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TO: Timothy Hill
Chief Financial Officer
Centers for Medicare & Medicaid Services

FROM: Dennis J. Duquette *Duquette*
Deputy Inspector General for Audit Services

SUBJECT: Oversight and Evaluation of the Fiscal Year 2003 Comprehensive Error Rate Testing Program (A-03-03-00014)

Attached is a copy of our final report on the results of our oversight and evaluation of the Comprehensive Error Rate Testing (CERT) program. The Centers for Medicare & Medicaid Services (CMS) developed CERT primarily to establish the Medicare fee-for-service paid claims error rate for all types of Medicare services other than inpatient acute care hospital services. The CERT program was designed to determine the underlying reasons for claim errors and to develop appropriate action plans to improve compliance with payment, claims processing, and provider billing requirements.

CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a tracking and reporting database and system. The CERT contractor is responsible for obtaining information from Medicare contractors and health care providers to determine whether the Medicare contractors have met CMS's goal of paying Medicare claims correctly.

Our objectives were to determine whether (1) the CERT contractor followed established CERT error rate review policies and procedures and (2) the CERT quality assurance program ensured the reliability of the CERT claims review process.

Our review of 105 claims found that the CERT contractor generally followed established CERT error rate review policies and procedures for 99 claims. However, the medical records for six claims were never received, and letters requesting medical records were often sent late. In addition, our review of another 45 claims found that the CERT contractor had not fully implemented the quality assurance program in accordance with established procedures. Our specific findings follow:

- For 73 of the 105 claims sampled, the initial request for medical records was sent to the provider 9 to 20 days later than required.

- Followup requests for missing medical records were sent 1 to 204 days later than required.
- Quality assurance reviews were not performed for 22 of the 45 claims sampled, and the results of those reviews that were performed were not shared with medical review specialists.

We recommended that CMS direct the CERT contractor to:

- send requests for medical records, including followup requests, in accordance with established time schedules and
- complete all required quality assurance reviews and use the results to provide feedback and training to medical reviewers.

If you have any questions, please contact me or your staff may call Joseph Vengrin, Assistant Inspector General for Financial Management Audits, at (410) 786-7103. To facilitate identification, please refer to report number A-03-03-00014 in all correspondence.

Attachment

cc:

Medicare Program Integrity Group, CMS

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OVERSIGHT AND EVALUATION
OF THE FISCAL YEAR 2003
COMPREHENSIVE ERROR RATE
TESTING PROGRAM**



**November 2003
A-03-03-00014**

Office of Inspector General

<http://oig.hhs.gov>

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the Comprehensive Error Rate Testing (CERT) program primarily to establish the Medicare fee-for-service paid claims error rate for all types of Medicare services other than inpatient acute care hospital services. The CERT program is designed to determine the underlying reasons for claim errors and to develop appropriate action plans to improve compliance with payment, claims processing, and provider billing requirements.

CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a tracking and reporting database system. The CERT contractor is responsible for obtaining information from Medicare contractors and health care providers to determine whether the Medicare contractors have met CMS's goal of paying Medicare claims correctly.

OBJECTIVES

Our objectives were to determine whether (1) the CERT contractor followed established CERT error rate review policies and procedures and (2) the CERT quality assurance program ensured the reliability of the CERT claims review process.

SUMMARY OF FINDINGS

Our review of 105 claims found that the CERT contractor generally followed established CERT error rate review policies and procedures for 99 claims. However, the medical records for six claims were never received, and letters requesting medical records were often sent late. In addition, our review of another 45 claims found that the CERT contractor had not fully implemented the quality assurance program in accordance with established procedures. Our specific findings follow:

- For 73 of the 105 claims sampled, the initial request for medical records was sent to the provider 9 to 20 days later than required.
- Followup requests for missing medical records were sent 1 to 204 days later than required.
- Quality assurance reviews were not performed for 22 of the 45 claims sampled, and the results of those reviews that were performed were not shared with medical review specialists.

RECOMMENDATIONS

We recommend that CMS direct the CERT contractor to:

- send requests for medical records, including followup requests, in accordance with established time schedules and
- complete all required quality assurance reviews and use the results to provide feedback and training to medical reviewers.

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LIST OF ACRONYMS

CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
FY	fiscal year
OIG	Office of Inspector General

INTRODUCTION

BACKGROUND

Medicare Program

Medicare, established by title XVIII of the Social Security Act, as amended, is a broad health insurance program that covers persons 65 years of age and older, along with those under 65 who are disabled or who have end stage renal disease. CMS administers the program.

Medicare Error Rate

The Office of Inspector General (OIG) initiated annual Medicare fee-for-service paid claims error rate reviews in fiscal year (FY) 1996 because a preliminary assessment identified Medicare benefit payments as a high-risk area. That assessment was based on the complexity of CMS's policies and reimbursement systems, the decentralized structure of the Medicare program, and reported instances of fraud and abuse.

The purpose of OIG's error rate reviews was to determine whether Medicare benefit payments were made in accordance with the provisions of title XVIII and, specifically, 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 the beneficiaries' medical records.

In FY 2000, in response to an OIG recommendation to develop its own error rate process, CMS initiated two programs. The CERT program, which is the subject of this report, was established to produce an error rate for all provider claims other than inpatient acute care hospital claims. The Hospital Payment Monitoring Program (HPMP), the subject of another OIG report (A-03-03-00015), was established to produce an error rate for inpatient acute care hospitals. When aggregated, these error rates produce an overall Medicare fee-for-service paid claims error rate similar to the one developed by OIG. Beginning in FY 2003, CMS assumed responsibility for error rate development.

