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

FROM: *David M. Long*
for Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Oversight and Evaluation of the Fiscal Year 2004 Hospital Payment Monitoring Program (A-03-04-00008)

Attached is a copy of our final report on the results of our oversight and evaluation of the fiscal year (FY) 2004 Hospital Payment Monitoring Program (HPMP). The Centers for Medicare & Medicaid Services (CMS) developed HPMP primarily to establish the Medicare fee-for-service paid claims error rate for inpatient acute care hospital services. Under contracts with CMS, several companies are responsible for operating HPMP. The CMS includes the HPMP results in its annual report on erroneous Medicare payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

Our objectives were to determine whether (1) HPMP controls were adequate to ensure that contractors followed established procedures for admission-necessity and diagnosis-related group (DRG) validation screenings and for quality control reviews and (2) HPMP contractors accurately calculated and reported the net error amounts for claims with DRG coding changes made by the quality improvement organizations.

The HPMP contractors generally had appropriate controls to ensure that admission-necessity and DRG validation screenings and quality control reviews were performed in accordance with established procedures. However, in two instances, HPMP procedures were either not timely or not adequately documented. The HPMP contractors took corrective action on those problems and completed the claim reviews and the Medicare error rate calculations by the required due date.

As to our second objective, the methodology for calculating net error amounts was not accurate for some of the claims we reviewed. Our calculation of the net error amounts for DRG coding changes was based on CMS's standard pricing information (known as PRICER software). An HPMP contractor, on the other hand, used an alternate methodology, which was not always accurate. Nevertheless, our sample projection showed that the net error amount differences were not significant in relation to the HPMP projection of erroneous Medicare payments for FY 2004.

We recommend that CMS direct the HPMP contractors to use the most current PRICER software to calculate error amounts for DRGs revised by the quality improvement organizations.

In informal comments on a draft of this report, CMS officials agreed with the audit results and the recommendation.

If you have any questions, please contact me, or your staff may call David M. Long, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at david.long@oig.hhs.gov. Please refer to report number A-03-04-00008 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OVERSIGHT AND EVALUATION
OF THE FISCAL YEAR 2004
HOSPITAL PAYMENT
MONITORING PROGRAM**



**NOVEMBER 2004
A-03-04-0008**

Office of Inspector General

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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 Hospital Payment Monitoring Program (HPMP) primarily to establish the Medicare fee-for-service paid claims error rate for inpatient acute care hospital services. Under contracts with CMS, several companies are responsible for operating HPMP. The CMS includes the HPMP results in its annual report on erroneous Medicare payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

OBJECTIVES

Our objectives were to determine whether (1) HPMP controls were adequate to ensure that contractors followed established procedures for admission-necessity and diagnosis-related group (DRG) validation screenings and for quality control reviews and (2) HPMP contractors accurately calculated and reported the net error amounts for claims with DRG coding changes made by the quality improvement organizations (QIOs).

SUMMARY OF RESULTS

HPMP Controls. During the fiscal year (FY) 2004 error rate process, HPMP contractors generally had appropriate controls to ensure that admission-necessity and DRG validation screenings and quality control reviews were performed in accordance with established procedures. However, in two instances, procedures were either not timely or not adequately documented. The contractors took corrective action on those problems and completed the claim reviews and the Medicare error rate calculations by the required due date.

Net Error Calculations. The methodology for calculating net error amounts was not accurate for some of the claims we reviewed. Our calculation of the net error amounts for DRG coding changes was based on CMS's standard pricing information (known as PRICER software). An HPMP contractor, on the other hand, used an alternate methodology, which was not always accurate. Nevertheless, our sample projection showed that the net error amount differences were not significant in relation to the HPMP projection of erroneous Medicare payments for FY 2004.

RECOMMENDATION

We recommend that CMS direct the HPMP contractors to use the most current PRICER software to calculate error amounts for DRGs revised by the QIOs.

CMS COMMENTS

In informal comments on a draft of this report, CMS officials agreed with the audit results and the recommendation.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Program.....	1
Medicare Error Rate.....	1
Hospital Payment Monitoring Program.....	1
OBJECTIVES, SCOPE, AND METHODOLOGY	2
Objectives	2
Scope.....	3
Methodology.....	3
RESULTS OF REVIEW	4
HPMP CONTROLS	4
NET ERROR CALCULATIONS	4
RECOMMENDATION	5
CMS COMMENTS	5

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. The CMS administers the program.

