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

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Medicare Claim Review Programs:

MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program

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Background

The Centers for Medicare & Medicaid Services (CMS) implemented several initiatives to prevent improper payments before a claim is processed, and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. The Government estimates that about 10 percent of all Medicare Fee-For-Service (FFS) claim payments are improper. For the most current information, visit http://paymentaccuracy.gov/programs/medicare-fee-service on the Internet.

CMS employs a variety of contractors to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and submits payment to those providers in accordance with the Medicare rules and regulations. The contractors discussed in this booklet are described in Table 1.

Table 1. Medicare Contractors and Their Responsibilities

Type of Contractor	Responsibility
Affiliated Contractors (ACs) – Medicare claims processing contractors such as carriers and Fiscal Intermediaries (FIs) Medicare Administrative Contractors (MACs)	Process claims submitted by physicians, hospitals, and other health care providers/suppliers, and submit payment to those providers in accordance with Medicare rules and regulations. This includes identifying and correcting underpayments and overpayments.
Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs)	Identify cases of suspected fraud and take appropriate corrective actions.
Comprehensive Error Rate Testing (CERT) contractors – CERT Documentation Contractor (CERT DC) and CERT Review Contractor (CERT RC)	Collect documentation and perform reviews on a statistically-valid random sample of Medicare FFS claims to produce an annual error rate.
Recovery Auditors	Identify and correct underpayments and overpayments, as part of the Recovery Audit Program.

This booklet describes the following five claim review programs and their role in the life cycle of Medicare claims processing. The columns in Table 2 divide the programs based on performance of prepayment or postpayment reviews.

Table 2. Medicare Prepayment and Postpayment Claim Review Programs

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

The first two programs (NCCI edits and MUEs) review claims **before** they are paid (prepayment review). The second two programs (CERT and the Recovery Audit Program) review claims **after** they are paid (postpayment review). The MR program can perform both prepayment and postpayment reviews. Table 5, provided at the end of this booklet, summarizes the five programs and how they proactively identify potential billing errors concerning coverage and coding.

National Correct Coding Initiatives (NCCI) Edits

Performed by: ACs/MACs

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Medicare Part B claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, Healthcare Common Procedure Coding System (HCPCS) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. NCCI edits are updated quarterly.

The NCCI contains two tables of prepayment edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the NCCI Coding Policy Manual. If a provider submits the two codes of an edit pair, the Column One code is eligible for payment and the Column Two code is denied. However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment. The medical record must include supporting documentation for the appropriate NCCI-associated modifier.

HCPCS/CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice of Noncoverage" (Form CMS-R-131) to seek payment from a Medicare beneficiary. Furthermore, since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "Notice of Exclusions from Medicare Benefits" form.

NOTE: Outpatient Code Editor (OCE) edits and NCCI edits are two different editing systems used to process claims. The NCCI edits are used to process physician services under the Medicare Physician Fee Schedule (PFS), while the OCE edits are used to 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 hospital OPPS – they are not used within the Medicare PFS.

Medically Unlikely Edits (MUEs)

Performed by: ACs/MACs

CMS developed MUEs to reduce the paid claims error rate for Medicare claims. Just like the NCCI edits, the MUEs are automated prepayment edits that help prevent inappropriate payments. The AC's/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 do not exist for all HCPCS/CPT codes. Prior to implementation of MUEs, national health care organizations are offered an opportunity to review and comment about proposed edits. 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 that may be reported without concern about medical review. Providers should continue to report only services that are medically reasonable and necessary. Table 3 provides answers to Frequently Asked Questions (FAQs).

Table 3. MUEs FAQs

Question	Answer
1. How are claims adjudicated with MUEs?	All CMS ACs/MACs adjudicate MUEs against each line of a claim rather than the entire claim. Thus, if an HCPCS/CPT code is reported on more than one line of a claim by using CPT modifiers, each line with that code is separately adjudicated against the MUE. ACs/MACs deny the entire claim line if the units of service on the claim line exceed the MUE value for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed. Submit appeals to local ACs/MACs, not the MUE contractor, Correct Coding Solutions, LLC.
2. How do I report medically reasonable and necessary units of service in excess of an MUE value?	Since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value. CPT modifiers such as -76 (repeat procedure by same physician), -77 (repeat procedure by another physician), anatomic modifiers (e.g., -RT, -LT, -F1, -F2), -91 (repeat clinical diagnostic laboratory test), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service. The medical record must include supporting documentation for the appropriate modifier.

