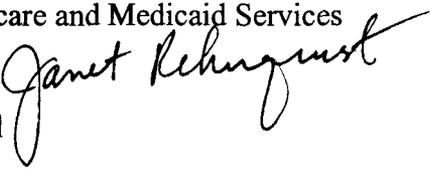




JAN 16 2003

**TO:** Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

**FROM:** Janet Rehnquist   
Inspector General

**SUBJECT:** Improper Fiscal Year 2002 Medicare Fee-for-Service Payments  
(A-17-02-02202)

Attached, in accordance with our memorandum of understanding with the Centers for Medicare and Medicaid Services (CMS), is the final report on our review of fiscal year (FY) 2002 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations.

In informal comments on a draft of this report, CMS officials concurred with our findings and recommendations.

If you have any questions or comments about this report, please do not hesitate to call me or David M. Long, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at [dlong@oig.hhs.gov](mailto:dlong@oig.hhs.gov). To facilitate identification, please refer to report number A-17-02-02202 in all correspondence.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**IMPROPER FISCAL YEAR 2002  
MEDICARE FEE-FOR-SERVICE  
PAYMENTS**



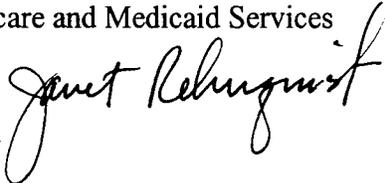
**JANET REHNQUIST**  
Inspector General

**JANUARY 2003**  
A-17-02-02202



JAN 16 2003

**TO:** Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

**FROM:** Janet Rehnquist   
Inspector General

**SUBJECT:** Improper Fiscal Year 2002 Medicare Fee-for-Service Payments (A-17-02-02202)

This final report presents the results of our review of fiscal year (FY) 2002 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. This is the seventh year that the Office of Inspector General (OIG) has estimated these improper payments. As part of our analysis, we have profiled the last 7 years' results and identified specific trends where appropriate.

Our review of 4,985 claims valued at \$6.2 million disclosed that 1,030 did not comply with Medicare laws and regulations. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2002 totaled \$13.3 billion, or about 6.3 percent of the \$212.7 billion in processed fee-for-service payments reported by the Centers for Medicare and Medicaid Services (CMS). These improper payments, as in past years, could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. The overwhelming majority (95 percent) of the improper payments were detected through medical record reviews that we coordinated. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

The FY 2002 estimate of improper payments is significantly less than the \$23.2 billion that we first estimated for FY 1996. As a rate of error, the current 6.3-percent estimate is the same as last year's rate—which was the lowest to date—and less than half of the 13.8 percent reported for FY 1996. However, we cannot conclude that it is statistically different from the FYs 1998-2000 estimates, which ranged from 6.8 to 8 percent. The decrease may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

We believe that since we developed the first error rate for FY 1996, CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. For example, CMS has worked with provider groups, such as the American Medical Association and the American Hospital Association, to clarify reimbursement rules and to impress upon health care providers the importance of fully documenting services. Such efforts have contributed to the large reduction in the rate. In addition, due to efforts by CMS and the

provider community, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In this regard, since FY 1998, over 92 percent of Medicare fee-for-service payments have contained no errors. Lastly, fraud and abuse initiatives on the part of CMS, the Congress, the Department of Justice (DOJ), and OIG have had a significant impact.

However, continued vigilance is needed to ensure that providers maintain adequate documentation supporting billed services, bill only for services that are medically necessary, and properly code claims. These problems have persisted for the past 7 years.

## **BACKGROUND**

***The Medicare Program.*** The Medicare program (Title XVIII of the Social Security Act) was established by the Social Security Amendments of 1965 to cover the health care needs of people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. In FY 2002, more than 40 million beneficiaries were enrolled in the program, and CMS incurred about \$254.5 billion nationwide in Medicare benefit payments. Fee-for-service payments accounted for about \$212.7 billion of this total.

Medicare consists of two major programs, each with its own enrollment, coverage, and financing:

- Hospital insurance, also known as Medicare Part A, is usually provided automatically to people aged 65 and over and to most disabled people. It covers services rendered by participating hospitals (including prospective payment system (PPS) hospitals), skilled nursing facilities, home health agencies, and hospice providers.
- Supplementary medical insurance, also known as Medicare Part B, is available to nearly all people aged 65 and over and the disabled entitled to Part A. This optional insurance is subject to monthly premium payments by beneficiaries. Medicare Part B covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by Medicare Part A.

