Provider Website

- [CERT C3HUB](#)
  - Submit records to CERT
    - Submission methods
  - Letter and contact information
    - Schedule for initial and subsequent request
    - Chain Address Program and Group Calls
  - Claim Status Search
    - Current status of claim under CERT review
  - Sample request letters
    - Samples of documentation request letters and envelope
  - Documentation request listings
    - Sample of documents required based on provider/billing type
  - FAQs
    - Answers about submitting CERT claims documentation

# CERT Provider Website - C3HUB



**C3HUB** MAC LOGIN

- Home
- About CERT
- Submit Records to CERT
- Letters and Contact Information
- Completion Status Chart
- Claim Status Search
- CERT Disaster Damage Administrative Relief
- Attestation Letters
- Sample Request Letters
- Document Request Listings
- Psychotherapy Notes
- CERT Holiday Calendar
- FAQs
- CMS Links
- Contact Us

## Welcome to the CERT C3HUB

The CERT C3HUB web site is designed to provide Medicare providers, suppliers, and contractors with information about the Comprehensive Error Rate Testing (CERT) Program and to facilitate coordination, collaboration, and communications between all stakeholders.

This website contains the following features:

- About CERT** — This webpage covers a brief description about the CERT program and the functions of the two CERT contractors: The Review Contractor and the Statistical Contractor.
- Submit Records to CERT** — This webpage provides instructions to providers and suppliers on how to submit medical documentation to the CERT Review Contractor. There are five submission methods.
- Letter and Contact Information** — This webpage notifies providers and suppliers of the schedule the CERT Review Contractor uses to mail out the initial and subsequent Additional Documentation Request (ADR) letters. The timeline includes when providers and suppliers can expect to receive a telephone call. This webpage also identifies the source of the address the CERT Review Contractor will use to mail the initial and subsequent letters. It informs providers that telephone calls will be grouped in order to reduce multiple calls to the same provider. And provides instructions on how providers that have 10 or more PTAN/OSCAR numbers can join the chain address program.
- Completion Status Chart** — This webpage provides the completion status of the active report periods that the CERT Review Contractor is working on.
- Claim Status Search** — This webpage provides current status of a claim under CERT review.
- Administrative Relief for Damaged Areas From a Disaster** — This webpage provides guidance for how CERT claims processing is affected in the event of a natural disaster.
- Attestation Letters** — This webpage provides a sample of the Disaster Attestation Letter. Providers and suppliers are required to submit this letter when the medical documentation requested to support a claim has been wholly or partially destroyed in a disaster. It also includes a sample of a Signature Attestation Letter that providers and suppliers can use when the signature is illegible/missing.
- Sample Request Letters** — This webpage includes a sample of the initial and subsequent additional documentation request (ADR) letters that are sent to providers and suppliers. The letters are based on claim type. Both English and Spanish versions are available on this page.
- Documentation Request Listings** — This webpage includes a sample of the types of documents that the provider and supplier should include when they receive a CERT letter requesting medical records. This page allows the provider to select a specific documentation listing based on service within each claim/billing type.
- Psychotherapy Notes** — This webpage contains CMS special instructions for providing documentation for psychotherapy claims.
- CERT Holiday Calendar** — This webpage provides a calendar of holidays observed by the CERT program.
- FAQs** — This webpage contains a word document with the most frequent questions asked about the CERT program.
- CMS Links** — This webpage has hyperlinks to various CMS topics/resources related to CERT (e.g., CERT power point, Medicare Quarterly Provider Compliance Newsletter, and information on encryption).
- Contact Us** — This webpage has the CERT Review Contractor's mailing address, telephone and fax numbers and email address.

