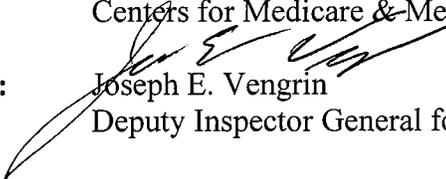




NOV 10 2005

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

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Oversight and Evaluation of the Fiscal Year 2005 Hospital Payment Monitoring Program (A-03-05-00007)

The attached final report provides the results of our oversight and evaluation of the fiscal year (FY) 2005 Hospital Payment Monitoring Program (HPMP). The Centers for Medicare & Medicaid Services (CMS) developed the HPMP primarily to establish the Medicare fee-for-service paid claims error rate for inpatient short term acute-care and long term care hospital services. CMS includes the HPMP results in its annual report on erroneous payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

Our objectives were to determine whether CMS ensured that its HPMP contractors (1) had appropriate controls to ensure that sampling procedures, admission-necessity and diagnosis-related group (DRG) validation screenings, and quality control reviews followed established procedures and operated effectively; (2) implemented our recommendation to accurately calculate error amounts for claims with DRGs revised by the Quality Improvement Organizations (QIOs); and (3) calculated and reported all error amounts for errors that the QIOs identified during their reviews of 10 percent of the claims that had passed the Clinical Data Abstraction Centers' (CDACs') review process.

A summary of our results follows:

- CMS generally ensured that its HPMP contractors had appropriate controls to ensure that admission-necessity and DRG validation screenings and quality control reviews followed established procedures and operated effectively. However, CMS and its HPMP contractors incorrectly sampled long term care hospital claims and did not complete the follow-up process for obtaining medical records. CMS could not calculate the impact of these issues on the error rate.
- CMS did not ensure that an HPMP contractor implemented our recommendation to use the CMS PRICER software to accurately calculate error amounts for claims with DRGs revised by the QIOs.
- Prior to the conclusion of our fieldwork, CMS did not calculate and report any error amounts for errors identified and reported by the QIOs during their quality control reviews of 10 percent of the claims that had passed the CDAC review process.

We recommend that CMS direct its HPMP contractors to (1) establish appropriate controls to select a long term care hospital sample in accordance with established criteria, (2) use the CMS PRICER software to reprice error amounts for claims with DRGs revised by the QIOs, and (3) include in future error rate calculations the error amounts identified by the QIOs during their quality control reviews.

In its comments on our draft report, CMS concurred with our first and third recommendations. With respect to our second recommendation, CMS stated that it would investigate the cost benefits of the various ways of incorporating PRICER into the HPMP process and would report its determination in February 2006. We continue to believe that the HPMP contractor should use CMS's PRICER software for repricing claims with DRG changes.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact 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-03-05-00007 in all correspondence.

Attachment

cc:

Kimberly Brandt
Director, Program Integrity Group

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OVERSIGHT AND EVALUATION
OF THE FISCAL YEAR 2005
HOSPITAL PAYMENT
MONITORING PROGRAM**



**Daniel R. Levinson
Inspector General**

**NOVEMBER 2005
A-03-05-00007**

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 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 the HPMP. Clinical Data Abstraction Centers (CDACs) conduct admission-necessity screenings and diagnosis-related group (DRG) validations. The CDACs forward claims that fail one or both of the CDAC screenings to Quality Improvement Organizations (QIOs) for a complete claim review and final determination. 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 CMS ensured that its HPMP contractors:

- had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively;
- implemented our recommendation to accurately calculate error amounts for claims with DRGs revised by the QIOs; and
- calculated and reported all error amounts for errors that the QIOs identified during their reviews of 10 percent of the claims that had passed the CDAC review process.

SUMMARY OF FINDINGS

For the fiscal year 2005 HPMP, CMS generally ensured that its HPMP contractors had appropriate controls to ensure that admission-necessity and DRG validation screenings and quality control reviews followed established procedures and operated effectively. However, CMS and its HPMP contractors incorrectly sampled long term care hospital claims and did not complete the follow-up process for obtaining medical records. CMS could not calculate the impact of these issues on the error rate.

CMS did not ensure that an HPMP contractor implemented our recommendation to use the CMS PRICER software to accurately calculate error amounts for claims with DRGs revised by the QIOs. Also, prior to the conclusion of our fieldwork, CMS did not calculate and report any error amounts for errors identified and reported by the QIOs during their quality control reviews of 10 percent of the claims that had passed the CDAC review process.

