

Improper Medicare Fee-For-Service Payments Report - November 2009 Long Report

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EXECUTIVE SUMMARY

Detecting and reducing Medicare waste, fraud and abuse is one of HHS's highest priorities to ensure that the program remains strong for current Medicare beneficiaries and future generations. To this end, CMS has significantly revised and improved the way that it calculates the Medicare fee-for-service error rate. The improved methodology provides a more accurate assessment of unsubstantiated claims. CMS and its partners cannot reduce waste, fraud, and abuse without the most accurate assessment of Medicare claims. The improvements are consistent with recommendations CMS has received from the Office of Inspector General (OIG).

As a result of these improvements and a more complete accounting of improper payments, this year's error rate is higher than last year's, 7.8 percent compared to 3.6 percent in FY 2008. The two areas with significant increases in errors were inpatient services and durable medical equipment (DME). Both of these areas had substantial changes to their medical record review methodologies based on recommendations from the OIG. This increase is NOT necessarily due to more fraud in the program. In fact, the error rate is not a measure of fraud. It should be noted that due to changes in the review methodology, the 2009 error rates are not comparable to previous years' error rates since we cannot quantify the impact these changes had on the measurement process.

In an effort to improve measurement accuracy, CMS made two distinct changes to the 2009 improper payments review process. First, CMS changed the way it reviewed inpatient hospital claims for error rate measurement. In the past, inpatient hospital reviews were completed in a separate program, known as the Hospital Payment Monitoring Program (HPMP), while the other Medicare FFS claim reviews were performed under the Comprehensive Error Rate Testing (CERT) program. Beginning with the November 2009 Report, CMS consolidated the HPMP program under CERT. This consolidation ensures that review procedures for acute inpatient hospital claims are now consistent with the procedures used for review of all other Medicare FFS claims.

Second, CMS implemented three separate revisions to the medical review criteria to more strictly enforce Medicare policies. The primary modification required the medical reviewers under CERT to strictly follow the documentation requirements outlined in Medicare regulation, statute, and policy, including Local Coverage Determinations (LCDs), rather than allowing for clinical review judgment based on billing history and other available information.

A significant portion of the new errors found in FY 2009 were due to a strict adherence to policy documentation requirements, signature legibility requirements, the removal of claims history as a valid source for review information, and the determination that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim.

CMS will work closely with its contractors to reduce the error rate by ensuring that Medicare FFS claims receive more vigilant review before being processed. The result of this more vigilant review will be more accurate claims payment and reductions in Medicare waste, fraud and abuse. To further reduce errors, CMS will also work closely with the healthcare industry to ensure that providers and suppliers understand and follow CMS' policies and medical record requirements.

CMS will analyze the improper payment data to determine if there are geographic trends that can assist in identifying errors that highlight programmatic weaknesses. CMS will review trends by types of service to locate potential vulnerabilities. CMS will use this knowledge to design new innovative approaches to reduce improper payments, particularly in high risk areas such as durable medical equipment and home health. As previously stated, the error rate is not a measure of fraud; however, it may be an indication of a program weakness that requires more oversight and diligence by CMS.