### Announcements

**May 6, 2022 — New CERT Documentation Center Location**  
The CERT review/documentation contractor is moving. Please send any hard copy correspondence to the following updated address:  
CERT Documentation Center

# CERT Process

- CERT selects a stratified random sample of paid or denied claims from all Medicare contractors
- CERT requests medical records from the billing and ordering provider by letter, phone and fax
  - If some of the requested records are housed at another site
    - Providers should forward a copy of the request to the other site
    - Or give CERT other site contact information; CERT will follow up with other site with additional record requests

# Requesting Medical Records

- Based on each individual CID
  - All **Initial** ADR letters are sent to the address the provider has on file with Medicare
  - All **Subsequent ADR** letters for that CID can be sent to a specific address designated by the provider by calling CERT, after you receive the initial ADR letter

# Requesting Medical Records

- Chain Address Program\*
  - Providers having at least five PTAN numbers can elect a single point of contact to participate in the “chain address” program
    - Call CERT office: 888-779-7477
      - Provide all PTAN numbers and the designated point of contact information
    - CERT will email/call the point of contact with a list of outstanding CID numbers
- Group Calls\*
  - When a provider has multiple CIDs with the same phone number, CERT will group together to discuss all outstanding requests
- Important Note: These processes are only regarding the CERT program

# CERT Documentation Center Envelope

**CENTERS FOR MEDICARE AND MEDICAID SERVICES**  
CERT DOCUMENTATION CENTER  
8701 Park Central Drive  
Suite 400-A  
Richmond, VA 23227

**Important Dated Information Enclosed**

**Immediate Response Required**  
**Medicare Record Request**



If no addressee name is shown, forward to Medical Records Department.



PROVIDER/SUPPLIER NAME  
ADDRESS LINE 1  
ADDRESS LINE 2  
CITY, STATE, ZIPCODE

Date: 4/19/2023  
Reference ID: CID #: 00000000  
NPI/Provider #: 0000000000  
Phone: 000-000-0000  
Fax: 000-000-0000

**Request Type & Purpose: First Letter**  
**Subject: Additional Documentation Required.**

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.<sup>1</sup> The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit [www.cms.gov/CERT](http://www.cms.gov/CERT).

#### Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

#### Action: Medical Records Required

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS 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.

#### When: 6/3/2023

Please provide the requested documentation by 6/3/2023 . A response is still required by 6/3/2023 even if you are unable to locate the requested information.

#### Consequences

If the billing provider/supplier fails to send the requested documentation or contact CMS by 6/3/2023 , the billing provider's/ supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

<sup>1</sup>Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986





## Instructions

- Specific information and instructions pertaining to the sampled claim and returning requested documents are shown on the following pages of this letter.
- Please include the barcoded cover sheet with your submission.

## Submission Methods

You may submit this documentation in any of the following ways:

- Via postal mail to: CERT Documentation Center,  
8701 Park Central Drive, Suite 400-A  
Richmond, VA 23227
- Via fax: 804-261-8100
  - 1) Use the Barcoded coversheet as the only coversheet.
  - 2) Do not add your own coversheet—this slows down the receipt and identification process.
  - 3) Send a separate fax transmission for each individual claim.
- Via Electronic Submission of Medical Documentation (esMD):
  - 1) Include a CID# or Claim number and the barcoded cover sheet in your file transmission.
  - 2) Information on esMD can be found at [www.cms.gov/esMD](http://www.cms.gov/esMD).
  - 3) For questions about esMD please contact: [esMDBusinessOwners@cms.hhs.gov](mailto:esMDBusinessOwners@cms.hhs.gov).
- Via CD:
  - 1) The images should be encrypted per HIPAA security rules.
  - 2) If encrypted, the password and CID# must be provided via email to [CERTMail@empower.ai](mailto:CERTMail@empower.ai) or via fax to 804-261-8100.
  - 3) Must contain only images in TIFF or PDF format.
- Via Email Attachment to [CERTMail@empower.ai](mailto:CERTMail@empower.ai):
  - 1) The email attachment(s) should be encrypted per HIPAA security rules.
  - 2) If encrypted, the password and CID# must be provided via phone to 888-779-7477 or via fax to 804-261-8100.
  - 3) Must contain only attachments in TIFF or PDF format.

