The CERT Program:

What It Is and What a Practice Needs to Know

The Comprehensive Error Rate Testing (CERT) program is a crucial component of the Medicare program that helps ensure the government is paying only for the services and care that beneficiaries actually receive. The program is designed to identify improper payments made to healthcare providers and suppliers under Medicare Part A and B and Durable Medical equipment MACs (DMACs). This article will explore what the CERT program is, how it works, what a practice should do if a CERT request for records arrives, and how the CERT report can be used to help a practice stay compliant.

What Is the CERT Program?

In 1996, the measurement of the Medicare FFS improper payment rate commenced. The estimation of the national Medicare FFS improper payment rate from 1996 through 2002 was the responsibility of the Office of Inspector General (OIG) under the Department of Health and Human Services (HHS). The OIG's sampling method was designed to only determine a national Medicare FFS paid claims improper payment rate. However, due to the small sample size of approximately 6,000 claims, the OIG was unable to produce valid breakdowns of improper payment rates by contractor, contractor type, service type, or provider type. The OIG recommended an increase in sample size, which was implemented by CMS when they began producing the Medicare FFS improper payment rate in 2003 with the CERT program. It has been updated periodically to reflect changes in Medicare policies and regulations. The program is overseen by CMS and is carried out by a contractor that is responsible for collecting and analyzing the data.

The goal of the CERT program is to quantify the rate of improper payments made by the Medicare program and to identify the root causes of these errors. The program collects data on a sample of claims that have been paid by Medicare and then reviews those claims to determine if they were paid

correctly. The program then calculates an error rate based on the number of claims that were paid incorrectly.

According to the Centers for Medicare & Medicaid Services (CMS), the CERT program is designed to provide a national estimate of the Medicare fee-for-service (FFS) improper payment rate. The program is also used to identify areas of vulnerability in the Medicare program and to develop strategies to reduce improper payments.

How Does the CERT Program Work?

The CERT program uses a statistically valid stratified random sampling process to select about 50,000 claims that will be reviewed. The sample is drawn from claims that have been paid by Medicare Parts A and B during a given year. The sample is stratified by provider type and by the amount of the claim. An independent medical review contractor then reviews each claim to determine if it was paid correctly. If a claim is found to be paid incorrectly, the contractor will calculate the amount of the overpayment or underpayment.

The CERT review auditors look for five specific types of billing and medical necessity errors that cause improper payments:

- Duplicate payments
- Payments for incorrect amounts
- Payments for ineligible services
- Payments for services not rendered
- Payments to ineligible recipients

Billing errors occur when a healthcare provider or supplier bills Medicare for services or items that were not provided or were provided at a different level of care than what was billed. Medical necessity errors occur when a service or item is not medically necessary or is not supported by the medical record.

The results of the CERT program are published annually in a report that is available to the public. The report includes the error rate for the year, the types of errors identified, and the root causes of those errors. The report also includes recommendations for improving the Medicare program and reducing improper payments.

The most recent report (2022) found that the Medicare FFS improper payment rate was 7.46%, or $31.46 billion, in improper payments.

The report also broke the error rate down by the top reasons for improper payments:

- **Insufficient documentation:** This error indicates that the provider's documentation is insufficient to determine whether the claim is payable. Examples are inadequate documentation or documentation that is missing elements that are required as a condition of payment. This accounted for 63.6% of the errors in the 2022 report.
- **Incorrect coding:** This error may indicate things like the incorrect code was reported for the services provided, the services were performed by someone other than the billing provider, and the services reported were unbundled.
- **No documentation:** This error indicates that the provider does not supply the records requested.
- **Lack of medical necessity:** This error indicates that the services billed were not medically necessary based upon Medicare coverage and payment policies.
- **Other:** This error is used for any error that does not fit in any of the above error reasons.

The report recommended several strategies for reducing improper payments, such as increasing education and outreach to healthcare providers, improving claims processing systems, and enhancing the use of data analytics.

The CERT program has been successful in identifying improper payments and reducing the rate of errors in the Medicare program. Since the program was implemented, the overall error rate has decreased from 14.2% in 1996 to 7.25% in 2020. The program has also helped to identify areas of vulnerability in the Medicare program and to develop strategies for reducing improper payments.

Why Is the CERT Program Important?

In addition to its primary function of identifying improper payments, the CERT program also provides valuable data to researchers and policymakers. The data collected by the program can be used to identify trends and patterns in Medicare claims and to develop policies and regulations that improve the quality and efficiency of healthcare delivery.

The CERT program is an essential component of the Medicare program. The program provides critical information about the state of the Medicare program and helps to ensure that taxpayer dollars are being used in the most efficient and effective manner possible.

