

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Medicare Claim Review Programs



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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Background

The Federal Government estimates that about 12.7 percent of all Medicare Fee-For-Service (FFS) claim payments are improper. The Centers for Medicare & Medicaid Services (CMS) implemented several initiatives to prevent or identify and recover improper payments before CMS processes a claim, and to identify and recover improper payments after processing a claim. The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types. This booklet is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors – in particular, coverage and coding errors.

Claim Review Contractors

Under the authority of the Social Security Act, CMS employs a variety of contractors to process and review claims according to Medicare rules and regulations. Table 1 describes the contractors discussed in this booklet.



Key Terms

- **Prepayment Review:** Review of claims **prior** to payment. Prepayment reviews result in an initial determination.
- **Postpayment Review:** Review of claims **after** payment. Postpayment reviews may result in either no change to the initial determination or a revised determination, indicating an underpayment or overpayment.
- **Underpayment:** A payment a provider receives **under** the amount due for services furnished under Medicare statute and regulations.
- **Overpayment:** A payment a provider receives **over** the amount due for services furnished under Medicare statute and regulations. Common reasons for overpayment are:
 - Duplicate submission and subsequent payment of the same service or claim;
 - Payment to an incorrect payee;
 - Payment for excluded or medically unnecessary services;
 - Payment for services that were furnished in a setting that was not appropriate to the patient's medical needs and condition; or
 - Billing for excessive or non-covered services.

Table 1. Medicare Contractors and Responsibilities

Type of Contractor	Responsibilities
Medicare Administrative Contractors (MACs)	Process claims submitted by physicians, hospitals, and other health care professionals, and submit payment to those providers according to Medicare rules and regulations (includes identifying and correcting underpayments and overpayments)
Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs)*	Perform investigations that are unique and tailored to the specific circumstances and occur only in situations where there is potential fraud and take appropriate corrective actions
Supplemental Medical Review Contractor (SMRC)	Conduct nationwide medical review as directed by CMS (includes identifying underpayments and overpayments)
Comprehensive Error Rate Testing (CERT) Contractors	Collect documentation and perform reviews on a statistically valid random sample of Medicare FFS claims to produce an annual improper payment rate
Medicare FFS Recovery Auditors	Review claims to identify potential underpayments and overpayments in Medicare FFS, as part of the Recovery Audit Program

* All PSCs transitioned to ZPICs with the exception of Zone 6. For more information, refer to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1204.pdf> on the CMS website.

For contact information for these contractors, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.

While all contractors have a specific area of focus, each contractor conducting a claims review must apply all Medicare policies to the claims under review. Additionally, once a claim is reviewed, a different contractor should not reopen it. Therefore, it is important when conducting claims review, contractors review each claim in its entirety.

Claim Review Programs

This booklet describes the five claim review programs and their role in the life cycle of Medicare claims processing. Each claim review program has at least one of the following levels of review:

- **Non-complex review:** Does not require a clinical review of medical documentation; or
- **Complex review:** Requires licensed professionals who review additional requested documentation associated with a claim.

The columns in Table 2 divide the Medicare claim review programs based on performance of prepayment or postpayment reviews. See Table 4 for a summary of the five claim review programs and how they proactively identify potential coverage and coding errors.

Table 2. Medicare Prepayment and Postpayment Claim Review Programs

Prepayment Claim Review Programs*	Postpayment Claim Review Programs
National Correct Coding Initiative (NCCI) Edits	Comprehensive Error Rate Testing (CERT) Program
Medically Unlikely Edits (MUEs)	Recovery Audit Program
Medical Review (MR)	Medical Review (MR)

* In 2012, CMS introduced the Recovery Audit Prepayment Review Demonstration, which allows Recovery Auditors to conduct **prepayment** reviews on certain types of claims that historically result in high rates of improper payments. The demonstration focuses on 11 States: California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas.

National Correct Coding Initiative (NCCI) Edits

Performed by: MACs, ZPICs, CERT, RACs

Complexity: Non-complex

For more information, visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd> and <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html> on the CMS website.

CMS developed the NCCI to promote national correct coding methods and to control improper coding that leads to inappropriate payment in Medicare Part B claims. NCCI edits prevent improper payments when incorrect code combinations are reported. NCCI edits are updated quarterly.