RECOMMENDATIONS

We recommend that CMS direct its HPMP contractors to:

- establish appropriate controls to select a long term care hospital sample in accordance with established criteria,
- use the CMS PRICER software to reprice error amounts for claims with DRGs revised by the QIOs, and
- include in future error rate calculations the error amounts identified by the QIOs during their quality control reviews.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S COMMENTS

In its comments on our draft report, CMS concurred with our first and third recommendations. With respect to our second recommendation, CMS stated that it would investigate the cost benefits of the various ways of incorporating PRICER into the HPMP process and would report its determination in February 2006.

CMS's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We continue to believe that the HPMP contractor should use CMS's PRICER software for repricing claims with DRG changes.

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INTRODUCTION

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established Medicare as 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 Centers for Medicare & Medicaid Services (CMS) administers the Medicare program through a number of contractors.

Beneficiaries who use covered Medicare Part A services are subject to deductible and coinsurance requirements. For the first 60 days in a benefit period, a beneficiary is responsible for a deductible amount for inpatient hospital services furnished. After the 60th day in a benefit period, a beneficiary is responsible for a coinsurance amount for each day spent in the hospital. The difference between the amount due to the hospital and the amount paid by the beneficiary is the Medicare payment to the hospital.

Medicare Error Rate

In fiscal year (FY) 2000, CMS initiated two programs to develop a fee-for-service Medicare error rate. The Hospital Payment Monitoring Program (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 report (A-03-05-00006), 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. An error is the difference between the amount that Medicare paid to a hospital and the amount that it should have paid.

Using the results of the Medicare error rate programs, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims pursuant to the Improper Payments Information Act of 2002 (Public Law 107-300).

Hospital Payment Monitoring Program

The HPMP establishes the Medicare paid claims error rate for inpatient acute-care hospitals on a State and national level and provides statistical and administrative data for use in reducing improper admissions and payments. As described below, CMS assigns responsibilities for the HPMP to several contractors.

Clinical Data Abstraction Centers. Under CMS contracts for the FY 2005 error rate review, DynKePRO and AdvanceMed served as Clinical Data Abstraction Centers (CDACs). Each month, CMS provides a sample of several thousand claims to the CDACs. The CDACs

¹As in prior years, the FY 2005 HPMP error rate calculation included short term inpatient acute-care claims and excluded critical access, psychiatric, and rehabilitation hospital claims. For FY 2005, the HPMP added long term care hospital claims and zero-dollar payment claims to the calculation.

obtain related medical records from health care providers and perform admission-necessity and diagnosis-related group (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 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. The CDACs forward to 1 of the 53 Quality Improvement Organizations (QIOs) those claims that fail 1 or both of the CDAC screenings 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. According to the “Payment Error Surveillance Tracking System Manual” (the HPMP Manual), the QIO must advise the fiscal intermediary to make a financial adjustment if the QIO identifies a medically unnecessary admission or an error in DRG assignment.

Quality Control Reviews. CMS tries to ensure the accuracy of the screening and medical review process 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.

In November 2004, AdvanceMed transferred its functions to DynKePRO, and in April 2005, DynKePRO changed its name to the Computer Science Corporation (CSC). Because CSC is now the only CDAC, it discontinued the inter-CDAC quality control reviews and increased the monthly intra-CDAC samples from 30 to 60 claims.

Other Hospital Payment Monitoring Program Contractors. CMS contracts with two additional organizations to operate the 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, the data management contractor, maintains, collates, and analyzes information provided by the CDACs and the QIOs. CMS uses that information to calculate the HPMP paid claims error rate.

Other Medicare Contractors

CMS also contracts with fiscal intermediaries to process and pay inpatient hospital claims. The intermediaries determine the total payments for claims using a program called PRICER, which CMS updates as needed during the FY. The intermediaries use the updated version of the software when they reprice claim payments. The intermediaries are required to make claim payment adjustments when the QIOs advise them of payment errors.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether CMS ensured that its HPMP contractors:

- had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively;
- implemented our recommendation to accurately calculate error amounts for claims with DRGs revised by the QIOs; and
- calculated and reported all error amounts for errors that the QIOs identified during their reviews of 10 percent of the claims that had passed the CDAC review process.