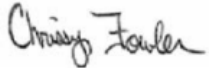
## Questions

If you have any questions, please contact:

CERT Documentation Center  
8701 Park Central Drive, Suite 400-A Richmond,  
VA 23227

Email questions to: [CERTProvider@empower.ai](mailto:CERTProvider@empower.ai)  
Toll Free: 888-779-7477  
Fax: 804-261-8100

Sincerely,



Chrissy Fowler  
Director, Payment Accuracy & Reporting Group  
Office of Financial Management  
Centers for Medicare & Medicaid Services

## Attachments / Supplementary Information

1. Claim Information
2. Bar Coded Cover Sheet



### Claim Information

**Due Date:** 6/3/2023

Medicare Part B Provider

NPI/Provider #:	000000000	Request Date:	4/19/2023
Patient Name:	Patient Name		
Date of Birth:	11/20/1950	<b>Date(s) of Service:</b>	<b>10/15/2020 - 10/16/2020</b>
CERT Claim ID (CID):	0000000	Patient Identifier:	000000000A
Claim Date:	2/3/2023	Claim Control Number (CCN):	0000000000000000
Ref/Ord Provider/NPI #:	000000000 Referring/Ordering Provider		
Medical Record Number:	00000000000000000000	Patient Account #:	00000000000000000000

#### Diagnoses Codes

Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8
XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX

Line Item Date	Revenue Code	Performing Provider/NPI #	Provider Specialty	Diagnosis Code	HCPCS Code	HCPCS Modifier 1	HCPCS Modifier 2	HCPCS Modifier 3	HCPCS Modifier 4
xx/xx/xxxx	xxxx	000000000	xxx	xxxxx	xxxxx	xxx	xxx	xxx	xxx



PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

Medicare CERT Review Contractor  
GS-00F-263CA CERT



CID: 0000000

Due Date: 6/3/2023 Medicare Part B Provider  
Patient Name: Patient Name  
Claim Control Number: 0000000000000000  
Request Date: 4/19/2023 Date(s) of Service: 10/15/2020 - 10/16/2020  
NPI/Provider #: 0000000000 Universe Date: 11/20/2020  
Contractor: 00000 Contractor Type: B  
Patient Date of Birth: 11/20/1950  
Letter Sequence: Initial Request

Providers and suppliers are required to maintain documentation supporting the submission of Medicare claims and to submit this documentation upon request. The documents listed in the following chart may be needed to support Medicare payment of the claim with the date(s) of service specified above. Please provide all of the pertinent medical records/documentation and any additional documentation needed to support this claim. If any pertinent documentation is missing, incomplete, or requires explanation, please include this information in the comments section.

**Consequences:** If the provider/supplier fails to send the requested documentation or contact CMS by the Due Date specified above, the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Please provide the name and contact phone number of the individual submitting the documents in support of this request. This information may be used if additional information is necessary.

NAME: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Documents that may be required

List of potential documentation required by CERT.

CERT Documentation Center - Attn: CID # 0000000  
8701 Park Central Drive, Suite 400-A, Richmond VA 23227  
FAX 804-261-8100 PH 888-779-7477



# Timeframe

- Respond to requests timely
  - Be sure staff places a high priority on responding to requests
    - 45 days – response is due
    - 46 days – response is overdue
    - 76 days – receive nonresponse error 99 and subject to overpayment recovery by MAC
  - National Government Services may contact to remind you

# CERT Timetable – Watch the Days

- **Initial Request Schedule**

- Day 0: Send letter 1 requesting documentation. The provider has 45 days from this letter to furnish the requested documentation.
- Day 21: Telephone contact to follow-up on request and/or offer assistance.
- Day 30: Send letter 2. The provider has 15 days left to complete the request.
- Day 35: Telephone contact to follow-up on request and/or offer assistance.
- Day 45: Send letter 3. (**Response is due**)
- Day 49: Telephone contact to follow-up on request and/or offer assistance. (**Response is overdue**)
- Day 60: Send letter 4. (**Response is overdue**)
- Day 76: Claim is counted as **nonresponse** error and is subject to overpayment recovery by the Medicare Administrative Contractor (MAC).