Medicare Error Rate

In FY 2000, CMS initiated two programs to develop a fee-for-service Medicare error rate. The HPMP, which is the subject of this report, was established to produce an error rate for inpatient acute care hospital claims.¹ The Comprehensive Error Rate Testing program, the subject of another Office of Inspector General (OIG) report (A-03-04-00007, issued November 9, 2004), was established to produce an error rate for all other provider claims. When aggregated, those error rates produce an overall Medicare fee-for-service paid claims error rate similar to the one previously developed by OIG.

Using the results of its Medicare error rate programs, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims in accordance with the Improper Payments Information Act of 2002.

Hospital Payment Monitoring Program

The goals of HPMP are to establish the Medicare paid claims error rate for inpatient acute care hospitals on a State and national level and to provide statistical and administrative data for use in reducing improper admissions and payments. As described below, responsibilities for HPMP are assigned to several entities.

Clinical Data Abstraction Centers. Under CMS contracts, DynKePRO and AdvanceMed serve as Clinical Data Abstraction Centers (CDACs). Each month, CMS provides a sample of several thousand claims to the CDACs to screen medical charts for inpatient acute care payments. The CDACs obtain related medical records from health care providers and perform admission-necessity and DRG validation screenings for Medicare discharges.

- During the admission-necessity screening, nonphysician medical personnel use standardized, commercially available, clinical decision software to screen the first 24 hours of the medical records. This software contains measurable clinical indicators to assess the appropriateness of hospitalization.
- During the DRG validation screening, coding specialists review diagnostic and procedural information and the discharge status shown in the medical records to

¹Excludes critical access, psychiatric, and rehabilitation inpatient hospital claims.

determine the appropriate DRG. For Maryland claims, nonphysician reviewers perform length-of-stay screenings because those claims are not paid based on DRGs.

Quality Improvement Organizations. Claims that fail one or both of the CDAC screenings are forwarded to QIOs for a complete claim review and final determination. For each claim, the QIO evaluates the medical necessity, quality, and appropriateness of services provided using professionally developed criteria on providing care, diagnosis, and treatment. If the QIO identifies an error in medical necessity or DRG assignment, the QIO advises the fiscal intermediary to make a financial adjustment.

Quality Control Reviews. CMS tries to ensure the accuracy of the screening and medical review processes through several ongoing HPMP quality control reviews.

- Each CDAC selects a monthly sample of 10 percent of the claims for which the CDAC screening found no errors and forwards those claims to the QIO for review.
- Each CDAC selects a monthly sample of 30 already-reviewed claims for an intra-CDAC quality control review. The CDAC performs a second admission-necessity and DRG validation screening, compares the results of the two reviews, finalizes the review decision if the results differ, and reports the results to CMS.
- Each CDAC selects a quarterly sample of 30 claims previously reviewed by the other CDAC for an inter-CDAC quality control review. If the results differ, CMS coordinates a final determination with the CDACs.

Other HPMP Contractors. The CMS contracts with two additional organizations to operate HPMP and to provide analytical support and management. The Texas Medical Foundation maintains the Payment Error Surveillance and Tracking System and develops and makes available to QIOs best practices for identifying and reducing errors. The Iowa Foundation for Medical Care maintains, collates, and analyzes information provided by the CDACs and the QIOs. The CMS uses that information to calculate the HPMP paid claims error rate.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether:

- HPMP controls were adequate to ensure that contractors followed established procedures for admission-necessity and DRG validation screenings and for quality control reviews and
- HPMP contractors accurately calculated and reported the net error amounts for claims with DRG coding changes made by the QIOs.

Scope

For the FY 2004 HPMP error rate review, CMS selected for review by the two CDACs 38,448 of the 11,429,972 inpatient claims with discharge dates from July 2002 to June 2003. We selected two statistical acceptance samples from those claims to determine if:

- CDAC processing controls could be relied on to ensure the accuracy of the inpatient acute care hospital portion of the FY 2004 Medicare error rate (46 claims) and
- QIOs followed the established claim review process for claims forwarded by the CDACs (45 claims).

From January through December 2003, the two CDACs reviewed 720 intra-CDAC claims and 240 inter-CDAC claims as part of the internal quality control process. We selected two statistical acceptance samples (45 intra-CDAC and 42 inter-CDAC claims) to determine if those processes ensured the reliability of the CDAC claim review process.

For the 38,448 claims reviewed by the CDACs, the QIOs identified 1,465 claims for which the original DRGs were not correct and needed to be repriced. (Another 34,720 claims were determined to be correct, and the remaining 2,263 claims were found to have other types of errors.) We selected a simple random sample of 200 claims from the 1,465 claims to determine if the net error amounts (original payments less payments for the revised DRGs) included in the HPMP database were correct.