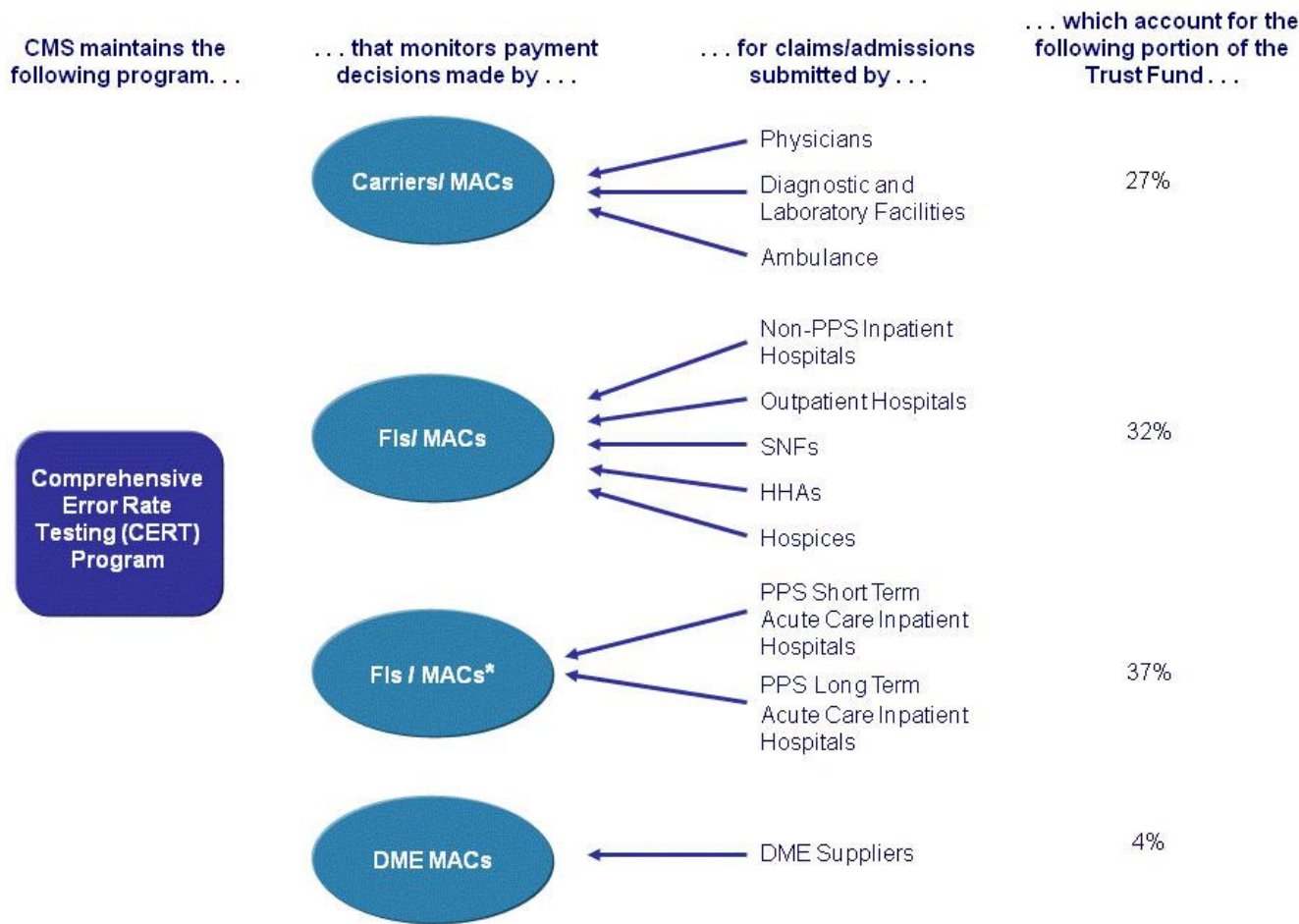
OVERVIEW

Background

The Social Security Act established the Medicare program in 1965. Medicare currently covers health care needs of people aged 65 and over, the disabled, people with End Stage Renal Disease (ESRD), and certain others that elect to purchase Medicare coverage. Both Medicare costs and the number of Medicare beneficiaries has increased dramatically since 1965. In fiscal year (FY) 2008, more than 44 million beneficiaries were enrolled in the Medicare program, and the total Medicare benefit outlays (both Medicare Fee-for-Service (FFS) and managed care payments) was estimated at about \$428 [B\(1\)](#). The Medicare budget represents almost 15% of the total federal budget.

CMS uses several types of contractors to prevent improper payments from being made for Medicare claims and admissions including: Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries (FIs).

The following figure (Figure 1) depicts the flow of claims by provider and supplier types through the Medicare contractor claims processing entities.



* FIs and MACs are responsible for payment decisions on Inpatient Hospital claims beginning with the November 2009 report.

The primary goal of each contractor is to "Pay it Right" - that is, to pay the right amount to the right provider for covered and correctly coded services. Budget constraints limit the number of claim reviews these contractors can conduct; thus, they must choose carefully which claims to review. It is through the detailed review of the medical records that errors and non-compliance with CMS policies are detected. To improve provider compliance, contractors must also determine how best to educate providers about Medicare rules and implement the most effective methods for accurately answering coverage and coding questions.

As part of its Improper Payments Information Act (IPIA) of 2002 compliance efforts, and to help all Medicare FFS contractors better focus review and education, CMS established the Comprehensive Error Rate Testing (CERT) program to randomly sample and review claims submitted to Medicare. The CERT program considers any claim that was paid when it should not have been, an improper payment. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent.

History of Error Rate Production

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) estimated the Medicare FFS error rate from 1996 through 2002. The OIG designed their sampling method to estimate a national Medicare FFS paid claims error rate. Due to the sample size – approximately 6,000 claims – the OIG was unable to produce error rates by contractor type, specific contractor, service type, or provider type. Following recommendations from the OIG, CMS increased the sample size for the CERT program when production began on the Medicare FFS error rate for the November 2003 Report.

With the passage of the Improper Payments Act of 2002 (IPIA), CMS took responsibility for the error rate program beginning with fiscal year 2003. One of the key tenets of IPIA was that error rate measurement programs should be a critical part of an agency's internal controls. IPIA also ushered in the belief that agencies should use error rates to inform decision makers about program vulnerabilities and drive corrective actions for reducing future errors. When the program was transferred to CMS, the sample size for the CERT program was increased to approximately 120,000 paid and denied claims. The increase in sample size allowed CMS to project not only a national error rate but also allowed for contractor and service level error rates. It was believed that these additional error rates would allow CMS to develop more robust corrective actions and would provide contractors with information that would also assist them in the development of contractor specific

corrective actions. CMS originally established two programs to monitor the accuracy of the Medicare FFS Program: the CERT program and HPMP. The HPMP program measured the error rate for inpatient hospital claims only and CERT measured the error rate for the other claim types, including outpatient and durable medical equipment claims. As of this November 2009 report, the CERT program became fully responsible for sampling and reviewing inpatient hospital claims for improper payment measurement that were previously assigned to HPMP. All of the claims data generated for this report was created by the CERT program.

Each year the Medicare FFS error rate is reported in both CMS' and HHS' audited financial reports. The HHS Agency Financial Reports can be found at <http://www.hhs.gov/aftr>. As part of the annual CMS Chief Financial Officer's (CFO) audit, the OIG conducts an audit of the CERT process and provides recommendations to CMS for consideration in refining the error rate process. In 2008, due in part to Congressional interest, the OIG performed a more extensive review of the durable medical equipment (DME) payment decisions selected for review by CERT for the FY 2006 report period. In 2009, working in collaboration with the OIG, CMS conducted an independent review of the FY 2008 CERT findings for all claim types. The results of these audits prompted CMS to revise the error rate measurement methodology for the FY 2009 report.