The coding policies are based on coding conventions defined in the following:

- American Medical Association (AMA) Current Procedural Terminology (CPT) Manual;
- Healthcare Common Procedure Coding System (HCPCS) Manual;
- National and local Medicare policies and edits; and
- Coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice.

The Column One/Column Two Correct Coding Edits file describes the code pairs that you should not report together for reasons explained in the NCCI Coding Policy Manual. For more information, visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html> on the CMS website.

If a claim contains the two codes of an edit pair, the Column One code is eligible for payment, but CMS will deny the Column Two code. However, if both codes are clinically appropriate and you use an appropriate NCCI-associated modifier, the codes in both columns are eligible for payment. The medical record must include supporting documentation for the appropriate NCCI-associated modifier.

You cannot bill Medicare beneficiaries for services denied based on NCCI edits. Because the denials are based on incorrect coding rather than medical necessity, you cannot use an “Advance Beneficiary Notice of Noncoverage (ABN)” (Form CMS-R-131) to seek payment from a Medicare beneficiary. Also, because the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, you cannot use a “Notice of Exclusions from Medicare Benefits” form to seek payment from a Medicare beneficiary.

Help Prevent Improper Payments

Providers may conduct self-audits to identify coverage and coding errors. The Office of Inspector General (OIG) offers Compliance Program Guidelines at <http://oig.hhs.gov/compliance/compliance-guidance> and statistical guidelines at <http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf> on the OIG website.

NOTE: Outpatient Code Editor (OCE) edits and NCCI edits are two different editing systems for processing claims. The NCCI edits are used when processing physician services under the Medicare Physician Fee Schedule (PFS), while the OCE edits are used when MACs process hospital outpatient services under the Hospital Outpatient Prospective Payment System (OPPS). While a number of the NCCI edits are included in the OCE edits, the OCE edits are used exclusively under the OPPS – they are not used within the Medicare PFS.

An add-on code is an HCPCS/CPT code that describes a service, **with one exception**, always performed in conjunction with another primary service. Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is only eligible for payment if one of its primary codes is also eligible for payment, with one exception. For more information on add-on codes, visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html> on the CMS website.

Medically Unlikely Edits (MUEs)

Performed by: MACs

Complexity: Non-complex

For more information, visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html> on the CMS website.

CMS developed MUEs to reduce the paid claims error rate for Medicare claims. Just like the NCCI edits, the MUEs are automated prepayment edits. The MAC's systems analyze the procedures on the submitted claim to determine if they comply with the MUE policy.

An MUE for an HCPCS/CPT code is the maximum units of service that a provider would report, under most circumstances, for a single beneficiary on a single date of service. MUEs are categorized into claim line edits and date of service edits based on policy or clinical benchmarks. MUEs do not exist for all HCPCS/CPT codes. National health care organizations have the opportunity to review and comment on proposed edits prior to implementation of MUEs. While the majority of MUEs are publicly available on the CMS website, CMS will not publish all MUE values because of fraud and abuse concerns. CMS updates MUEs quarterly.

Providers should **not** interpret MUE values as utilization guidelines. MUE values do **not** represent units of service providers may report and avoid further medical review. Providers should continue to report only services that are medically reasonable and necessary. For more information on MUEs and the MUE process, refer to the MLN Matters® Article “Revised Modification to the Medically Unlikely Edit (MUE) Program” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8853.pdf> on the CMS website.

Medical Review (MR) Program

Performed by: MACs, ZPICs/PSCs, and SMRC

Complexity: Complex

For more information, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review> on the CMS website.

CMS, MACs, and other claim review contractors identify suspected billing problems through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, analysis of claims data, and evaluation of other information (for example, complaints). CMS, MACs, and other claim review contractors target MR activities at identified problem areas appropriate for the severity of the problem.