Once the CERT report is given to the Medicare Administrative Contractors (MACs), they must remit any underpayments to providers and recoup any overpayments. Besides that, they can also require prepayment reviews of all a provider's future Medicare claims, suspend the provider from the program, or refer a provider to a law enforcement agency for further review. So, any CERT request for records must be acted upon.

What to Do if a Records Request Arrives at a Practice

A practice may want to contact a healthcare attorney should they receive a request for records notifying them they are under a CERT audit. This can be especially helpful if the practice has never undergone a CERT audit. The request will specify that it is a request for records for a CERT audit. The practice needs to be aware of the deadline for submission of records, which is within 45 calendar days of the request. If the practice needs more time, an extension can be requested to comply with the record request. If the practice is notified that errors were found and overpayments are requested to be paid back, the practice can appeal the decision to their MAC. The process will follow the normal Medicare appeals process: redetermination, reconsideration, administrative law judge (ALJ), appeals court, and finally to a federal district court.

A practice should have protocols set for requests of CERT records. This will help ensure that the practice does not miss the deadline for submission of the records. The practice should have an employee that is responsible for overseeing the records submission. This will help to ensure that everyone knows who is responsible for overseeing the records submission and who the backup person is in case the main person is out of the office.

Here are steps to take if a records request is received:

- **Verify the request:** Make sure that the request is legitimate. CERT requests are typically sent by mail and include a unique control number. If you have any doubts about the authenticity of the request, contact the CERT contractor to confirm.
- **Review the request:** Carefully read the request and identify the specific information that is being requested. This may include medical records, billing information, and other documentation related to the patient's care.
- **Gather the information:** Collect all the information requested in the request. Make sure that the information is accurate and complete.
- **Organize the information:** Organize the information in a clear and logical manner. Use tabs or dividers to separate different types of documents.
- **Make copies:** Make copies of all the documents being submitted. Keep a copy of everything sent together for reference.
- **Submit the information:** Send the requested information to the address specified in the request. Make sure that the information is sent within the specified time frame.
- **Follow up:** After submitting the information, follow up with the CERT contractor to confirm that they have received it. Keep a record of all communications with the contractor.

Receiving a CERT records request can be a daunting experience for a medical practice. A consultant can assist in organizing the requested records and ensuring that they are complete and accurate. They can also provide guidance on how to respond to the request, including timelines and any necessary documentation.

A healthcare attorney can provide legal advice and representation throughout the audit process. They can help to identify any potential legal issues or liabilities and provide guidance on how to address them. Additionally, they can help to negotiate any settlements or appeals that may arise from the audit.

It is important to note that failing to comply with a CERT records request can result in serious consequences, including fines, penalties, and even exclusion from Medicare and Medicaid programs. As such, seeking the guidance of a consultant and healthcare attorney can help to mitigate these risks and ensure that the medical practice is in compliance with all relevant regulations and laws.

How the CERT Report Can Be Used to Keep a Practice Compliant

The yearly CERT report can be a valuable resource for a medical practice to stay compliant with Medicare regulations. The report provides information on the improper payment rates for Medicare claims, including the types of errors that were made and the reasons for those errors.

By reviewing the CERT report, a medical practice can identify any areas where they may be at risk for noncompliance and take steps to address those issues. For example, if the report shows a high rate of errors related to coding or documentation, the practice may need to provide additional training to staff members on these topics.

Additionally, the CERT report can be used to monitor the effectiveness of any compliance measures that have been implemented. By comparing the results of the report from one year to the next, a practice can determine whether their efforts to improve compliance have been successful or if further action is needed.

Overall, the yearly CERT report can serve as a valuable tool for a medical practice to maintain compliance with Medicare regulations and ensure they are providing high-quality care to their patients.

In Conclusion

The CERT program has been around since 1996 and is used to estimate the national Medicare FFS improper payment rate. A practice needs to have a plan on how to respond if they receive a CERT records request. Since the CERT contractor may refer a practice for further review from other agencies, it is important to follow the request and respond within the given time frame. External assistance from a healthcare consultant and healthcare attorney may be warranted.

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Compliant Health Care Solutions (CHCS) was founded by Betty A Hovey, BSHAM, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I. Coders, Auditors, Physicians, Other Providers, Clinics, and Facilities need assistance in navigating today's healthcare environment, especially when it comes to coding and compliance. CHCS' philosophy is to offer every single client extraordinary service that is customized to their situation. No cookie-cutter answers here. Each person, practice, and situation is unique; so is our response. We are honored to partner with every client we serve and will continue to show it for the long haul.
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