Table 3a: National Error Rates by Year

Year	Total Dollars Paid	Overpayments		Underpayments		Overpayments + Underpayments	
		Payment	Rate	Payment	Rate	Improper Payments	Rate
1996	\$168.1 B	\$23.5B	14.0%	\$0.3 B	0.2%	\$23.8 B	14.2%
1997	\$177.9 B	\$20.6B	11.6%	\$0.3 B	0.2%	\$20.9 B	11.8%
1998	\$177.0 B	\$13.8B	7.8%	\$1.2 B	0.6%	\$14.9 B	8.4%
1999	\$168.9 B	\$14.0B	8.3%	\$0.5 B	0.3%	\$14.5 B	8.6%
2000	\$174.6 B	\$14.1B	8.1%	\$2.3 B	1.3%	\$16.4 B	9.4%
2001	\$191.3 B	\$14.4B	7.5%	\$2.4 B	1.3%	\$16.8 B	8.8%
2002	\$212.8 B	\$15.2B	7.1%	\$1.9 B	0.9%	\$17.1 B	8.0%
2003	\$199.1 B	\$20.5B	10.3%	\$0.9 B	0.5%	\$12.7 B	6.4%
2004	\$213.5 B	\$20.8B	9.7%	\$0.9 B	0.4%	\$21.7 B	10.1%
2005	\$234.1 B	\$11.2 B	4.8%	\$0.9 B	0.4%	\$12.1 B	5.2%
2006	\$246.8 B	\$9.8 B	4.0%	\$1.0 B	0.4%	\$10.8 B	4.4%
2007	\$276.2 B	\$9.8 B	3.6%	\$1.0 B	0.4%	\$10.8 B	3.9%
2008	\$288.2 B	\$9.5 B	3.3%	\$0.9 B	0.3%	\$10.4 B	3.6%
2009	\$308.4 B	\$23.0 B	7.5%	\$1.1 B	0.4%	\$24.1 B	7.8%

The CERT Process

CMS established the CERT program to monitor the accuracy of Medicare FFS payments made by Carriers, DMERCs, FIs, and the new MACs. The main objective of the CERT program is to measure the degree to which CMS and contractors are meeting the goal of "Paying it Right".

Sampling and Medical Record Requests

For this report, the CERT Contractor randomly sampled approximately 100,000 claims from Carriers, FIs, and MACs. CERT designed this process to pull a blind, electronic sample of claims each day from all of the claims providers submitted that day.

The CERT Contractor requested the medical record associated with the sampled claim from the provider that submitted the claim. The CERT Contractor sent the initial request for medical records via letter. If the provider failed to respond to the initial request after 30 days, the CERT Contractor sent up to three subsequent letters in addition to follow-up phone calls to the provider.

In cases where the CERT Contractor received no documentation from the provider once 75 days had passed since the initial request, the CERT Contractor considered the case to be a no documentation claim and counted it as an error. The CERT Contractor considered any documentation received after the 75th day "late documentation." If the CERT Contractor received late documentation prior to the documentation cut-off date for this report, they reviewed the records and, if justified, revised the error in each rate throughout the report. If the CERT Contractor received late documentation after the cut-off date for this report, they attempted to complete the review process before the final production of the report. Claims that completed the review process were included in the report. Claims for which the CERT contractor received no documentation were counted as no documentation errors.

Review of Claims

Upon receipt of medical records, the CERT Contractor's clinicians conducted a review of the claims and submitted documentation to identify any improper payments. They checked the Common Working File to see if the person receiving the services was an eligible Medicare beneficiary, to see if the claim was a duplicate and to make sure that no other insurer was responsible for paying the claim. When performing these reviews, the CERT contractor followed Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective contractor's Local Coverage Determinations (LCDs), and articles.

Appeal of Claims

In the November 2003 reporting period, the CERT Contractor did not remove an error from the error rate if a provider appeal (using the normal appeals process) of a CERT initiated denial resulted in a reverse decision. In the November 2004 Report, the CERT Contractor implemented an appeals tracking system and began to back out overturned CERT initiated denials from the error rate; however, some

contractors did not enter all the appeals information into the new tracking system before the cut-off date for the report. Therefore, CERT only backed out some of the determination reversals from the error rate in the November 2004 Report. As of the November 2005 Report, all contractors in the CERT program have the opportunity to ensure that all overturned appeals are entered into the appeals tracking system in sufficient time for production of the error rates.

Methodology Overview

The CERT contractor randomly selects a sample of paid claims submitted to Carriers, FIs, and MACs during the reporting period. Then, CERT requests supporting medical records from the health care providers and suppliers that submitted the claims in the sample.

When medical records are submitted by the provider, CERT reviews the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules. If not, CERT assigns the erroneous claims to the appropriate error category. When medical records are not submitted by the provider, CERT classifies the case as a no documentation claim and counts it as an error.

Then, CERT sends providers overpayment letters/notices or makes adjustments for claims where an overpaid or underpaid determination was made. Finally, CERT calculates the projected improper payment rate based on the actual erroneous claims identified in the sample.

CERT reports a *paid claims error rate* which is based on dollars paid after the Medicare contractor made its payment decision on the claim. This rate includes fully denied claims. The paid claims error rate is the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied and is a good indicator of how claim errors in the Medicare FFS Program impact the trust fund. CMS calculated the gross rate by adding underpayments to overpayments and dividing that sum by total dollars paid.