If the MAC verifies that an error exists through a review of a sample of claims, it classifies the severity of the problem as minor, moderate, or significant and imposes corrective actions appropriate for the severity of the infraction. The following types of corrective actions can result from MR:

- **Provider Notification/Feedback:** The MAC informs the provider of appropriate billing procedures when it detects problems at minor, moderate, or significant levels;
- **Prepayment review:** The MAC may place providers with identified problems submitting correct claims on prepayment review, in which a percentage of their claims undergo MR before the MAC authorizes payment. Once providers re-establish the practice of billing correctly, prepayment review ends; and
- **Postpayment review:** Contractors perform postpayment claims review most commonly by using statistically valid sampling. Sampling allows estimation of an underpayment or overpayment (if one exists) without requesting all records on all claims from providers. This reduces the administrative burden for Medicare and costs for both Medicare and providers.

NOTE: SMRC reviews are selected by CMS.

Both prepayment and postpayment reviews may require providers to submit medical records. Following a request for medical records, the provider must submit them within the specified time frame.

To help prevent improper payments, the MAC's Provider Outreach and Education (POE) department provides education for providers submitting claims. Find contact information for your local MAC so you can get information on its POE department by going to <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.

Electronic Submission of Medical Documentation (eSMD)

Providers may submit medical record documentation electronically. For more information, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD> on the CMS website.

Comprehensive Error Rate Testing (CERT) Program

Performed by: CERT Review Contractor (RC), CERT Documentation Contractor (DC), and CERT Statistical Contractor (SC)

Complexity: Complex

For more information, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT> on the CMS website.

The Improper Payments Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Improvement Act of 2012, requires CMS to calculate the national Medicare FFS improper payment rate. CERT randomly selects a statistically valid sample of processed Medicare FFS claims, and requests medical documentation from the provider or supplier that submitted the sampled claim. CERT review professionals review the claim and the supporting documentation to determine whether the claim was paid appropriately according to Medicare coverage, payment, coding, and billing rules.

CMS calculates a national Medicare FFS improper payment rate and improper payment rates by claim type to accurately measure the performance of the MACs and gain insight into the causes of errors. CMS publishes the results of these reviews annually. The Medicare FFS Improper Payment Rate is a good indicator of how claims errors in the Medicare FFS Program impact the Medicare Trust Fund.

Table 3 specifies each of the five error categories that CERT contractors identify.



Table 3. CERT Error Categories

Type of Error	Description
No Documentation	Provider or supplier fails to respond to repeated requests for the medical records or they do not have the requested documentation.
Insufficient Documentation	Submitted medical documentation is inadequate to support payment for the services billed, or a specific documentation element that is required as a condition of payment is missing (for example, a physician signature on an order).
Medical Necessity	There is adequate documentation in the medical records to make the informed decision that the services billed were not medically necessary based upon Medicare coverage policies.
Incorrect Coding	Provider or supplier submits medical documentation supporting: <ul style="list-style-type: none">• A different code than was billed;• The service was performed by someone other than the billing provider or supplier;• The billed service was unbundled; or• A beneficiary was discharged to a site other than the one coded on a claim.
Other	When a claim error does not fit in any other category (for example, duplicate payment error, non-covered or unallowable service).

Claims selected for CERT review are subject to potential postpayment denials, payment adjustments, or other actions depending on the result of the review. Normal appeal rights and processes apply. For more information on the Medicare appeals process, refer to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243294.html> on the CMS website. CMS analyzes improper payment rate data and develops corrective actions to reduce improper payments. Potential corrective actions include:

- Improving system edits;
- Increasing and focusing medical review on problem areas;
- Updating coverage policies and manuals; and
- Conducting provider education efforts.

Recovery Audit Program

Performed by: Medicare FFS Recovery Auditors

Complexity: Complex

For more information, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program> on the CMS website.

Recovery Auditors review past Medicare FFS claims for potential overpayments or underpayments, reviewing medical records when necessary to make appropriate determinations. When performing these reviews, Recovery Auditors follow Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions, and the respective MAC's Local Coverage Determinations (LCDs). Recovery Auditors do not develop or apply their own coverage, payment, or billing policies.

In general, Recovery Auditors do not review a claim previously reviewed by another entity. Recovery Auditors analyze claims data using their proprietary software to identify claims that clearly or likely contain improper payments.