The CMS pays the following types of contractors to process fee-for-service claims:

- Fiscal intermediaries (FIs) process Part A payments for hospitals, skilled nursing facilities, home health agencies, rural health clinics, hospices, end stage renal disease facilities, and other institutional providers.
- Carriers process Part B payments for physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers.
- Durable medical equipment regional carriers (DMERCs) process claims from suppliers of durable medical equipment, prosthetics, orthotics, and other supplies under Medicare Part B except those for items incident to physician services in rural health clinics or

included in payments to such providers as hospitals, skilled nursing facilities, and home health agencies.

To ensure the quality of care provided to Medicare beneficiaries, CMS also contracts with quality improvement organizations (QIOs) to conduct a wide variety of improvement programs. For example, QIO medical review personnel assess medical record documentation to determine whether the services rendered met professionally recognized standards of care and were medically necessary and appropriate.

***The Medicare Error Rate.*** The FY 2002 Medicare fee-for-service error rate will be the last one published by the OIG. From FY 2003 forward, CMS will publish a national error rate developed through Comprehensive Error Rate Testing (CERT) and the Hospital Payment Monitoring Program (HPMP) (formerly known as the Payment Error Prevention Program). The CMS initiated these programs, which build on the OIG methodology, in response to our recommendation that CMS develop its own error rate process.

The CERT and HPMP will establish, for the first time, baselines to measure each contractor's progress toward correctly processing and paying claims. The results will reflect the contractor's performance and will identify specific provider billing anomalies in the region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claim reviews, and other activities, and CMS will evaluate their rate of improvement.

## **AUDIT OBJECTIVE**

Our primary objective was to determine whether Medicare fee-for-service benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR). Specifically, we determined whether services were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in beneficiaries' medical records.

## **AUDIT SCOPE AND METHODOLOGY**

***Statistical Selection Method.*** To accomplish our objective, we used a multistage, stratified sample design. In the first stage, our sample frame consisted of 136 contractor quarters. Twelve contractor quarters were selected based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used fourth quarter FY 2000 Medicare fee-for-service benefit payments and the first, second, and third quarters of FY 2001 as the selection weighting factors (size of each contractor quarter). The 12 contractor quarters included 8 contractors, of which 4 were FIs; 2 were both FIs and carriers; and 2 were FIs, carriers, and DMERCs.

The second stage of our sample design consisted of a random sample of 50 beneficiaries from each of the 12 contractor quarters sorted into 4 strata by total payments for services. The random sample of 610 beneficiaries<sup>1</sup> produced 4,985 claims valued at \$6.2 million for review. To ensure the completeness of the claim data, we reconciled Medicare contractor claim data to the CMS 1522 Monthly Financial Reports for the 12 contractor quarters selected. The CMS used these reports in preparing the FY 2002 financial statements.

The relative probability of selection for the contractor quarters and beneficiaries was incorporated into the overpayment estimate so that the estimate was not biased by a focus on the larger contractors or the beneficiaries with higher payments. The statistical software used to compute the estimate included the appropriate formulas for the relative probabilities of selection, which are referred to as “weights.”

We used a variable appraisal program to estimate the dollar value of improper payments in the total population. The population represented \$212.7 billion in fee-for-service payments.

***Audit Procedures.*** We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. We contacted each provider in our sample by letter and requested copies of all medical records supporting services billed. In the event that we did not receive a response to our initial letter, we made numerous follow-up contacts by letter and, in most instances, by telephone calls. At selected providers, we also made onsite visits to collect requested documentation.

Medical review staff from the CMS Medicare contractors and QIOs assessed the medical records to determine whether the services billed were reasonable, adequately documented, medically necessary, and coded in accordance with Medicare reimbursement rules and regulations. To make these determinations, the staff applied coverage guidelines, including the Medicare carrier and FI manuals. In the case of physician evaluation and management codes, the medical staff used the Current Procedural Terminology (CPT) Manual developed by the American Medical Association. We coordinated these medical reviews to ensure their consistency and accuracy.

Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (i.e., Medicare secondary payer); and

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<sup>1</sup> For one contractor quarter, the initial universe did not include all beneficiaries. Therefore, an additional random sample of 10 beneficiaries was selected for review.

- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

We made this review in accordance with generally accepted government auditing standards.