Sampling Methodology

For this report, the CERT Contractor randomly sampled approximately 99,500 claims from Carriers, FIs, and MACs. CERT designed this process to pull a blind, electronic sample of claims each day from all of the claims providers submitted that day. The original target sample for FY 2009 was 120,000. Due to the modifications to the CERT review criteria, CMS was not able to meet the target sample. Of the 99,500 claims reviewed, 19,000 claims were reviewed using the most stringent criteria. However, CMS consulted with the OIG concerning the limited time period that the 19,000 claims covered and determined that reporting the error rate for this subset of claims only would not be in compliance with IPIA requirements. Therefore, the national paid claims error rate reported reflects all claims reviewed for the report period.

Medical Record Requests

The CERT Contractor requested the medical record associated with the sampled claim from the provider that submitted the claim. The CERT Contractor sent the initial request for medical records via letter. If the provider failed to respond to the initial request after 30 days, the CERT Contractor sent up to three subsequent letters in addition to follow-up phone calls to the provider.

In cases where the CERT Contractor received no documentation from the provider once 75 days had passed since the initial request, the CERT Contractor considered the case to be a no documentation claim and counted it as an error. The CERT Contractor considered any documentation received after the 75th day "late documentation." If the CERT Contractor received late documentation prior to the documentation cut-off date for this report, they reviewed the records and, if justified, revised the error in each rate throughout the report. If the CERT Contractor received late documentation after the cut-off date for this report, they attempted to complete the review process before the final production of the report. Claims that completed the review process were included in the report. Claims for which the CERT contractor received no documentation were counted as no documentation errors.

Review of Claims

Upon receipt of medical records, the CERT Contractor's clinicians conducted a review of the claims and submitted documentation to identify any improper payments. They checked the Common Working File to see if the person receiving the services was an eligible Medicare beneficiary, to see if the claim was a duplicate and to make sure that no other insurer was responsible for paying the claim. When performing these reviews, the CERT contractor followed Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective contractor's Local Coverage Determinations (LCDs), and articles.

Error Categories

Based on the review of the medical records, claim errors are categorized into 5 different error categories. The 5 categories of error under the

CERT program are described below. Please see Appendix for further details.

No documentation—Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medical records in support of the claim.

Insufficient documentation—Claims are placed into the category when the medical documentation submitted does not include pertinent patient facts (e.g. the patient's overall condition, diagnosis, and extent of services performed).

Medically unnecessary service—Claims are placed into this category when claim review staff identify enough documentation in the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies.

Incorrect coding—Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted.

Other—Represents claims that do not fit into any of the other categories (e.g. service not rendered, duplicate payment error, not covered or unallowable service).

Weighting and Determining the Final Results

The error rates were weighted so that each contractor's contribution to the error rate was in proportion to the percent of allowed charges for which they were responsible. The confidence interval is an expression of the numeric range of values for which CMS is 95% certain that the mean values for the improper payment estimates will fall. As required by the IPIA, the CERT program has included an additional calculation of the 90% confidence interval for the national error rate calculation. The size of the associated confidence interval which represents the extent of variability should always be considered when evaluating estimated payment error rates.

Appeal of Claims

Providers can appeal denials (including no documentation denials) following the normal appeal processes by submitting documentation supporting their claims. All contractors in the CERT program have the opportunity to ensure that all overturned appeals are entered into an appeals tracking system in sufficient time for production of the error rates. After the calculation of the error rate, appeal decisions are not considered. The CERT program deducted \$1.1 B in projected appeals reversals from the error rates contained in this report.

Overpayments/Underpayments

In the CERT program, contractors are notified of detected overpayments and underpayments so that they can implement the necessary adjustments. Sampled claims for which providers failed to submit documentation were considered overpayments.

The CERT program identified \$4.7 M in actual overpayments and, as of the final cut-off date for this report, contractors had collected \$2.6 M of those overpayments. CMS and its contractors will never collect a small proportion of the identified overpayments because:

- The responsible provider appealed the overpayment and the outcome of the appeal overturned the CERT decision.
- The provider has gone out of business and CMS contractors cannot contact the provider after multiple attempts.

However, for all other situations, the contractor will continue their attempts to collect the overpayments.

Improvements to the CERT Process

Based on both the recommendations contained in recent OIG audit reports and those of CMS' advisory medical staff, CMS modified the medical review process for the fiscal year 2009 error rate measurement period. CMS implemented three separate revisions to the CERT review criteria.

The following describes the modifications made to the CERT medical review criteria:

- **February 23, 2009** - CMS directed the CERT contractor that clinical review judgment cannot override statutory, regulatory, ruling, national coverage decision or local coverage decision provisions and that all documentation and policy requirements must be met before clinical review judgment applies.
- **May 15, 2009** - CMS provided guidance on a variety of issues related to review of durable medical equipment claims. This included guidelines on period of medical necessity documentation requirements, policy requirements added after the original order, and medical necessity requirements for DME accessories, repairs, and maintenance.
- **May 31, 2009** - Based on CMS policy, during the course of a complex medical review, a claim must be denied if the signature on the

medical record is absent or illegible. Through their audit, OIG found that CMS contractors were not uniformly applying this policy. Thus, CMS provided guidance to the CERT contractor that claims should be counted as an error if the CERT reviewer could not identify the author of the medical record entry.

The increase in errors for 2009 resulted from a strict adherence to policy documentation requirements, the removal of claims history as a valid source for review information, and the determination that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim.

The specific impact of these changes is a reduction in the flexibility allowed for reviewers to determine medical necessity. Previously, the CERT program attempted to determine whether the services listed on a claim were indeed provided and necessary. The reviewers were allowed certain latitude in determining this based on their training, experience and judgment. The new review approach requires that every condition listed in a policy be met in exactly the way the policy describes it or the claim is considered an error. This results in many more errors than previously reported. Specific examples of the impact of the review changes are listed in the sections describing the error rate data.