Table 3. MUEs FAQs (continued)

Question	Answer
3. How are claim lines adjudicated against an MUE for a repetitive service reported on a single claim line?	Some contractors allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the "from date" and "to date" on the claim line. Contractors are instructed to divide the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line.
4. How were MUEs developed?	MUEs were developed based on HCPCS/CPT code descriptors, CPT coding instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. All edits based on clinical judgment as well, as many others, were reviewed by workgroups of contractor medical directors. Prior to implementation of MUEs, the proposed edits were released for a review and comment period to the AMA, national medical/surgical societies, and other national health care organizations, including non-physician professional societies, hospital organizations, laboratory organizations, and durable medical equipment organizations. MUE files are updated quarterly, including MUEs for additional codes.
5. How do I request a change in the MUE value for an HCPCS/CPT code?	If a provider/supplier, health care organization, or other interested party believes that an MUE value should be modified, it may write Correct Coding Solutions, LLC at the address below. The party should include its rationale and any supporting documentation. However, it is generally recommended the party contact the national health care organization whose members perform the procedure prior to writing to Correct Coding Solutions, LLC. The national health care organization may be able to clarify the reporting of the code in question. If the national health care organization agrees the MUE level should be modified, its support and assistance may be helpful in requesting the modification of an MUE level. Requests for modification of an MUE level should be sent to the following: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907 Carmel, IN 46082-0907 Fax: 317-571-1745
6. How do I make an inquiry about the MUE program other than about MUE values for specific HCPCS/CPT codes?	Inquiries about the MUE program other than those related to MUE values for specific HCPCS/CPT codes should be sent to the following: Valeria Allen (valeria.allen@cms.hhs.gov)

AC/MAC MR Program

Performed by: ACs/MACs

Through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, analysis of claims data, and evaluation of other information (e.g., complaints), ACs/MACs identify suspected billing problems. ACs/MACs target MR activities at identified problem areas appropriate for the severity of the problem.

If the AC/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:

Electronic Submission of Medical Documentation

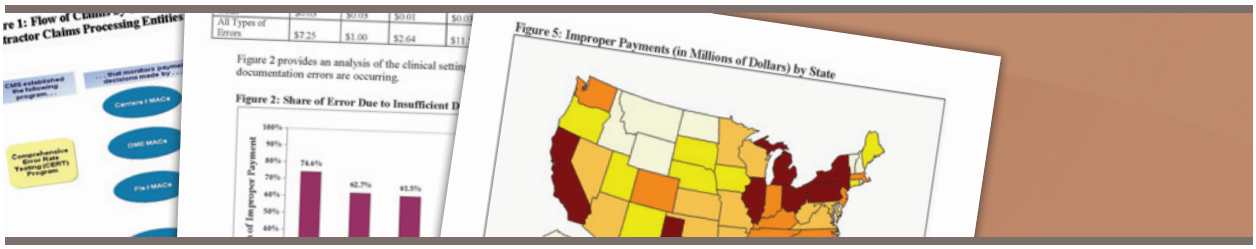
Beginning September 2011, providers may submit medical record documentation electronically in some cases under the Electronic Submission of Medical Documentation (esMD) pilot project. For more information, visit http://www.cms.gov/esmd or refer to Medicare Learning Network® (MLN) Matters® Special Edition Article SE1110 at http://www.cms.gov/MLNMattersArticles/Downloads/SE1110.pdf on the CMS website.

- **Provider Notification/Feedback** – When it detects problems at minor, moderate, or significant levels, the AC/MAC informs the provider of appropriate billing procedures.
- **Prepayment review** – Prepayment review consists of MR of a claim prior to payment. Providers with identified problems submitting correct claims may be placed on prepayment review, in which a percentage of their claims undergo MR before the AC/MAC authorizes payment. Once providers re-establish the practice of billing correctly, prepayment review ends.
- **Postpayment review** – Postpayment review involves MR of a claim after payment. Postpayment review is commonly performed 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.

