Assignment of Error Categories

Medical review professionals review the claim and submitted documentation to make a determination of whether the claim was paid or denied appropriately. These review professionals include nurses, medical doctors, and certified coders. Before reviewing documentation, the Comprehensive Error Rate Testing (CERT) program examines the Centers for Medicare & Medicaid Services (CMS) claims systems to check for (1) Medicare beneficiary eligibility, (2) duplicate claims, and (3) Medicare as the primary insurer. When performing claim reviews, the CERT program checks for compliance with Medicare statutes and regulations, billing instructions, National Coverage Determinations (NCDs),[1] Local Coverage Determinations (LCDs),[2] and provisions in the CMS instructional manuals.

The reason for the improper payment determines the error category for the claim. There are five major error categories.

No Documentation
Claims are placed into this category when the provider or supplier fails to respond to repeated requests for the medical records or when the provider or supplier responds that they do not have the requested documentation.

Insufficient Documentation
Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, 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. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

Medical Necessity
Claims are placed into this category when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.

[1] An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. All MACs are required to follow NCDs. If an NCD does not specifically exclude or limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the MAC to make an LCD.
[2] An LCD is a decision by the MAC to cover or non-cover a particular service, procedure or technology on a contractor–wide basis in accordance with the Social Security Act section 1862(a)(1)(A), which describes the reasonable and necessary conditions of coverage.

Incorrect Coding
Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.

Other
Claims are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service).