Comprehensive Error Rate Testing Program

CMS developed CERT primarily to establish the Medicare paid claims error rate for all types of claims other than inpatient acute care hospital claims. The CERT program is designed to determine the underlying reasons for claim errors and to develop appropriate action plans to

improve compliance with payment, claims processing, and provider billing requirements. CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a tracking and reporting database system.

The CERT contractor performs medical reviews of approximately 120,000 claims each year. These reviews cover claims processed by Medicare carriers, fiscal intermediaries, and durable medical equipment regional contractors. Each month, the CERT contractor randomly selects about 200 claims from each Medicare contractor. This process is designed to pull a blind, electronic sample from all claims submitted and accepted for processing each day. For the sampled items, the CERT contractor requests medical records from providers and Medicare contractors. If the provider fails to respond to the initial request within 19 days, the CERT contractor sends followup requests.

In reviewing the claims and medical records, the CERT contractor follows Medicare regulations, national coverage decisions, coverage provisions in interpretive manuals, and Medicare contractor local medical review policies and articles. In the absence of written policies or articles, the CERT medical review specialists apply their clinical expertise.

The CERT contractor's quality assurance program covers claims for which the medical review specialists agree with the Medicare contractor's medical determination. Quality assurance reviews are intended to ensure the accuracy and consistency of medical review decisions and the documentation of case results consistent with CERT procedures.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether:

- the CERT contractor followed established CERT error rate review policies and procedures and
- the CERT quality assurance program ensured the reliability of the CERT claims review process.

Scope and Methodology

We did not assess the complete internal control structures at the CERT contractor, nor did we independently evaluate the medical review decisions. Also, the scope of this review did not include testing the statistical reliability of the Medicare paid claims error rate calculated through the CERT process.

To accomplish our objectives, we:

- reviewed the policies and procedures related to the CERT review process,

- interviewed CERT personnel and performed limited testing of internal controls, and
- reviewed and analyzed supporting decisionmaking documentation for claims we selected for detailed review.

Our review of controls was limited to observing selected aspects of the overall CERT medical review and reporting process, including information maintained in the CERT database and the medical records used to support review decisions. We reviewed system reports and control logs and physically observed procedures and practices.

To test and evaluate the reliability of the primary review process, we selected a random sample of 105 claims reviewed by the CERT medical review specialists. These claims were submitted by providers from July 1 through December 31, 2002. We reviewed compliance with established policies and procedures, including the timeliness of requests for medical records and the adequacy of documentation supporting medical review decisions.

To review compliance with the CERT quality assurance program, we also sampled 45 claims that were subject to quality assurance reviews from January 1 through June 30, 2003. As in the primary review process sample, we reviewed the adequacy of documentation supporting medical review decisions.

We performed our review from March to October 2003 at the CERT contractor in Richmond, VA, and at CMS headquarters in Baltimore, MD. We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Our review of 105 claims showed that for 99 claims, the CERT contractor generally followed established CERT error rate review policies and procedures. However, the medical records for six claims were never received, and letters requesting medical records were often sent late. In addition, our review of another 45 claims found that the CERT contractor had not fully implemented the established quality assurance program.

REQUESTS FOR MEDICAL RECORDS

The CERT contractor did not always follow established procedures for requesting medical records. Once a claim entered the CERT sample database, the contractor was to send the initial request for medical records to the provider within 5 business days. If the CERT contractor did not receive the records within 19 days, it was required to take followup actions, as needed to obtain the records, within specified intervals from the date of the initial request:

- Send the first followup letter within 20 days.
- Telephone the provider within 25 days.
- Send the second followup letter within 35 days.

- Send a certified letter stating that the provider was subject to possible sanctions by OIG within 45 days.

The CERT Operations Center tracking system identified those claims for which a followup request was required to be sent within the established periods.

As shown in the following table, the CERT contractor’s initial and followup requests for medical records were often late. For 73 of the 105 claims sampled, the initial requests were 9 to 20 days late. Followup requests were 1 to 204 days late.

	Initial Letter Day 5	Followup Actions			
		1st Day 20	Phone Day 25	2nd Day 35	3rd Day 45
Minimum days late	9	1	1	2	34
Maximum days late	20	24	25	36	204
Average days late	13	8	14	13	103
Number of claims late	73	34	24	17	6
<hr/>					
Number of claims received as a result of the initial or followup action	71	8	9	11	0

CERT contractor officials explained that initial and followup letters were not sent timely because of workload delays and human error. Further, they said that the phone calls required within 25 days might have been made earlier but not recorded as completed until a customer service representative spoke directly with the provider. At the time of our review, the CERT contractor was developing software to automatically track all phone calls made by its customer service representatives in order to have a complete record.

QUALITY ASSURANCE PROCESS

The CERT quality assurance process provided for medical reviews of approximately 150 claims each quarter for which the medical determinations by the CERT contractor and the Medicare contractor agreed. For 22 of 45 claims that were subject to the quality assurance process, the CERT contractor did not perform the required medical reviews. While such reviews were performed on the remaining 23 claims, the results and analysis from those reviews were not shared with the medical review specialists. This type of feedback is necessary to ensure consistency in future medical review decisions.

RECOMMENDATIONS

We recommend that CMS direct the CERT contractor to:

- send requests for medical records, including followup requests, in accordance with established time schedules and
- complete all required quality assurance reviews and use the results to provide feedback and training to medical reviewers.

CMS COMMENTS

To expedite the processing of this report, we obtained oral comments from CMS officials. These officials agreed with our findings and recommendations. Their comments have been incorporated in this report where appropriate.

ACKNOWLEDGEMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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