# Role of CERT

- The documentation is reviewed by independent medical reviewers to determine if the claim was paid properly under Medicare coverage, coding and billing rules
- If the documentation does not support that the rules were met, the claim is counted as either a total or partial improper payment

# Role of CERT

- The error is then categorized into one of five major categories
  - No documentation
  - Insufficient documentation
  - Medical necessity
  - Incorrect coding
  - Other
- CERT notifies the MAC of the claims with CERT errors

# Role of MAC

- NGS receives notification of review results and responds to all identified errors (over and underpayments)
- Claims will be adjusted through normal claim adjustment process to allow additional payment if underpaid or recoup any overpayments
- Providers will be notified through the normal adjustment process that will include appeal rights



# Role of Provider

- Verify all addresses are up-to-date with Medicare
  - Update by using [PECOS](#) or the appropriate [CMS-855](#) application
- Identify and respond timely to ADRs
  - Within 45 days
- Be familiar with documentation requirement
  - [CERT Document Request Lists](#)
  - NGS [Medicare Topics](#) and [Specialties](#)
  - NGS [Medical Policies/LCDS](#) (Local Coverage Determinations)
- Submit documents to support all services and dates of service on claim

# Role of Provider

- Obtain documentation from third party
  - Forward a copy of the request to other provider's office, hospital or health care facility
  - Or, give CERT the other facility's contact information
    - CERT will follow up by sending an ADR letter
- If you disagree with CERT decision
  - Use local MAC's appeal process

# CERT A/B MAC Outreach & Education Task Force Logo



# CERT A/B MAC Outreach & Education Task Force Goal

- The goal of the A/B MAC Outreach & Education Task Force is to ensure consistent communication and education to reduce the Medicare Part A and Part B error rates
  - A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
  - Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions
- Disclaimer: The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate

# CERT A/B MAC Outreach & Education Task Force

- CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force
  - CMS has a web page dedicated to education developed by the [CERT A/B MAC Outreach & Education Task Force](#)
- NGS CERT Task Force Link
  - Log into [our website](#) by selecting Type Provider and State
    - On welcome page select Resources > Medicare Compliance > Comprehensive Error Rate Testing > List on right, select CERT Task Force (link to CMS webpage)

# CERT A/B MAC Outreach & Education Task Force

The screenshot shows the 'Resources' page for Medicare Compliance on the National Government Services website. The navigation bar includes 'HOME', 'EDUCATION', 'RESOURCES', 'EVENTS', 'ENROLLMENT', and 'APPS'. The main heading is 'MEDICARE COMPLIANCE' with the sub-heading 'What can we help you with?'. Below this, there are seven buttons for different services: 'Targeted Probe and Educate', 'Comprehensive Error Rate Testing', 'Fraud & Abuse', 'Prior Authorization', 'Supplemental Medical Review Contractor', 'Recovery Audit', and 'Medical Review'.

## Helpful Resources

[CERT Denial Finder](#)

[CERT Task Force](#)

[CMS CERT Compliance](#)

## Options for submitting medical records to CERT

Include barcode coversheet with all submissions.

### Option to submit Electronic using esMD:

More information on esMD can be found at

[www.cms.gov/esMD](http://www.cms.gov/esMD)

, be sure to route medical records to the CERT Contractor at:

804-261-8100

### Option to Mail:

CERT Documentation Center

Attn: CID

# Prepare for a Medicare Audit/Review

# How to Prepare

- Determine who is accountable for specific roles within office and ensure an understanding of their goals and objectives
- Be familiar with the documentation requests
  - Required documentation lists will indicate components needed to review claim (letter or website)
  - Documentation submission method
  - Contact information



# How to Prepare

- Documentation submitted is
  - The contractor's only picture of the patient and the care you provided
  - The proof that the claim is accurate
    - The services billed were delivered
    - The services delivered and billed met Medicare standards of medical necessity
- If it wasn't documented, it did not happen