## **RESULTS OF REVIEW**

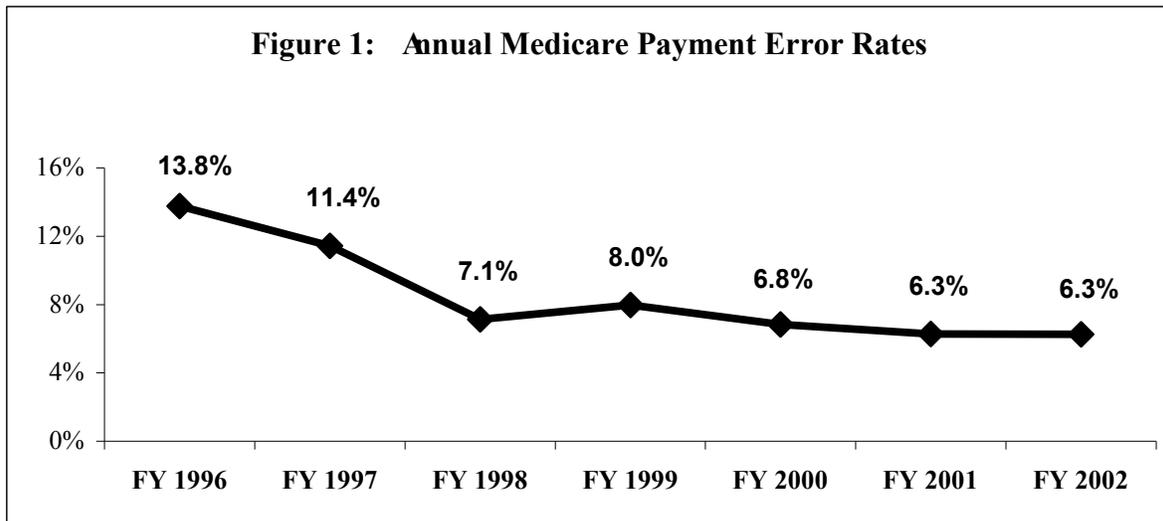
Through detailed medical and audit reviews of a statistical selection of 610 beneficiaries nationwide with 4,985 fee-for-service claims processed for payment during FY 2002, we found that 1,030 claims did not comply with Medicare laws and regulations. We refer to these instances of noncompliance as improper payments. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claim adjudication process.

It should be noted that in cases where there was no or insufficient documentation supporting Medicare claims (estimated at \$3.8 billion this year), medical reviewers could not reach a decision on whether the services were properly authorized and medically necessary. In several cases, it was quite clear that Medicare beneficiaries had, in fact, received services, but the physician's orders or documentation supporting the beneficiary's medical condition was missing. While these erroneous claims did not meet Medicare reimbursement rules regarding documentation, we cannot conclude that the services were not provided or were otherwise wasteful.

Based on our statistical sample, the point estimate of improper Medicare benefit payments made during FY 2002 was \$13.3 billion, or about 6.3 percent of the \$212.7 billion in processed fee-for-service payments reported by CMS. The estimated range of the improper payments at the 95-percent confidence level is \$8.2 billion to \$18.4 billion, or about 4 percent to 9 percent, respectively.

Our historical analysis indicates that CMS has sustained its progress in reducing improper payments. For FY 1996, estimated improper payments totaled \$23.2 billion, or 13.8 percent of the fee-for-service payments reported by CMS. Thus, we have seen the estimate drop by almost \$10 billion, a significant reduction in 7 years. This reduction, in our opinion, is attributable to CMS's continuing corrective actions; efforts by health care providers to comply with Medicare reimbursement regulations; and fraud and abuse initiatives on the part of CMS, the Congress, DOJ, and OIG.

As illustrated in figure 1, the FY 2002 error rate is less than half that first estimated for FY 1996. The current 6.3-percent estimate is the same as last year's rate, which was the lowest to date. However, we cannot conclude that it is statistically different from the estimates for FYs 1998-2000, which ranged from 6.8 to 8 percent. The decrease may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.



The following table demonstrates the trends in improper payments by the major categories of errors we have identified: (1) documentation errors, (2) medically unnecessary services, (3) coding errors, and (4) noncovered services and miscellaneous errors. Unsupported and medically unnecessary services have been pervasive problems, accounting for more than 80 percent of the total improper payments over the 7 years. It should be noted that CMS upheld over 90 percent of the overpayments identified in our FYs 1996-2001 samples and recovered the bulk of them. (The exceptions concerned cases under investigation.)