Impact of the More Stringent Review Criteria

The more stringent review criteria for review of claims selected for the November 2009 report resulted in increases in the error rates due to:

- **Records from the treating physician not submitted or incomplete**

In the past, CERT would review available documentation, including physician orders, supplier documentation, and patient billing history and apply clinical review judgment. Now, CERT requires medical records from the treating physician and does not review other available documentation or apply clinical review judgment.

- **Missing evidence of the treating physician's intent to order diagnostic tests**

In the past, CERT would consider an unsigned requisition or physicians' signatures on test results. Now, CERT requires evidence of the treating physician's intent to order tests, e.g., signed orders, progress notes.

- **Medical records from the treating physician did not substantiate what was billed**

In the past, CERT would review available documentation, including physician orders, supplier documentation, and patient billing history and apply clinical review judgment. Now, CERT requires medical records from the treating physician and does not review other available documentation or apply clinical review judgment.

- **Missing or illegible signatures on medical record documentation**

In the past, CERT would apply clinical review judgment in considering medical record entries with missing or illegible signatures. Now, CERT disallows entries if a signature is missing or illegible.

FINDINGS

National Medicare FFS Error Rate

The national paid claims error rate in the Medicare FFS program for this reporting period is 7.8% (which equates to \$24.1 B). The 95% confidence interval for the Medicare FFS program paid claims error rate was 7.3% - 8.4%. The 90% confidence interval (required to be reported by IPIA) was 7.3% - 8.3%.

Based on both the recommendations contained in recent OIG audit reports and those of CMS' advisory medical staff, CMS modified the medical review process for the November 2009 Improper Payments report. CMS implemented three separate revisions to the CERT review criteria based on these recommendations. Approximately 99,500 claims completed the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria. The national paid claims error rate for those claims reviewed under the strictest criteria, when applied to the entire year, is 12.4% or \$35.4 billion. However, CMS consulted with the OIG concerning the limited time period covered by these claims, and determined that reporting the error rate for this subset of claims only would not be in compliance with IPIA requirements.

Table 3b summarizes the overpayments, underpayments, improper payments, and error rates by contractor type.

Table 3b: Error Rates and Projected Improper Payments by Contractor Type

Sort This Table							
Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier/MAC	\$78.7B	\$7.6B	9.7%	\$0.1B	0.2%	\$7.8B	9.9%
DME MAC	\$10.4B	\$5.4B	51.9%	\$0B	0.0%	\$5.4B	51.9%
FI/MAC - Non-Inpatient	\$108.2B	\$4B	3.7%	\$0.2B	0.2%	\$4.2B	3.9%
FI/MAC - Inpatient	\$111.2B	\$6.1B	5.5%	\$0.8B	0.7%	\$6.8B	6.1%
All Medicare FFS	\$308.4B	\$23B	7.5%	\$1.1B	0.4%	\$24.1B	7.8%

(2)

The DME MAC (51.9%) error rate was much higher than that of the Carrier/MAC (9.9%), FI/MAC Non-Inpatient (3.9%) and FI/MAC Inpatient (6.1%) rates because CMS' stricter adherence to policies disproportionately affected DME claims. More DME claims were determined to be paid in error because of the more strict enforcement of documentation requirements rather than allowing for clinical review judgment. In the past, reviewers applied clinical review judgment to claims to fill in the gaps of knowledge where documentation was missing. Once CMS clarified that clinical review judgment may not override documentation requirements, more errors were found on DME items. Additionally, it is often more difficult for DME contractors to obtain the proper documentation because they request documentation from the supplier who billed for the item, not the medical professional who ordered the item. The supplier then is responsible for submitting documentation to CMS that they have collected from the ordering provider. The involvement of multiple parties can cause a delay in documentation receipt and incomplete documentation. CMS also recently clarified that documentation produced by the supplier alone is insufficient to warrant payment of the claim.

As previously stated, the national paid claims error rate for FY 2009 is 7.8% or \$24.1 B. Last year's error rate was 3.6% or \$10.4 B. The increase in the error rate can be attributed to several programmatic changes. These changes and their impacts are further discussed below.

Consolidation of HPMP and CERT

Differences in error rate measurement methodology in the HPMP and CERT programs resulted in an increased error rate for inpatient hospital claims. HPMP sampled claims three months after month of discharge which allowed time for adjustment bills. CERT reviews the iteration of the claim that was randomly selected, even if the provider subsequently submitted an adjustment claim. HPMP allowed appeals to be submitted and adjudicated before calculating the error rate. The CERT program includes only appeals that have been adjudicated by a designated cutoff date in the error rate calculations. Therefore, the CERT program counts fewer appeal overturns. Additionally, CERT more strictly applied all national and local policies when reviewing inpatient claims.

Documentation Requirements

Many of the new errors resulted from a strict adherence to policy documentation requirements. In the past, the CERT contractor requested physician medical records but if all documentation was not submitted, the reviewers considered all available information (medical records, supplier notes, beneficiary payment history, etc.) and applied clinical review judgment to determine if sufficient information was available to make a payment decision. Now, CERT requires that physician records be present and doesn't consider additional available information until all of the documentation requirements are met. Consider for example, a bill submitted by a supplier for an oxygen concentrator. The supplier documentation includes a Certificate of Medical Necessity (CMN) which lists the oxygen saturation at rest and during exercise as required by the local coverage determination (LCD). The LCD also requires that the information on the CMN be supported by the ordering/referring physician's medical records. If the physician's medical record documentation is not submitted to the review entity, the supplier claim is denied.