# How to Prepare

- Review details of medical records
  - Signature, legibility, clarity, complete
  - All lab tests and other pertinent information included in medical record
  - Ensure documentation supports the level of coding
  - Check to be sure number of units documented are the same in the medical record as submitted on claim

# How to Prepare

- Missing or Illegible Signatures
  - Signature log or signature page
  - Signature attestation
    - “I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”  
M.D. Signature \_\_\_\_\_
- Reference
  - [CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4](#)

# How to Prepare

- Know how to locate resources
  - ICD-10; CPT/HCPCS; documentation requirements
- Know local and national coverage determinations that apply
- Understand Medicare rules and regulations
- Know your appeal rights with local MAC
- Establish a quality assurance program for your practice

# How to Prepare

- Final Check
  - Timely response is critical
  - Provide all requested records
  - Records must be legible
  - Include appropriate signatures and credentials
  - Check right beneficiary, right service, right date of service
  - Clear copies of both sides of document
  - Verify mailing address and/or fax numbers are correct

# Resources

# Resources

The screenshot displays the website's navigation bar with the following items: Contact Us, NGSConnex, Subscribe for Email Updates, Part B Provider in Illinois (J6), national government SERVICES logo, HOME, EDUCATION, RESOURCES (highlighted), EVENTS, ENROLLMENT, APPS, and a search icon. Below the navigation is a 'Resources' section with a blue header for 'MEDICARE COMPLIANCE'. The main content area is titled 'What can we help you with?' and features seven service boxes: Targeted Probe and Educate, Comprehensive Error Rate Testing, Fraud & Abuse, Prior Authorization, Supplemental Medical Review Contractor, Recovery Audit, and Medical Review.

# Resources

The screenshot shows the 'Resources' page on the National Government Services website. The page is titled 'CLAIMS AND APPEALS' and is divided into two main sections: 'Claims' and 'Appeals'. The 'Claims' section includes links for 'CMS 1500 Claim Form', 'Fee Schedule Lookup', and 'Medicare Beneficiary Identifier (MBI)'. The 'Appeals' section includes links for 'About Appeals', 'Levels of Appeals and Time Limits for Filing', and 'Reopenings for Minor Errors and Omissions'. The website header includes the National Government Services logo, navigation links for HOME, EDUCATION, RESOURCES, EVENTS, ENROLLMENT, and APPS, and a search icon. The current user location is identified as 'Part B Provider in Connecticut (JK)'.

Contact Us NGSConnex Subscribe for Email Updates Part B Provider in Connecticut (JK) ▾

national government SERVICES

HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾

Resources

## CLAIMS AND APPEALS

### Claims

- CMS 1500 Claim Form
- Fee Schedule Lookup
- Medicare Beneficiary Identifier (MBI)
- Medicare Secondary Payer (MSP)
- NGSConnex
- Top Claim Errors

### Appeals

- About Appeals
- Levels of Appeals and Time Limits for Filing
- Reopenings for Minor Errors and Omissions



# Resources

Contact Us NGSConnex Subscribe for Email Updates **Part B Provider in Connecticut ( JK )** ▾

**national government SERVICES** HOME EDUCATION ▾ **RESOURCES ▾** EVENTS ENROLLMENT APPS ▾

Resources

## MEDICAL POLICIES/LCDS

### National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below.

**Please note:** There are many procedures for which NGS does not have an LCD/Billing and Coding Article. If your search does not return any coverage documents, then NGS does not have a local coverage statement for that procedure.

For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

**Local Coverage Determinations** Medical Policy Articles

### Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing <i>Related terms: tilt table, sudomotor</i>	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95999

# Resources

The screenshot shows the 'Education' section of the National Government Services website. The page is titled 'MEDICARE TOPICS' and features a grid of 27 topic buttons for users to click and learn more. The topics are arranged in a grid that is 8 rows high and 3 columns wide, with the final row containing only two buttons.