To help prevent improper payments, the AC's/MAC's Provider Outreach and Education (POE) department provides education for providers submitting claims.

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 or the AC/MAC will deny the claim.

NOTE: In addition to ACs/MACs, other entities such as PSCs/ZPICs perform MR.



Comprehensive Error Rate Testing (CERT) Program

Performed by: CERT RC and CERT DC

CMS developed the CERT Program to produce a national Medicare FFS error rate. After the claims process, CERT randomly selects a statistically-valid sample of Medicare FFS claims and requests documentation from the provider/supplier who submitted the sampled claim. CERT clinicians review the claim and the supporting documentation to determine whether the claim was submitted and paid appropriately. In order to accurately measure the performance of the ACs/MACs and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims error rate and a provider compliance error rate and publishes the results of these reviews annually. Table 4 describes these error rates in more detail.

Table 4. CERT Error Rates

Type of Error Rate	Description
Paid Claims Error Rate	• Based on dollars paid after the ACs/MACs made its payment decision on the claims (including fully denied FFS claims) • Equal to the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied • Gross rate calculated by adding underpayments to overpayments and dividing that sum by total dollars paid • Good indicator of how claims errors in the Medicare FFS Program impact the Medicare Trust Fund
Provider Compliance Error Rate	• Based on how the claims looked when the first arrived at the AC/MAC before it applied any edits or conducted any reviews • Good indicator of how well the AC/MAC educates the provider community, since it measures how well providers prepare claims for submission
Other Error Rates	• May be included in the CERT report to provide the most specific information available to target problem areas (including error rates by service type and by provider type) • Includes 4 supplemental measures: ◇ Power Mobility Devices (PMDs) ◇ Chiropractic Services ◇ Pressure Reducing Support Services ◇ Short Hospital Stays

When performing these reviews, the CERT contractor follows Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions, and the respective AC's/MAC's Local Coverage Determinations (LCDs).

Claims selected for CERT review are subject to potential postpayment denials, payment adjustments, or other administrative or legal actions depending on the result of the review. Normal appeals rights and processes apply.

Recovery Audit Program

Performed by: Medicare FFS Recovery Auditors

The Recovery Audit Program (formerly known as Recovery Audit Contractors or RACs) began as a three-state demonstration project in 2005. In 2006, Congress made the program permanent and directed CMS to expand it nationwide by January 2010. CMS awarded four regional contracts, whose jurisdictions are the same as those of the Durable Medical Equipment (DME) MACs.

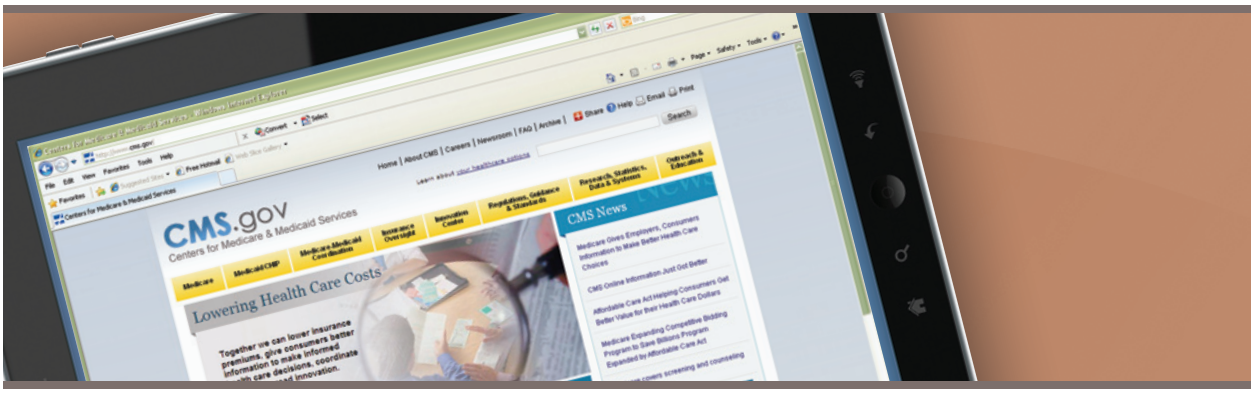
Recovery Auditors review past Medicare FFS claims for potential overpayments or underpayments, reviewing medical records when necessary to make appropriate determinations. When performing these reviews, Recovery Auditors follow Medicare regulations, billing instructions, NCDs, coverage provisions, and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