Type of Payment Error <sup>2</sup>	Fiscal Year						
	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
Documentation errors	46.8%	44.3%	16.8%	40.4%	36.4%	42.9%	28.6%
Medically unnecessary services	36.8%	36.9%	55.6%	32.8%	43.0%	43.2%	57.1%
Coding errors	8.5%	14.7%	18.0%	15.8%	14.7%	17.0%	14.3%
Noncovered/other	<u>7.9%</u>	<u>4.1%</u>	<u>9.6%</u>	<u>11.0%</u>	<u>5.9%</u>	<u>(3.1%)<sup>3</sup></u>	<u>0.0%<sup>4</sup></u>
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Details on these error categories follow.

<sup>2</sup> For these error categories, the sample was not designed to allow for the same level of precision as in the estimate of the overall error rate.

<sup>3</sup> The -3.1 percent applied primarily to “other” errors. In these cases, medical reviewers determined that the amounts billed should have been higher or that amounts previously denied were correct.

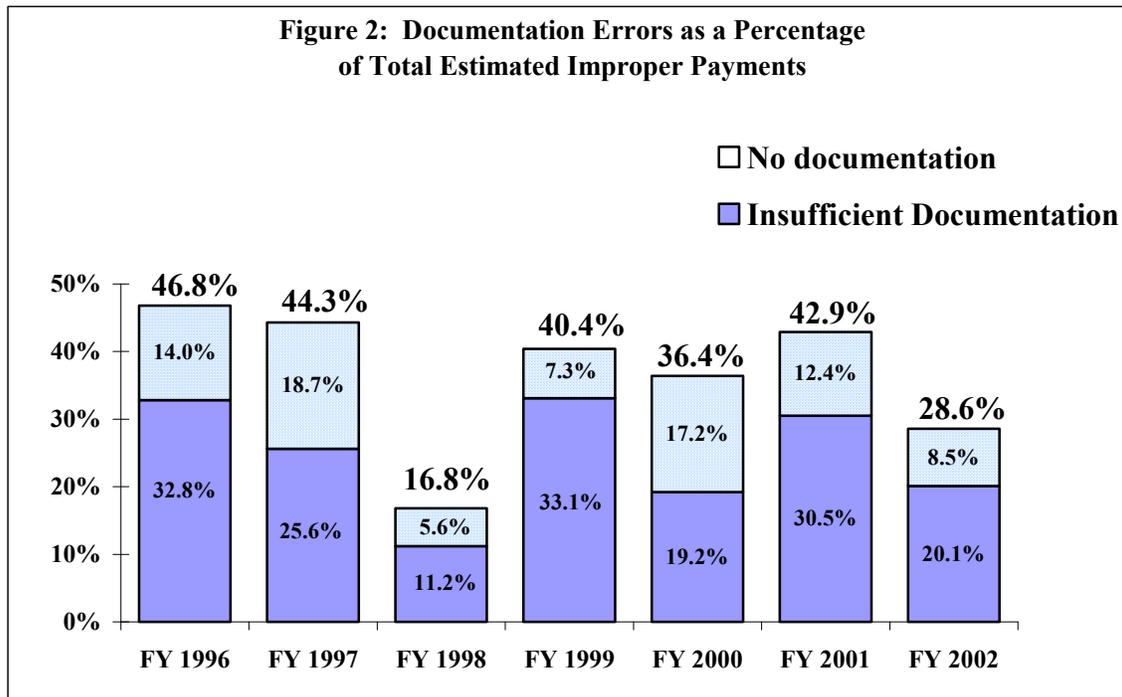
<sup>4</sup> The actual figure was 0.03 percent.

## Documentation Errors

Documentation errors dropped by almost 26 percent in FY 2002.

Documentation errors represented the largest error category in 3 of the last 7 years. For FY 2002, the dollar amount of these types of errors decreased by almost 26 percent compared with FY 2001. However, they remain a significant problem, accounting for an estimated \$3.8 billion in improper payments.

As illustrated in figure 2, the overall category of documentation errors includes two components: (1) insufficient documentation to determine the patient’s overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. The dollar value of this year’s errors in the “insufficient documentation” category decreased by over 27 percent, while those in the “no documentation” category decreased by 25 percent since FY 2001.



Like other insurers, Medicare makes payments based on a standard claim form. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If sampled providers failed to provide documentation or submitted insufficient documentation, the contractors or OIG staff requested supporting medical records at least three times—and, in most instances, four or as many as five times—before determining that the payment was improper. Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries, the extent of services performed, or their medical necessity. In several cases, it was quite clear that beneficiaries had, in fact, received services, but the physician’s orders or documentation

supporting the beneficiary's medical condition was missing. While these erroneous claims did not meet Medicare reimbursement rules regarding documentation, we cannot conclude that the services were not provided or were otherwise wasteful.