MEDICARE TOPICS		
Select a Topic to Learn More!		
Additional Development Requests	Appropriate Use Criteria	Beneficiary Notices Initiatives
Billing	Care Management	Clinical Trials
Coding and Edits	COVID-19	Critical Care
Diabetes Awareness	Documentation	Drugs and Biologicals
Drugs and Vaccines	Eligibility	Evaluation and Management
Global Surgery	Health Professional Shortage Area	Home Health Benefit
Home Infusion Therapy	Incident To Services	Medically Unlikely Edits
Modifiers	National Correct Coding Initiative	New Provider Center

A grid of 10 topic buttons arranged in four rows. The first three rows have three buttons each, and the fourth row has one button centered under the first three columns.

Pain Management	Remittance Advice	Remote Monitoring Services
RuralServ	Sacroiliac Joint Injections and Procedures	Sleep Studies
Telehealth	Timely Filing	Tobacco Cessation
Transplant Services		

# Resources

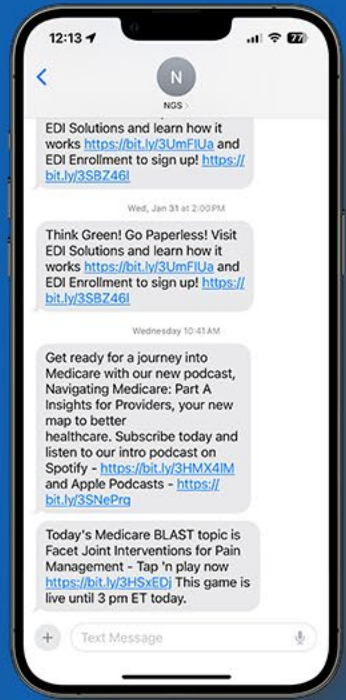
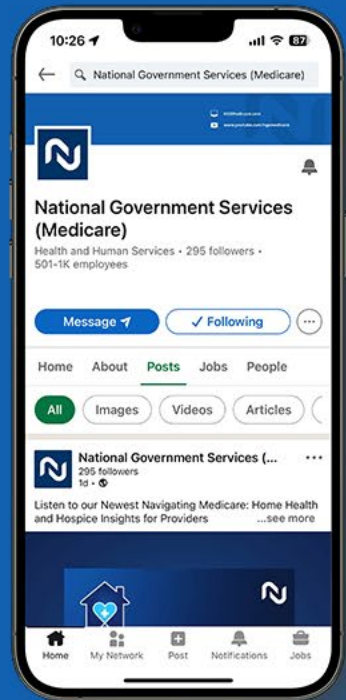
The screenshot shows the 'SPECIALTIES' page on the National Government Services website. The page features a navigation bar with links for HOME, EDUCATION (selected), RESOURCES, EVENTS, ENROLLMENT, and APPS. Below the navigation bar, the 'SPECIALTIES' section is titled 'Select a Specialty to Learn More!' and contains a grid of 18 specialty options:

Ambulance	Anesthesia	Audiology
Cardiac	Chiropractic Services	Dental
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Independent Diagnostic Testing Facility	Laboratory/ Pathology
Mental Health	Nephrology	Oncology
Ophthalmology/ Optometry	Opioid Treatment	Physical Therapy/ Occupational Therapy/ Speech Therapy
Podiatry	Preventive Services	Radiology




# Questions?


Thank you!



# Connect with us on social media

 [YouTube Channel](#)  
Educational Videos

medicare **mobile**  
Text NEWS to 37702; Text GAMES to 37702

 [www.MedicareUniversity.com](http://www.MedicareUniversity.com)  
Self-paced online learning

 [LinkedIn](#)  
Educational Content

# Find us online



[www.NGS Medicare.com](http://www.NGS Medicare.com)

Online resources, event calendar, LCD/NCD, and tools



IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



[Sign up for Email Updates](#)

Subscribe for Email updates at the top of any NGS Medicare.com webpage to stay informed of news