Scope

For the FY 2005 HPMP error rate calculation, CMS selected 38,448 of the 11,700,277 short term acute-care inpatient claims with discharge dates between July 2003 and June 2004. The two CDACs reviewed 36,159 of the 38,448 claims and submitted 19,343 of them to the QIOs for case reviews. The QIOs also reviewed 2,191 claims that the CDACs did not review because the QIOs received the medical records directly from providers. Neither the CDACs nor the QIOs received the medical records for the remaining 98 claims. We judgmentally selected 30 (15 from each CDAC) of the 38,448 claims to test whether the CDACs followed established HPMP policies and procedures. In addition, we selected an acceptance discovery sample of 45 of the 19,343 claims reviewed by the QIOs to test whether adequate QIO documentation supported the results reported in the HPMP database.

Beginning in FY 2005, CMS and its HPMP contractors selected two additional samples for review: 1,383 of the 147,674 long term care inpatient claims paid between February 2004 and January 2005 and 1,140 of the 303,838 inpatient claims for which no payment was made (zero-

dollar payment claims) between January and December 2004. The QIOs reviewed the 1,383 long term care inpatient claims, and the CDACs reviewed the 1,140 zero-dollar payment claims.

In calendar year 2004, the two CDACs reviewed 690 intra-CDAC claims and 230 inter-CDAC claims as part of the CDAC internal quality control process. We judgmentally selected 30 intra-CDAC (15 from each CDAC) and 15 inter-CDAC quality control claims to determine whether the quality control process ensured the reliability of the CDAC claim review process.

We limited our review of internal controls to obtaining an understanding of CMS's and the HPMP contractors' policies and procedures used to obtain medical records, review claims, and calculate the HPMP error rate, including selection of the long term care hospital payment error sample and CDAC follow-up letters. However, we did not independently evaluate the CDAC claim screenings or the QIO medical review decisions.

We performed the review from July to August 2005 at CMS headquarters in Baltimore, MD, and at the CSC CDAC office in York, PA.

Methodology

To accomplish our objectives, we:

- identified changes in the HPMP process that CMS implemented after the FY 2004 review;
- performed limited testing and analysis of the CDAC case screenings and quality control reviews and the QIO case reviews;
- reviewed the actions taken by CMS to address the recommendation in our prior-year report "Oversight and Evaluation of the Fiscal Year 2004 Hospital Payment Monitoring Program" (A-03-04-00008, issued November 15, 2004);
- performed limited testing and analysis of the FY 2005 HPMP short term, long term, and zero-dollar payment acute-care hospital error rate databases for accuracy and completeness; and
- used the PRICER software to calculate error amounts for claims with DRG changes.

We performed the review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

CMS generally ensured that its HPMP contractors had appropriate controls to ensure that admission-necessity and DRG validation screenings and quality control reviews followed established procedures and operated effectively. However, CMS and its HPMP contractors incorrectly sampled long term care hospital claims and did not complete the follow-up process

for obtaining medical records. CMS could not calculate the impact of these issues on the error rate.

CMS did not ensure that an HPMP contractor implemented our recommendation to use the CMS PRICER software to accurately calculate error amounts for claims with DRGs revised by the QIOs. Also, prior to the conclusion of our fieldwork, CMS did not calculate and report any error amounts for errors identified and reported by the QIOs during their quality control reviews of 10 percent of the claims that had passed the CDAC review process.

HOSPITAL PAYMENT MONITORING PROGRAM CONTROLS

Although CMS and its HPMP contractors generally had appropriate controls, we identified two areas of concern.

Long Term Care Hospital Sample

CMS and the HPMP contractors did not fully comply with the FY 2005 HPMP sampling plan. That plan required selecting a sample of 1,392 long term care hospital claims with discharge dates between July 2003 and June 2004 and payment amounts greater than zero. Instead, CMS selected a sample of only 1,383 claims (9 fewer than required) with claim processing dates from February 2004 through January 2005. The claims selected had discharge dates between October 2003 and January 2005 and included three zero-dollar payment claims. CMS management stated that these deficiencies occurred because of programming errors.