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health, history (including past and present illnesses), examinations, tests, treatments, and outcomes. Medical records chronologically document the care of the patient and are an important element contributing to high quality of care. The records assist in:

- the evaluation and planning of the patient's immediate treatment and monitoring of the patient's health care over time by the physician and other health care professionals,
- communication and continuity of care among physicians and other health care professionals involved in the patient's care, and
- appropriate utilization review and quality-of-care evaluation.

Some examples of documentation errors follow:

- Physician.** A physician was paid \$182 for an office visit and scanning diagnosis services. After repeated attempts to obtain the supporting medical records, the medical reviewer was informed that the records could not be located. As a result, the entire payment was denied.
- Physician.** A physician was paid \$91 for an office consultation, which requires a detailed history, a detailed examination, and medical decisionmaking of moderate complexity. The medical reviewer determined that the provider had performed a detailed history and medical decisionmaking of moderate complexity. Because the physician failed to document a detailed examination, however, the medical reviewer denied the payment.
- Physician.** A physician was paid \$199 for evaluation and management services provided in a hospital emergency room. Based on the medical records, the medical reviewer was unable to determine the level of services provided, if any, or their medical necessity. As a result, the entire payment was denied.
- Outpatient.** An outpatient hospital was paid \$62 for an osteoporosis screening. The documentation did not include a doctor's order, a medical history, or notes to support the diagnosis. As a result, the \$62 payment was denied.
- Outpatient.** An outpatient hospital was paid \$258 for laboratory tests and radiology services that were not supported by written physician's orders or other documentation supporting the medical necessity of the services. As a result, the medical reviewer denied the total payment.

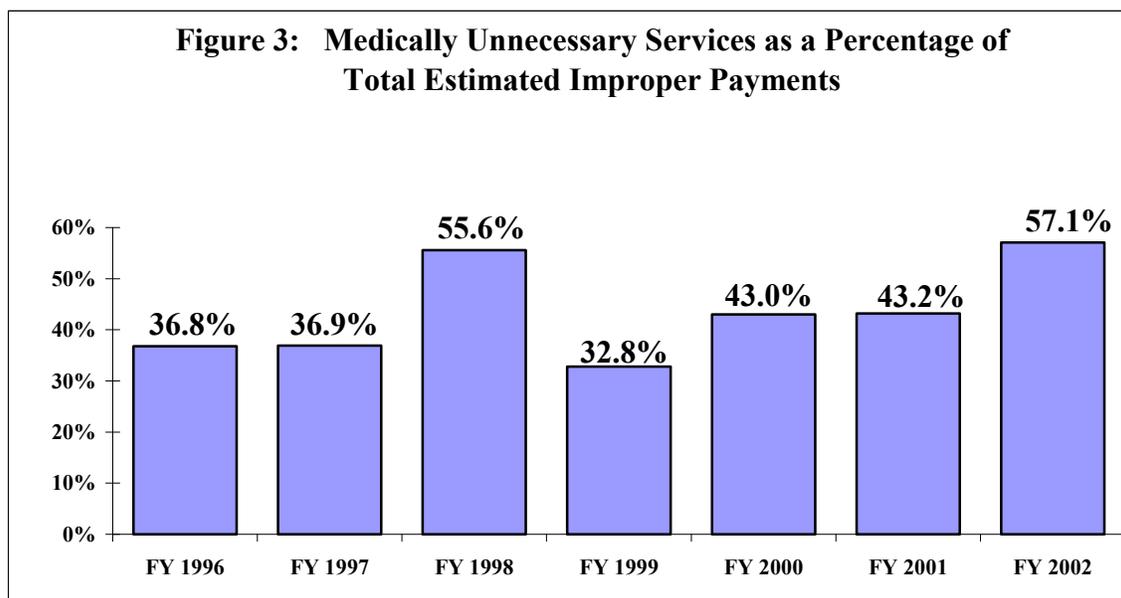
- ❑ **Outpatient.** An outpatient hospital was paid \$354 for a series of physical therapy treatments. The medical records did not contain the physician's order, certification of needs, or treatment plan for the services provided. Therefore, the reviewer denied the payment.

### Medically Unnecessary Services

Medically unnecessary services, the largest category in 4 of the last 7 years, increased significantly in FY 2002.

This error category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. As in past years, the Medicare contractor or QIO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations. They followed their normal claim review procedures to determine whether the medical records supported the Medicare claims. Making such determinations has been an integral part of the Medicare contractors' quality control function since the program's inception, and OIG and CMS have relied on their expertise to perform these services for many years.