Strict Enforcement of Signature Requirements

In addition, CMS directed the CERT contractor to more strictly adhere to its policy on signatures contained in the submitted medical record. For medical review purposes, Medicare requires that services provided/ordered be authenticated by a legible identifier and stamp signatures are not acceptable. In the past, if the provider's signature was missing or illegible, and there were no other reasons for denial of the claim, the CERT contractor did not deny the claim. After consultation with the OIG, CMS issued instructions to the CERT contractor directing them to strictly adhere to the CMS policy requiring a legible identifier.

Disallowance of Supplier Documentation

CMS determined that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim. For example, CERT reviewed a claim for enteral formula (liquid nutrition given by a feeding tube) and received a Certificate of Medical Necessity (CMN) and dietary progress notes signed by a licensed dietician. The beneficiary had oral cancer, which was treated with radiation, and a tracheostomy. However, the licensed dietician was employed by the supplier and under the new policy, CERT must deny the claim.

Removal of Billing History as a Valid Source of Information

Based on recommendations from the OIG, CMS removed claims history as a valid source for review information. Claims that previously would have been paid based on information from claims history were then denied. For example, CERT reviewed a claim for a bedside commode. The supplier provided the treating physician's signed and dated order to the CERT Contractor indicating a 79 year old patient was recovering from a total knee replacement. A review of claims history showed the beneficiary had a Medicare covered inpatient hospital stay for total knee replacement with a comorbid diagnosis of urinary tract infection shortly before this claim. The policy states a commode is covered when the

patient is physically incapable of using regular toilet facilities. The CERT Contractor would have previously determined that the total knee replacement combined with the urgency of urination associated with a urinary tract infection was sufficient to meet this requirement. Now, however, the CERT contractor may not use claims history as a basis for payment. CERT would not know the patient had urinary incontinence unless a medical record indicating the condition was also submitted.

It is likely that additional documentation, as required by the newly clarified policies, would have supported payment of the claim in many cases. For a detailed description on the types of errors and the error rate for each type, see Appendix.

GPRA Goals

Based on the CERT results for 2007 and 2008 CMS established the following error rate goals under the Government Performance and Results Act (GPRA):

1. Reduce the National Medicare FFS Paid Claims Error Rate.

- By November 2009, reduce the percent of improper payments under Medicare FFS to 3.5%.

Status: This goal was not met. The national paid claims error rate for the November 2009 reporting period was 7.8%. Because of the increase in the error rate, CMS is revising the goal for November 2010.

2. Reduce the Contractor-Specific Paid Claim Error Rate.

- By November 2009, 90% Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for November 2008.

Status: Due to the reduced number of claims reviewed – 99,500 versus the 120,000 originally planned – CMS did not produce contractor-specific error rates for 2009. This goal was not calculated for 2009.

Corrective Actions

CMS strives to eliminate improper payments in the Medicare program to maintain the Medicare trust funds and protect beneficiaries. To better account for improper payments, CMS altered the CERT process and called for a more strict enforcement of its policies. CMS will analyze the improper payment data garnered from the CERT program and make changes in areas that show programmatic weakness. CMS will also work with its contractors to ensure a more comprehensive review is done on all Medicare FFS claims. CMS plans to make several programmatic changes in order to decrease improper payments.

CMS has several correction actions in place to reduce administrative and documentation errors.

- CMS implemented improvements to the Medicare FFS error rate measurement program to ensure that providers and suppliers submit the required documentation.
 - CMS revised the medical record request letters to clarify the components of the medical record that are required for a CERT review.
 - CMS contacts third party providers to request documentation when the billing provider indicated that a portion of the medical record is possessed by a third party.
 - CMS conducts ongoing education to inform providers about the importance of submitting thorough and complete documentation of all medical records, especially those where the provider is ordering additional services or medical equipment.

CMS is dedicated to reducing authentication and medical necessity errors and is exploring the following corrective actions.

- CMS is revising Medicare FFS manuals to clarify requirements for reviewing documentation to promote uniform interpretation of our policies across all medical reviews performed by Medicare contractors.
- CMS is revising Medicare FFS manuals to address the errors related to signature requirements. CMS is currently devising a process whereby providers can attest to their signature if it is illegible or missing in a medical record under review. CMS also plans to conduct provider education related to signature requirements.
- CMS is developing comparative billing reports to help Medicare contractors and providers analyze administrative claims data.
- CMS is undertaking an automated edit demonstration to evaluate the accuracy of several commercial products that purport to deny health care claims that contain Medicare improper payments. The demonstration will determine whether these products are feasible in the Medicare FFS environment and would result in added value to the Medicare FFS program.
- CMS tasked each Carrier, FI, and MAC with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.
- CMS requires the Carriers, FIs, and MACs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce medical necessity and incorrect coding errors.
- CMS increased and refined educational contacts with providers who are billing in error.
- CMS developed and installed new correct coding edits.

CMS is expanding educational efforts to inform providers of Medicare coverage and coding rules.

APPENDIX

Paid Claims Error Rate by Error Type

Table 3c summarizes the percent of the total dollars improperly allowed by error category for this and previous reports.