We did not assess all internal controls at CMS, the HPMP contractors, or the QIOs. Also, we did not independently evaluate the CDAC claim screening or QIO claim review decisions.

Methodology

To accomplish our objectives, we:

- reviewed CMS policies and procedures related to the HPMP review process and interviewed CMS and contractor personnel;
- performed limited control testing and obtained and analyzed documentation related to CMS's oversight of HPMP and HPMP contractors;
- analyzed the CDAC and QIO decisionmaking process and supporting documentation for claims selected for the screening, claim review, and quality control review samples; and
- performed limited testing of the HPMP sample database, including tests to ensure that the database was complete and that the net error amounts were correctly calculated.

We performed our review from December 2003 to October 2004 at CMS headquarters in Baltimore, MD; DynKePRO in York, PA; and AdvanceMed in Columbia, MD.

We conducted our audit in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

HPMP CONTROLS

The HPMP contractors generally had appropriate controls to ensure that admission-necessity and DRG validation screenings were performed in accordance with established procedures and that the results of those screenings were adequately maintained, updated, and reported. Also, quality control reviews were generally operating effectively to ensure the reliability of the screening process and the consistency of the screening decisions. However, in two instances, HPMP procedures were either not timely or not adequately documented. The HPMP contractors took corrective action on those problems and completed the claim reviews and the Medicare error rate calculations by the required due date.

- **Request for Medical Records.** During a limited period, a substitute CDAC employee did not send the required followup letters for 2 of the 46 claim reviews. Despite the lack of followup, the providers submitted the medical records within 30 days of the original request, and the CDAC was able to screen those claims in a timely manner.
- **Quality Control Procedures.** For 1 of the 42 inter-CDAC quality control claims, CMS and the HPMP contractors did not resolve an admission-necessity screening decision disputed by the CDACs. Consistent with HPMP review procedures, the CDACs and CMS discussed the differing decisions, but the supporting documentation stated that the CDACs “agree to disagree.” The documentation did not disclose that CMS’s experts agreed with the necessity of the hospital admission until we questioned the “nondecision.” The CMS’s clarification was necessary to help ensure consistency in future screening decisions. This claim passed admission necessity and did not affect the Medicare error rate.

NET ERROR CALCULATIONS

For claims with DRGs revised by the QIOs, the methodology for calculating the error amounts was not accurate for some of the 200 claims we reviewed. Using the standard CMS PRICER software, we validated the net payment for the original DRG recorded in the HPMP database and determined whether there were any deductible or coinsurance amounts for those claims. We calculated the net payment amount for the revised DRG using the same PRICER software and found that for 152 claims, our calculation of the net error amounts differed from the HPMP calculation.

The PRICER software, which the fiscal intermediaries use for pricing information, is an automated program available on the CMS Web site. It calculates the Medicare payment using information supplied on the provider claim. The program uses current national and hospital-specific factors to calculate the total payment amount before any deductible or coinsurance

amounts are applied. The deductible and coinsurance amounts must be subtracted from the PRICER payment amount to determine the net amount paid to the provider.

The Texas Medical Foundation did not use the PRICER software but instead calculated the error amount as the original net payment less the “estimated” payment for the new DRG. Foundation officials stated that they used this alternate methodology, which was developed 4 to 5 years ago, to calculate the estimated payment for the new DRG because they did not have access to the PRICER software. The alternate methodology did not accurately calculate the revised payment amount because it did not consider the impact of outlier, deductible, and coinsurance amounts and because it did not recognize that factors used by the PRICER software could change quarterly.

The use of the alternate methodology did not have a significant effect on the results of reviewing the 38,448 claims in the HPMP sample. Our projection of the difference based on our sample of 200 claims (of the 1,465 claims with DRGs revised by the QIOs) is not significant in relation to CMS’s FY 2004 projection of billions of dollars in erroneous payments—based on a sample of 38,448 claims from a universe of 11,429,972 claims. Staff from CMS agreed with our conclusion on the effect.

RECOMMENDATION

We recommend that CMS direct the HPMP contractors to use the most current PRICER software to calculate error amounts for DRGs revised by the QIOs.

CMS COMMENTS

To expedite the processing of this report, we obtained informal comments from CMS officials. The officials agreed with the audit results and the recommendation. They stated that they believed they could incorporate the PRICER software into the revised payment calculations.