Medically unnecessary services represented the largest error category for the last 3 years and for 4 of the 7 years. From FY 2001 to FY 2002, these errors increased from 43.2 percent (or \$5.2 billion) to 57.1 percent (or \$7.6 billion) of the total improper payments. (See figure 3.) Inpatient PPS claims accounted for 52 percent of the errors this year.



Following are examples of medically unnecessary services:

- ❑ **Skilled nursing facility.** A skilled nursing facility was paid \$14,269 for a 90-day inpatient stay. The medical reviewer determined that the first 13 days were devoted to a very high level of rehabilitation in an attempt to restore functions. However, the medical

records indicated that the beneficiary exhibited minimal response to the treatment due to confusion, agitation, and decreased cooperation. Because there was no reasonable expectation of functional improvement, the reviewer concluded that the beneficiary should have been transferred to a long-term-care facility and that the last 77 days of the inpatient stay were not medically necessary. As a result, \$10,138 was denied.

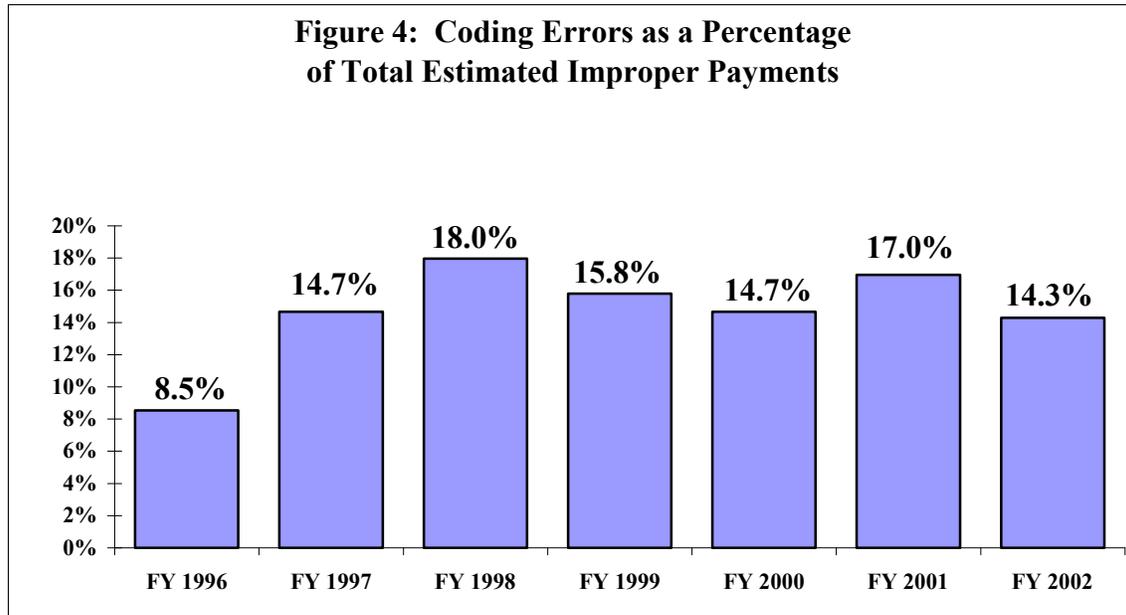
- ❑ ***Inpatient.*** A hospital was paid \$11,751 for a beneficiary admitted for an aortogram (an image of the aorta obtained through radiography) to check the openness of a bypass. Bilateral stents had been inserted as an outpatient procedure. The medical reviewer determined that the patient could have been evaluated in an observation setting and did not require an acute care admission. As a result, the entire payment was denied.
- ❑ ***Inpatient.*** A hospital was paid \$13,750 for a beneficiary admitted with complaints of upper chest pains and a history of severe, chronic, obstructive pulmonary disease. The hospital physicians indicated that the patient's examination revealed wheezes; however, no significant abnormalities were noted in the patient's oxygen level. The patient was discharged the day after admission. The medical reviewer determined that the care could have been provided in a less acute setting and, as a result, denied the total payment.
- ❑ ***Inpatient.*** A hospital was paid \$3,457 for a beneficiary admitted with complaints of swelling of the knee. According to the medical records, the patient was not in acute distress and had no fever. The medical reviewer determined that the care could have been provided in a less acute setting and denied the total amount.
- ❑ ***Inpatient.*** A hospital was paid \$6,319 for a beneficiary admitted to assess the functioning of a catheter. Based on the medical records, the reviewer determined that the patient's catheter was functioning and that an observation period was appropriate; however, an acute care admission was not required. Therefore, the payment was denied.