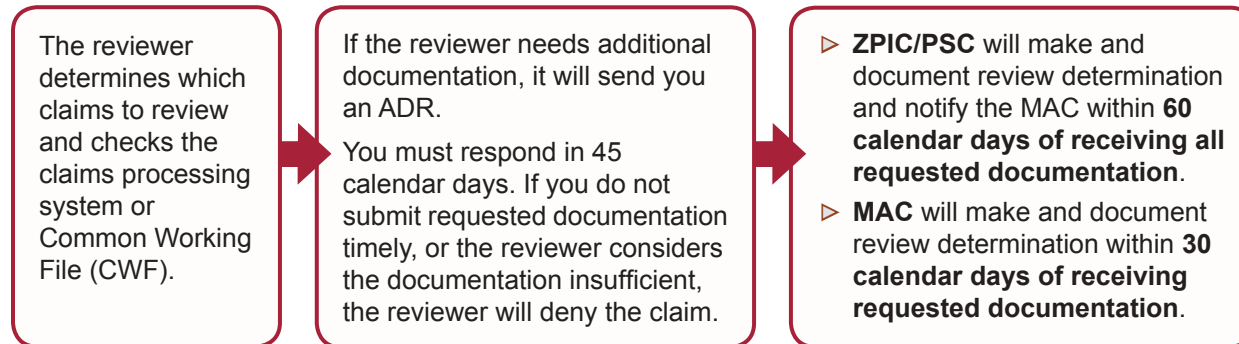
Services Targeted by Recovery Auditors

Recovery Auditors post a description of all approved reviews to their websites. Find the Recovery Auditor for your claims at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.

The Medicare FFS Claims Review Process

The charts below diagram the Medicare FFS Claims Review Process.

Prepayment Review Process: MACs and ZPICs/PSCs

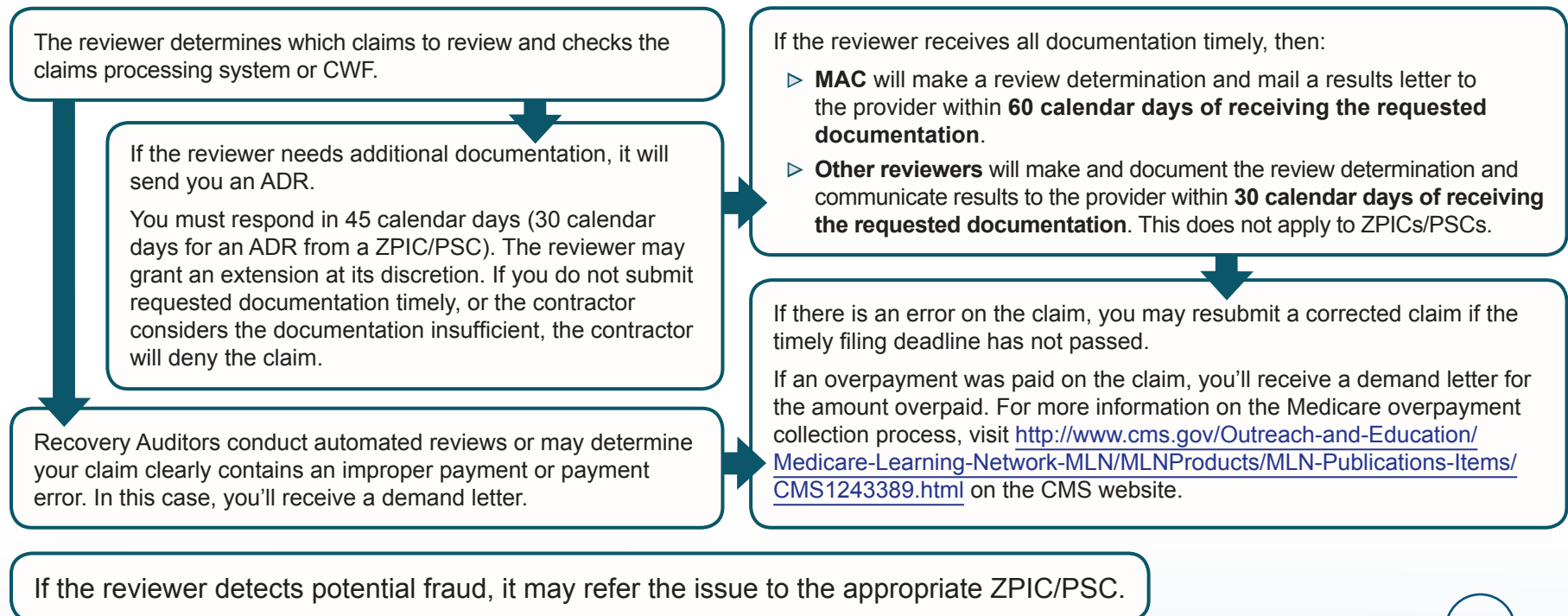


What's in an Additional Documentation Request (ADR) Letter?