Table 3c: Summary of Error Rates by Category

Type Of Error	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross	Gross	Gross	Gross
No Documentation Errors	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%	0.6%	0.2%	0.1%
Insufficient Documentation Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%	0.4%	0.6%	1.9%
Medically Unnecessary Errors	5.1%	4.2%	3.9%	2.6%	2.9%	2.7%	3.6%	1.1%	1.6%	1.6%	1.4%	1.3%	1.4%	4.0%
Incorrect Coding Errors	1.2%	1.7%	1.3%	1.3%	1.0%	1.1%	0.9%	0.7%	1.2%	1.5%	1.6%	1.5%	1.3%	1.6%
Other Errors	1.1%	0.5%	0.7%	0.9%	0.4%	-0.2%	0.0%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
IMPROPER PAYMENTS	13.8%	11.4%	7.1%	8.0%	6.8%	6.3%	6.3%	9.8%	10.1%	5.2%	4.4%	3.9%	3.6%	7.8%
CORRECT PAYMENTS	86.2%	88.6%	92.9%	92.0%	93.2%	93.7%	93.7%	90.2%	89.9%	94.8%	95.6%	96.1%	96.4%	92.2%

(3)

Table 3d summarizes the percent of total dollars improperly allowed by error category and contractor type.

Table 3d: Type of Error Comparison for 2007 and 2009

Type of Error	Nov 2008 Report	2009 Report				
	Total	Total	Carrier	DMERC	FI	QIO
No Documentation Errors	0.2%	0.1%	0.1%	0.0%	0.0%	0.0%
Insufficient Documentation Errors	0.6%	1.9%	1.2%	0.0%	0.5%	0.2%
Medically Unnecessary Errors	1.4%	4.0%	0.5%	1.7%	0.5%	1.3%
Incorrect Coding Errors	1.3%	1.6%	0.7%	0.0%	0.0%	0.6%
Other Errors	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
Improper Payments	3.6%	7.8%	2.5%	1.7%	1.4%	2.2%

(4)

No Documentation Errors

No documentation means the provider did not submit any medical record documentation to support the services provided. No documentation errors accounted for 0.1% of the total dollars all Medicare FFS contractors allowed during the reporting period. This data breaks down by contractor type as follows:

Part B	DME	Part A	Inpatient	Total
0.1%	0.0%	0.0%	0.0%	0.1%

(5)

The following are examples of No Documentation errors:

- A Carrier paid \$183.24 for a subsequent hospital visit performed by a physician. After multiple attempts to obtain the record, we received a letter from the provider stating, "No record for time period found". The Carrier recouped the entire payment.
- A Fiscal Intermediary (FI) paid a provider \$ 520.30 for a colonoscopy. After multiple attempts to obtain the record, we received a letter from the provider stating "Patient was not seen on this date of service". The FI recouped the entire payment.

Insufficient Documentation Errors

Insufficient documentation means that the provider did not include pertinent patient facts (e.g., the patient's overall condition, diagnosis, and extent of services performed) in the medical record documentation submitted.

Insufficient documentation errors accounted for 1.9% of the total dollars allowed during the reporting period. This data breaks down as follows:

Part B	DME	Part A	Inpatient	Total
1.2%	0.0%	0.5%	0.2%	1.9%

(6)

In several cases of insufficient documentation, it was clear that Medicare beneficiaries received services, but the physician's orders or documentation supporting the beneficiary's medical condition were incomplete. While these errant claims did not meet Medicare reimbursement rules regarding documentation, CMS could not conclude that the services were not provided.

In some instances, components of the medical documentation were located and maintained at a third party facility. For instance, although a lab may have billed for a blood test, the physician who ordered the lab test maintained the medical record. If the billing provider failed to contact the third party or the third party failed to submit the documentation to the CERT Contractor, CMS counted the claim as a full or partial insufficient documentation error.

The following are examples of insufficient documentation errors:

- A FI paid \$2766.87 to a provider for an inpatient hospital stay. After multiple attempts to obtain the documentation, we received an initial history and physical and a brief discharge summary only. The CERT reviewer determined there was insufficient documentation to support the services billed. The FI recouped the entire payment.
- A Carrier paid \$136.01 for physical therapy visits. Multiple attempts were made to obtain the documentation. Documentation received included the initial evaluation signed by the physical therapist. Missing were the order, and/or plan of care signed by the ordering physician and treatment notes. As a result, the CERT Contractor counted the claim lines in error and the Carrier recouped the entire amount.

Medically Unnecessary Services

Medically Unnecessary Services includes situations where the CERT claim review staff identifies enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary. In the case of inpatient claims, determinations are also made with regard to the level of care; for example, in some instances another setting besides inpatient care may have been more appropriate. If an FI or MAC determines that a hospital admission was unnecessary due to not meeting an acute level of care, the entire payment for the admission is denied.

Medically Unnecessary Service errors accounted for 4.0% of the total dollars allowed during the reporting period. This data breaks down as follows:

Part B	DME	Part A	Inpatient	Total
0.5%	1.7%	0.5%	1.3%	4.0%

(7)

For inpatient claims, this is often related to hospital stays of short duration where services could have been rendered at a lower level of care. A smaller, but persistent amount of medically unnecessary payment errors is due to unnecessary inpatient admissions associated with discharges to a skilled nursing facility.