## Coding Errors

Net estimated coding errors decreased in FY 2002.
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The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding that were offset against identified upcoding situations.

In previous years, the estimated dollar amount of coding errors (the net of upcoding and downcoding) remained consistently in the \$2 billion to \$3 billion range. This year, incorrect coding, which is the third highest error category, was reduced to \$1.9 billion, or 14.3 percent of the total estimated improper payments. (See figure 4.)



The CMS has recognized problems with certain procedure codes. By letter dated June 1, 2000, the CMS Administrator notified Medicare physicians that CPT codes 99233 and 99214 for evaluation and management services had accounted for a significant portion of the FYs 1998 and 1999 coding errors. The Administrator noted that documentation for many of these services more appropriately supported CPT codes 99212 and 99231, respectively, and reminded providers to document the specific procedures performed. Our analysis indicates continuing problems with these same procedure codes:

- ***CPT code 99233, subsequent hospital care.*** The physician should typically spend 35 minutes with the patient and perform at least two of these key procedures: a detailed interval patient history, a detailed examination, and/or medical decisionmaking of high complexity. Medical reviews of 228 services in FY 2002 disclosed that 174 services, or 76.3 percent, were in error. This was a significant increase since last year. Of the 174 errors, 158 were incorrectly coded and subsequently downcoded to lower valued procedure codes. Most of the remaining errors related to documentation problems.

Our 7-year analysis follows.

<b>CPT Code 99233</b>			
<b>Fiscal Year</b>	<b>Number of Services Reviewed</b>	<b>Number of Services Questioned</b>	<b>Percent of Services in Error</b>
<b>1996</b>	217	115	53.0%
<b>1997</b>	416	128	30.8%
<b>1998</b>	457	114	24.9%
<b>1999</b>	187	102	54.5%
<b>2000</b>	449	220	49.0%
<b>2001</b>	338	142	42.0%
<b>2002</b>	228	174	76.3%

- CPT code 99214, office or other outpatient visit.*** The physician should typically spend 25 minutes face-to-face with the patient and perform at least two of the following procedures: a detailed patient history, a detailed examination, and/or medical decisionmaking of moderate complexity. As shown in the next table, medical reviews of 104 services in FY 2002 disclosed that 24 services, or 23.1 percent, were in error--a significant decrease from previous years. Of the 24 errors, 21 were incorrectly coded and the rest related primarily to documentation problems.

<b>CPT Code 99214</b>			
<b>Fiscal Year</b>	<b>Number of Services Reviewed</b>	<b>Number of Services Questioned</b>	<b>Percent of Services in Error</b>
<b>1996</b>	140	54	38.6%
<b>1997</b>	234	86	36.8%
<b>1998</b>	168	63	37.5%
<b>1999</b>	143	81	56.6%
<b>2000</b>	191	71	37.2%
<b>2001</b>	214	67	31.3%
<b>2002</b>	104	24	23.1%

In addition, although not highlighted in the Administrator's letter, we noted a high incidence of error in CPT code 99232, subsequent hospital care, in all years reviewed, as well as a significant increase for FY 2002. For this billing code, the physician should typically spend 25 minutes at bedside with the patient and should perform at least two of the following key procedures: an expanded problem-focused interval patient history, an expanded problem-focused examination, and/or medical decisionmaking of moderate complexity. As illustrated in the next table, medical reviews of 488 services in FY 2002 disclosed that 179 services, or 36.7 percent, were in error. The majority (133) were incorrectly coded, and the medical records supported lower valued procedure codes. Most of the remaining errors related to documentation problems.

<b>CPT Code 99232</b>			
<b>Fiscal Year</b>	<b>Number of Services Reviewed</b>	<b>Number of Services Questioned</b>	<b>Percent of Services in Error</b>
<b>1996</b>	597	266	44.6%
<b>1997</b>	1,159	350	30.2%
<b>1998</b>	911	181	19.9%
<b>1999</b>	837	279	33.3%
<b>2000</b>	881	270	30.6%
<b>2001</b>	964	146	15.1%
<b>2002</b>	488	179	36.7%

Over the 7 years reviewed, inpatient PPS and physician claims accounted for about 88 percent of coding errors. Some examples of incorrect coding in FY 2002 follow:

- ❑ ***Inpatient.*** A hospital was paid \$10,028 for an inpatient stay based on the principal diagnosis of postoperative wound disruption. The medical records and additional input from the hospital indicated that the principal diagnosis should have been coded as “other musculoskeletal system and connective tissue diagnoses,” which is reimbursed at a lower level. Therefore, the medical reviewer denied \$6,879 of the payment.
- ❑ ***Inpatient.*** A hospital was paid \$34,889 for a beneficiary admitted for a heart attack. The paid procedure was an angioplasty. However, the medical records showed that a cardiac catheterization had been performed instead. As a result, the medical reviewer changed the diagnosis-related group (DRG) and denied \$10,172 of the payment.
- ❑ ***Physician.*** A physician was paid \$630 for nine office visits for the evaluation and management of an established patient. This procedure requires at least two of three key components: a detailed history, a detailed examination, and/or medical decisionmaking

of moderate complexity. The medical reviewer determined that the services did not meet the minimum criteria for these key components because a licensed nurse rendered the services. The reviewer determined that this service should have been billed at a lower code and denied \$252 of the payment.

- ❑ **Physician.** A physician was paid \$165 for the evaluation and management of a critically injured patient for the first 30 to 74 minutes. The examination included a detailed interval history, a comprehensive examination, and medical decisionmaking of high complexity. However, the medical records did not indicate that the physician intervention met the definition of critical care. Therefore, the medical reviewer downcoded the service and denied \$102.
- ❑ **Physician.** A physician was paid \$170 for an office consultation. This procedure requires three key components: a comprehensive history, a comprehensive examination, and medical decisionmaking of high complexity. The medical reviewer determined that the provider lacked comprehensive documentation for the history component and for three body systems examined. Furthermore, the decisionmaking was only of moderate complexity. As a result, the reviewer downcoded the service and denied \$78.
- ❑ **Physician.** A physician was paid \$122 for the evaluation and management of a patient admitted to the hospital. The medical documentation supported a lower level admitting-physician procedure. As a result, the medical reviewer downcoded the procedure and denied \$68.

## Noncovered Services and Other Errors

Errors due to noncovered services have consistently constituted the smallest error category. For FY 2002, these errors represented 0.03 percent of the total improper payments.

Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the *Medicare Handbook*, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;
- eye and ear examinations to prescribe or to fit glasses or hearing aids;
- most prescription drugs;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray or by physical examination.

Following is an example of a noncovered service identified during our review:

- **Physician.** A physician was paid \$62 for an office visit to evaluate and manage the care of an established patient. This procedure requires at least two of three components: a detailed history, a detailed examination, and/or medical decisionmaking of moderate complexity. The medical reviewer determined that the service provided was a yearly physical examination. Since Medicare does not pay for such examinations, the payment was denied.

## CONCLUSIONS AND RECOMMENDATIONS

Based on our FY 2002 sample, we estimate that the Medicare fee-for-service payment error rate is 6.3 percent, or \$13.3 billion. This dollar amount is higher than the \$12.1 billion estimated for FY 2001, partially due to an increase in Medicare expenditures. However, the error rate remains at the lowest-ever level achieved last year. This rate may not be statistically different from the rates for FYs 1998-2000 due to sampling variability. As in past years, these improper payments could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse.

The large reduction in improper payments since FY 1996, we believe, demonstrates CMS's vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, significant contributions have been made by provider organizations, such as the American Medical Association and the American Hospital Association, in clarifying reimbursement rules and in impressing upon their membership the importance of fully documenting services. Lastly, fraud and abuse initiatives on the part of CMS, the Congress, DOJ, and OIG have had a substantial impact on reducing the error rate.

It is commendable that the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In this regard, over 92 percent of Medicare fee-for-service payments since FY 1998 have contained no errors. Thus, the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly.

While our 7-year analysis indicates progress in reducing improper payments, it also shows that medically unnecessary services and undocumented services continue to be pervasive problems. These two error categories accounted for more than 80 percent of the total improper payments over the 7 years. The CMS needs to increase its efforts to maintain progress in reducing these improper payments. In particular, CMS needs to increase its work with providers to ensure that medical records support billed services. These records not only assist providers in evaluating and planning the patient's treatment but also ensure continuity of care in the event that another caregiver must assume responsibility for the patient's care. In addition, medical records help to ensure the correct and timely processing and payment of provider claims.

We recommend that CMS:

- increase efforts to direct that the Medicare contractors expand provider training on the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare for services provided;

- continue to refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented;
- direct its QIOs to identify high-risk areas and continue selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews, to reduce medically unnecessary services and ensure continued provider integrity; and
- ensure that contractors recover the improper payments identified in our review.