- Reason your claim was selected;
- What actions you need to take;
- When you need to reply;
- Consequences of not replying;
- Instructions for replying; and
- Contractor contact information.

For more information on the ADR letter, refer to Exhibit 46 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83exhibits.pdf> on the CMS website.

Postpayment Review Process: CERT, MACs, Recovery Auditors, SMRC, and ZPICs/PSCs



Summary

Table 4 summarizes the Medicare claim review programs discussed in this booklet.

Table 4. Summary of NCCI Edits, MUEs, MR, CERT, and Recovery Audit Program

Topic	NCCI Edits	MUEs	MR Program	CERT Program	Recovery Audit Program
Providers & Suppliers Impacted are those who submit claims for:	Part B services using HCPCS/ CPT codes	Part B services using HCPCS/ CPT codes	FFS services & items	FFS services & items	FFS services & items
Medicare Contractor	NCCI Contractor develops the edits; MACs operate the edits	NCCI Contractor develops the edits; MACs operate the edits	MACs ZPICs/PSCs SMRC	CERT RC CERT DC CERT SC	Medicare FFS Recovery Auditors
Claims Impacted	All Part B practitioner, Ambulatory Surgical Center (ASC), and hospital OPPS claims screened	All Part B practitioner, ASC, outpatient hospital, Durable Medical Equipment (DME), and therapy claims screened	Targeted claim review – number varies by MR strategy, or by CMS direction	Limited random claim sample	Widespread or targeted claim review
Prepayment Edit/ Medical Record Review	Yes – tables updated quarterly	Yes – tables updated quarterly	Yes (MACs and ZPICs/PSCs)	No	No

Table 4. Summary of NCCI Edits, MUEs, MR, CERT, and Recovery Audit Program (cont.)

Topic	NCCI Edits	MUEs	MR Program	CERT Program	Recovery Audit Program
Postpayment Medical Record Review	No	No	Yes	Yes	No – if clear payment error Yes – if likely payment error
Provider Response to Audit Request	N/A	N/A	Prepayment Review – Providers must submit medical records to MAC/ZPIC/PSC within 45 calendar days of request. Postpayment Review – Providers must submit medical records to the MAC/SMRC within 45 calendar days of the request, 30 calendar days for ZPICs/PSCs*	Providers must submit medical records to the CERT DC within 45 calendar days of the request*	Providers must submit medical records to the Recovery Auditor within 45 calendar days of the request*
Right to Appeal	Yes	Yes	Yes	Yes	Yes

* Extension to submit medical records **may** be granted

Resources


Visit CMS' Frequently Asked Questions (FAQs) website at <https://questions.cms.gov> for common questions about claims review programs. In the search bar, type the Medicare claims review program for which you are searching for more information.

Table 5 provides a list of resources for more information on Medicare Claim Review Programs.

Table 5. Resources

Topic	Resources
CERT Program	http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT
Medicare Appeals	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243294.html
Medicare Overpayment Collection Process	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243389.html
MLN Guided Pathways (GPs)	<p>Basic Medicare Resources http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf</p> <p>All Other GP Resources http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html</p>
MR Program	<p>Medical Review Web Page http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review</p> <p>“Medicare Program Integrity Manual” http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html</p>

Table 5. Resources (cont.)

Topic	Resources
MUEs	http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
NCCI Edits	<p>Overview Web Page (including FAQs) http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd</p> <p>“Medicare Claims Processing Manual,” Chapter 23, Section 20.9 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf</p> <p>“How to Use the National Correct Coding Initiative (NCCI) Tools” http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243274.html</p>
Provider Compliance	<p>Provider Compliance Website http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device</p> <p>Provider Compliance Newsletter http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf</p> 
Recovery Audit Program	http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program



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