The following are examples of medically unnecessary services:

- An FI paid \$145.87 for outpatient diagnostic tests. Repeated attempts were made to obtain evidence of the treating physician's intent to order the specific tests that were performed. The reviewer determined that the documentation did not support medical necessity per the Internet Only Manual 100-2 chapter 15, sect 80.6.1 The CERT contractor counted the claim in error and the entire amount was recouped.
- A DME MAC paid \$5048.72 for a power wheelchair, group 2 standard. The reviewer requested additional documentation from the supplier and the ordering physician. The reviewer determined that the documentation did not support medical necessity per the National coverage Determination (NCD) - 'Mobility Assistive Equipment (MAE) (280.3)' and the Local Coverage Determination (LCD)-' Power mobility Devices'. Neither the diagnoses submitted, nor the face to face evaluation received from the physician's office, supported the inability to self-propel. No other valid rationale was offered for why a Power Mobility Device (PMD) versus another mobility device was reasonable and necessary. The entire amount was recouped.
- An FI MAC paid \$4698.94 for a one day inpatient hospital stay. The patient was admitted with a diagnosis of abdominal pain and stayed less than 12 hours. The patient failed to meet medical necessity criteria for an inpatient admission. Service could have been provided with the patient in an outpatient observation status. The FI recouped the entire amount.
- A DME MAC paid \$231.07 for the monthly charge for an oxygen concentrator and a portable gaseous unit. The Certificate of Medical Necessity (CMN) received was incomplete. Missing was required information such as: the answers to questions 1-10, the results of the oxygen saturation test, whether the patient was inpatient at the time of testing, and the oxygen flow rate. The CMN was signed and dated 4 months after the claim was adjudicated. The reviewer determined that the record did not meet medical necessity criteria per the LCD for Oxygen and Oxygen Equipment.

Incorrect Coding

Providers use standard coding systems to bill Medicare. For most of the coding errors, the medical reviewers determined that providers submitted documentation that supported a lower code than the code submitted (in these cases, providers are said to have *overcoded* claims). However, for some of the coding errors, the medical reviewers determined that the documentation supported a higher code than the code the provider submitted (in these cases, the providers are said to have *undercoded* claims).

Incorrect Coding errors accounted for 1.6% percentage of the total dollars allowed during the reporting period. This data breaks down as follows:

Part B	DME	Part A	Inpatient	Total
0.7%	0.0%	0.0%	0.6%	1.6%

(8)

A common error involved overcoding or undercoding E&M codes by one level on a scale of five code levels. Published studies suggest that under certain circumstances, experienced reviewers may disagree on the most appropriate code to describe a particular service. This may explain some of the incorrect coding errors in this report. CMS is investigating procedures to minimize the occurrence of this type of error in the future.

The following are examples of coding errors:

- An FI paid \$741.32 for a transthoracic echocardiography with contrast, real time, with exercise stress test. Upon receipt of additional documentation it was determined that the diagnostic study was performed without the use of contrast material. This coding error resulted in an overpayment to the provider of \$141.93, which was recouped by the contractor.
- A Carrier paid \$130.00 to a provider for initial nursing facility care, per day, CPT code 99306 which requires 3 of 3 key components: a comprehensive history, a comprehensive exam, and high complexity medical decision making (MDM). Upon review it was determined that documentation supported a downcode to CPT code 99304 by meeting/ exceeding 3 of 3 components with a detailed history, comprehensive exam, and moderate complexity MDM. The overpayment collected was \$54.17.

The OIG and CMS have noted problems with certain procedure codes for the past several years. These problematic codes include CPT codes 99214 (office or other outpatient visit), 99232 (subsequent hospital care level 2) and 99233 (subsequent hospital care level 3).

Other Errors

Under CERT, *other errors* include instances when provider claims did not meet billing requirements such as those for not covered or unallowable services and duplicate claim submissions. Billing errors include payments for claims where the stay was billed as non-exempt unit but was exempt, outpatient billed as inpatient, and HMO bills paid under FFS.

Other errors accounted for 0.1% of the total dollars allowed during the reporting period. This data breaks down as follows:

Part B	DME	Part A	Inpatient	Total
0.0%	0.0%	0.0%	0.1%	0.1%

(9)

The following are examples of other errors:

- **Not Covered or Unallowable Service error:** An FI MAC paid \$675.23 for a routine dental extraction. Per Medicare Benefit Policy - Basic Coverage Rules (PUB. 100-02) Chapter 16 - General Exclusions From Coverage §140 - Dental Services Exclusion; Medicare Benefit Policy - Basic Coverage Rules (PUB. 100-02) Chapter 15 - Covered Medical and Other Health Services §150 - Dental Services, this service is excluded from coverage. The entire amount was recouped by the FI.
- **Service Not Rendered:** A Carrier paid \$85.14 for a high level evaluation and management service. Upon request to the provider for additional documentation, the provider indicated that the patient was not seen by the physician. The entire amount was recouped by the Carrier.
- **Duplicate Payment error:** An FI paid \$73.43 to a provider for a clinic visit. The claim was a duplicate to another claim by the same provider, with the same diagnosis, and same date of service. The medical records received were also identical. Upon review, the reviewer discovered that the claim line had already been billed and paid. The overpayment amount was recouped.
- **Unbundling error:** An FI MAC paid \$77.70 to a speech-language therapist for therapy performed while the patient was in a Part A Skilled Nursing Facility (SNF) stay. Per the SNF Prospective Payment System (PPS) rules, these services are not paid separately. The FI recouped the full amount.
- **Other error:** An FI MAC paid \$1618.66 for outpatient radiation oncology therapy. Review of submitted documentation and a check of the Common Working file (CWF) revealed that patient was in a covered inpatient stay for the billed dates of service. The entire amount was recouped by the FI.

CONTACT INFORMATION

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1. 2009 CMS Statistics: U.S. Department of Health and Human Services, CMS pub. No 03455, September 2009
2. Some columns and/or rows may not sum correctly due to rounding.
3. The 2003 entries were adjusted to account for high non-response rates. Including non-response, the national projected improper payments would have been \$21.5B and the national paid claims error rate would have been 10.8%.
4. Some columns and/or rows may not sum correctly due to rounding.
5. Some columns and/or rows may not sum correctly due to rounding.
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