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

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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).

Table 6. Hyperlink Table, at the end of the document, provides the complete URL for each hyperlink.

Background

The Federal government estimates that about 12.1 percent of all Medicare Fee-For-Service (FFS) claim payments are improper. The Centers for Medicare & Medicaid Services (CMS) began 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 provider types. This booklet provides education on the different CMS claim review programs and assists 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 statutes and regulations. Common reasons for overpayment are:
  - Billing for excessive or non-covered services
  - Duplicate submission and subsequent payment of the same service or claim
  - 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
  - Payment to an incorrect payee

Table 1. Medicare Contractor Responsibilities

Type of Contractor	Responsibilities
Medicare Administrative Contractors (MACs)	Process claims from 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 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 The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs).

Use the Review Contractor Directory – Interactive Map to find contact information for these contractors.

While all contractors focus on a specific area, each contractor conducting a claim review must apply all Medicare policies to the claim under review. Additionally, once a claim is reviewed, a different contractor should not reopen it. Therefore, it is important when conducting claim reviews, 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 claim 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
- **Complex review:** Requires licensed professionals who review additional documentation associated with a claim

The columns in Table 2 display 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)

Help Prevent Improper Payments

Providers may conduct self-audits to identify coverage and coding errors. Review the following for more information offered by the Office of Inspector General (OIG):

- Compliance Program Guidance
- Self-Disclosure Protocol

National Correct Coding Initiative Edits

Performed by: MACs, ZPICs, CERT, and Medicare FFS Recovery Auditors

Complexity: Non-complex

For more information, visit National Correct Coding Initiative Edits and Add-on Code Edits webpages.

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 the following coding conventions:

- American Medical Association (AMA) Current Procedural Terminology (CPT) Manual
- National and local Medicare policies and edits
- 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. Find more information about Procedure-to-Procedure (PTP) edits on the PTP Coding Edits webpage.

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.

NOTE: Outpatient Code Editor (OCE) edits and NCCI edits are two different editing systems for processing claims. Refer to the NCCI edits for physician services under the Medicare Physician Fee Schedule (PFS). Refer to the OCE edits for claims for all outpatient institutional providers. While a number of the NCCI edits are included in the OCE edits, the OCE edits are not used within the Medicare PFS.

An add-on code is a Healthcare Common Procedure Coding System (HCPCS)/CPT code that describes a service, **with one exception**, always performed along 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, with one exception, is eligible for payment only if one of its primary codes is also eligible for payment.

Medically Unlikely Edits

Performed by: MACs

Complexity: Non-complex

For more information, visit the Medically Unlikely Edits webpage.

CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claim error rate for Medicare Part B claims. 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 a 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. Proposed edits are reviewed by national health care organizations, and their recommendations are considered before implementation. 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 MM8853 Revised Modification to the Medically Unlikely Edit (MUE) Program.

Medical Review Program

Electronic Submission of Medical Documentation (esMD)

Providers may submit medical record documentation electronically. Review the CMS esMD webpage for additional details.

Performed by: MACs, ZPICs/PSCs, and SMRC

Complexity: Complex

For more information, visit the Medical Review and Education webpage.

Claim review contractors identify suspected improper billing through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, claim data analysis, and evaluation of other information (for example, complaints). Generally, claim review contractors focus Medical Review (MR) activities on identified problem areas and select appropriate action for the severity of the problem.

For example, if the MAC reviews a sample of claims and verifies that an error exists, 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 Education/Feedback:** The provider receives notification of appropriate billing procedures when it detects problems at minor, moderate, or significant levels.
- **Prepayment review:** Providers with identified problems may be placed on prepayment review, in which a selection of their claims undergo MR before the MAC authorizes payment. Once providers reestablish the practice of billing correctly, prepayment review ends.
- **Postpayment review:** Contractors perform postpayment claim reviews 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. Refer to the Medicare FFS Claim Review Process chart later in this publication for more information on time frames.

To help prevent improper payments, the MAC's Provider Outreach and Education (POE) department educates providers submitting claims. Find contact information for your local MAC so you can get information on its POE department.

CERT Program

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

Complexity: Complex

For more information, visit the Comprehensive Error Rate Testing webpage.

CMS must 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 performs a complex medical review of 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 service 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 claim 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; the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary; 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 and payment policies.
Incorrect Coding	Provider or supplier submits medical documentation supporting: • A different code than was billed • The service was performed by someone other than the billing provider or supplier • The billed service was unbundled • 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 the Medicare Parts A & B Appeals Process fact sheet. CMS analyzes improper payment rate data and develops corrective actions to reduce improper payments. The following are all potential corrective actions:

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

Recovery Audit Program

Performed by: Medicare FFS Recovery Auditors

Complexity: Complex

For more information, visit the Recovery Audit Program webpage.

Services Targeted by Recovery Auditors

Recovery Auditors post a description of all approved reviews to their websites. Find the website for your Recovery Auditor for your claims in the Review Contractor Directory – Interactive Map.

Recovery Auditors review past Medicare FFS claim data 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 claim data using their proprietary software to identify claims that clearly or likely contain improper payments.