In general, Recovery Auditors will not review a claim previously reviewed by another entity. Recovery Auditors analyze claims data using their proprietary software to identify claims that contain improper payments and those that likely contain improper payments. If a Recovery Auditor finds an improper payment, it sends a file to the AC/MAC to adjust the claim and recoup payment. In the case of claims that likely contain improper payments, the Recovery Auditor requests the medical record from the provider, reviews the claim and medical record, and makes a determination as to whether the claim contains an overpayment, an underpayment, or a correct payment.

If the review of the records indicates a denial or adjustment, providers will receive overpayment/underpayment notification letters. Providers can appeal denials (including no documentation denials) following the normal appeal processes by submitting documentation supporting their claims.

Table 5. Summary of MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program

	NCCI Edits	MUEs	AC/MAC MR Program	CERT Program	Recovery Audit Program
Providers Impacted	Providers who submit claims for Part B services using HCPCS/ CPT codes	Providers/ suppliers who submit claims for Part B services using HCPCS/ CPT codes	Providers who submit FFS claims	Providers who submit FFS claims	Providers who submit FFS claims
Medicare Contractor	NCCI Contractor develops the edits AC/MAC operates the edits	NCCI Contractor develops the edits AC/MAC operates the edits	ACs MACs	CERT RC CERT DC	Medicare Recovery Auditors
Claims Impacted	All Part B practitioner, Ambulatory Surgical Center (ASC), and hospital OPPS claims screened	All Part B practitioner, ASC, outpatient hospital and therapy claims screened	Targeted claim review – number varies by AC's/MAC's MR strategy	Limited random claim sample	Widespread or targeted claim review – number varies by Recovery Auditor's audit strategy
Prepayment Edit	Yes – tables updated quarterly	Yes – tables updated quarterly	Yes	No	No
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	Providers must submit medical records to the AC/MAC within 30 days from the receipt date of the initial letter	Providers must submit medical records to the CERT DC within 75 days from the receipt date of the letter	Providers must submit medical records to the Recovery Auditor (or request an extension) within 45 days from the date of the initial letter requesting medical records
Right to Appeal	Yes	Yes	Yes	Yes	Yes



Resources

Table 6 provides a list of resources for more information.

Table 6. Resources

Topic	Resources
NCCI Edits	Overview Web Page (including FAQs) http://www.cms.gov/NationalCorrectCodInitEd "Medicare Claims Processing Manual," Chapter 23, Section 20.9 http://www.cms.gov/manuals/downloads/clm104c23.pdf "How to Use the National Correct Coding Initiative (NCCI) Tools" http://www.cms.gov/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf Providers/suppliers who have concerns regarding specific NCCI Edits can submit comments in writing to: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907 Carmel, IN 46082-0907 Attention: Niles R. Rosen, M.D., Medical Director, and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist Fax: 317-571-1745 You can obtain the "CCI Edits Manual" by purchasing the manual (or sections of the manual) from the National Technical Information Service (NTIS) at http://www.ntis.gov/products/cci.aspx on the Internet, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.
MUEs	MUEs Web Page http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp
AC/MAC MR Program	Medical Review Web Page http://www.cms.gov/Medical-Review "Medicare Program Integrity Manual" http://www.cms.gov/Manuals/IOM/list.asp

Table 6. Resources (continued)

Topic	Resources
CERT Program	Overview Web Page http://www.cms.gov/CERT/01_overview.asp CERT Reports Web Page http://www.cms.gov/CERT/CR/list.asp CERT DC Website https://www.certprovider.com/certproviderportal
Recovery Audit Program	Overview http://www.cms.gov/recovery-audit-program Recovery Auditors Contact Information http://www.cms.gov/recovery-audit-program/Downloads/RACAbbr.pdf
Additional Helpful Resources	MLN Provider Compliance Web Page http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp Office of the Inspector General (OIG) Compliance Web Page http://oig.hhs.gov/compliance Medicare Appeals Process http://www.cms.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf Medicare Claims Processing Contractors Contact Information http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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