The Medicare FFS Claim Review Process

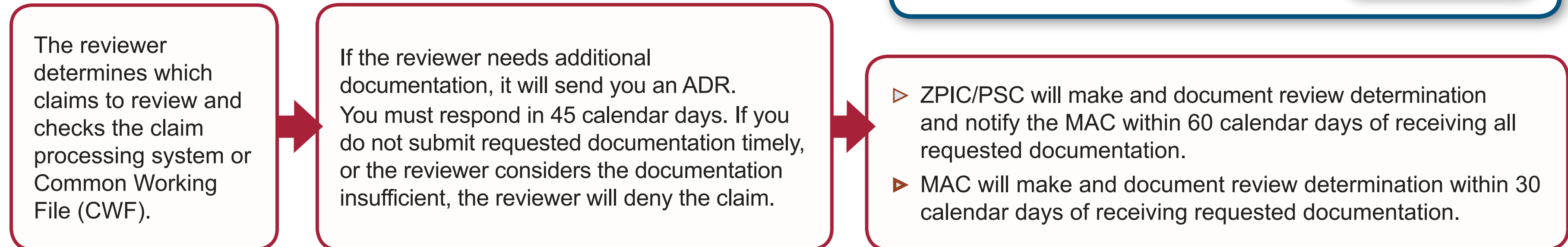
The charts below diagram the Medicare FFS Claim Review Process.

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
- Contractor contact information

See example ADR letters in the Medicare Program Integrity Manual, Exhibit 46.

Prepayment Review Process: MACs and ZPICs/PSCs



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

The reviewer determines which claims to review and checks the claim processing system or CWF.

If the reviewer needs additional documentation, it will send you an ADR.

You must respond in 45 calendar days (30 calendar days for an ADR from a ZPIC/PSC). The reviewer may grant an extension at its discretion. If you do not submit requested documentation timely, or the contractor considers the documentation insufficient, the contractor will deny the claim.

Medicare FFS Recovery Auditors conduct automated reviews or may determine your claim clearly contains an improper payment or payment error. In this case, you'll receive a demand letter.

If the reviewer receives all documentation timely, then:

- MAC will make a review determination and mail a results letter to the provider within 60 calendar days of receiving the requested documentation.
- Other reviewers will make and document the review determination and communicate results to the provider within 30 calendar days of receiving the requested documentation. This does not apply to ZPICs/PSCs or CERT.

If there is an error on the claim, you may resubmit a corrected claim if the timely filing deadline has not passed.

- If an overpayment was paid on the claim, you'll receive a demand letter for the amount overpaid. Refer to the Medicare Overpayments publication for more information on the Medicare overpayment collection process.
- This does not apply to CERT, although CERT will accept additional documentation and signature attestations, signature logs, and electronic signature protocols received prior to the deadline for the annual report.

If the reviewer detects potential fraud, it may refer the issue to the appropriate ZPIC/PSC.

Summary

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 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	Medicare FFS claims selected using a stratified random 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
Postpayment Medical Record Review	No	No	Yes	Yes	No – if clear payment error Yes – if likely payment error

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
Provider Response to ADR	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 RC within 45 calendar days of the request*	Providers must submit medical records to the Medicare FFS Recovery Auditor within 45 calendar days of the request*
Right to Appeal	Yes	Yes	Yes	Yes	Yes

* Late documentation may be accepted if submitted prior to the deadline for the annual report

Resources

Visit CMS' Frequently Asked Questions (FAQs) for common questions about claim review programs. In the search bar, type the Medicare claim 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	CERTProvider.admedcorp.com
Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1521.pdf
Medicare Learning Network® Guided Pathways	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
MR Program	Medicare Program Integrity Manual CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html
NCCI Edits	Overview Webpage (including FAQs) CMS.gov/Medicare/Coding/NationalCorrectCodInitEd Medicare Claims Processing Manual, Chapter 23, Section 20.9 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf How to Use the National Correct Coding Initiative (NCCI) Tools CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243274.html

Table 5. Resources (cont.)

Topic	Resources
Provider Compliance	Provider Compliance Webpage CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html Provider Compliance Newsletter CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf
Recovery Audit Program	CMS.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program

Table 6. Hyperlink Table

Embedded Hyperlink	Complete URL
Add-on Code Edits	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html
Advance Beneficiary Notice of Noncoverage	https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html
CMS esMD	https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD
CMS' Frequently Asked Questions	https://questions.cms.gov
Compliance Program Guidance	https://oig.hhs.gov/compliance/compliance-guidance
Comprehensive Error Rate Testing	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT
Contact Information for Your Local MAC	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map

Table 6. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Medical Review and Education	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review
Medically Unlikely Edits	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
Medicare Overpayments	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243389.html
Medicare Parts A & B Appeals Process	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243294.html
Medicare Program Integrity Manual, Exhibit 46	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83exhibits.pdf
National Correct Coding Initiative Edits	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd
PTP Coding Edits	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
Recovery Audit Program	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program
Review Contractor Directory – Interactive Map	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Revised Modification to the Medically Unlikely Edit (MUE) Program	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8853.pdf
Self-Disclosure Protocol	https://oig.hhs.gov/authorities/docs/selfdisclosure.pdf
The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1204.pdf

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