Follow-Up Letters

AdvanceMed did not send all required follow-up letters requesting medical records. The HPMP Manual requires the CDACs to send follow-up letters when they do not receive requested medical records within 15 days of the date requested. After 30 days, the CDACs must refer each claim to the appropriate QIO for case review.

For the 30 claims we selected (15 from each CDAC), DynKePRO sent all required follow-up letters. However, AdvanceMed did not send letters for 7 of the 10 selected claims that required followup. AdvanceMed received the medical records for six claims within the required 30 days but prematurely referred one of the six claims to the QIO. AdvanceMed received the medical records for the remaining claim after 30 days and referred the claim to the QIO for case review. Although it did not send the follow-up letters, AdvanceMed or one of the QIOs reviewed all seven claims, and the results of those reviews were included in the HPMP error rate.

We are not making any recommendation on this issue because AdvanceMed is no longer an HPMP contractor.

STATUS OF PRIOR-YEAR RECOMMENDATION

In our audit on the FY 2004 HPMP (A-03-04-00008), we reported that an HPMP contractor did not use CMS's PRICER software to calculate error amounts for claims with revised DRG codes.

Because the contractor's calculation method did not recognize the impact of outliers, deductibles, or coinsurance on the payment amounts, the contractor generated inaccurate error amounts. When claims had no outliers, deductibles, or coinsurance, the contractor calculated accurate error amounts. We recommended that CMS direct the HPMP contractors to use the appropriate PRICER software to calculate error amounts for DRGs revised by the QIOs.

CMS agreed with our recommendation but did not implement it. During our current review, a CMS official stated that “. . . in light of funding, resources, and complications from using a COBOL program. . . . we cannot implement this new system [PRICER] any time soon. And if we could, we do not have the necessary funds to support this effort.”

Our current review showed that error amounts computed using the contractor's method continued to differ from error amounts computed using the PRICER software. Appendix A compares the original payment amounts with the revised payment amounts using the contractor and PRICER methodologies for the 38,448 short term acute-care inpatient claims in the FY 2005 HPMP sample. The net errors calculated by the contractor and the PRICER software differed by \$216,293.

The PRICER software is available in a personal computer version. By devoting 20 staff days, we were able to reprice all 1,396 claims with DRG changes using the final version of PRICER for each applicable FY.

ERRORS FROM THE 10-PERCENT QUALITY CONTROL SAMPLE

According to a CMS official, CMS initially directed its HPMP contractors not to calculate error amounts for errors that the QIOs identified during their reviews of 10 percent of the claims that passed the CDAC screening process. The CDACs submitted those claims to the QIOs to evaluate the effectiveness of their screening process. The QIOs identified errors on 163 of the 1,981 quality control claims that the CDACs submitted. Those errors included admission necessity, DRG coding, billing, and Maryland length-of-stay errors. CMS did not include the errors in its error rate calculation or in the estimate of improper Medicare payments required by the Improper Payments Information Act.

We informed CMS management of this omission on October 21, 2005. On October 26, 2005, they acknowledged that the results of the 10-percent quality control sample should be included in the error rate calculation. Accordingly, CMS updated the FY 2005 error rate calculation. CMS officials further stated that they would appropriately report the revised estimate of improper payments.

RECOMMENDATIONS

We recommend that CMS direct its HPMP contractors to:

- establish appropriate controls to select a long term care hospital sample in accordance with established criteria,

- use the CMS PRICER software to reprice error amounts for claims with DRGs revised by the QIOs, and
- include in future error rate calculations the error amounts identified by the QIOs during their quality control reviews.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S COMMENTS

CMS concurred with our first and third recommendations and noted actions that it had already taken to prevent recurrence of the problems cited:

- CMS corrected the programming errors that caused the FY 2005 long term care hospital sample to be out of compliance with the sampling plan and implemented procedures to identify and prevent such programming errors in the future.
- CMS included error amounts found in the 10-percent quality control sample in its FY 2005 estimate and said that it would continue to include those error amounts. CMS also said that it would evaluate whether it would be more statistically valid to extrapolate these quality control findings to the entire population of records.

As to our second recommendation, CMS said that budget limitations required careful consideration of expensive changes to the error rate measurement programs. CMS stated that it would investigate the cost benefits of the various ways of incorporating PRICER into the HPMP process and would report its determination in February 2006.

CMS's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We continue to believe that the HPMP contractor should use CMS's PRICER software for repricing claims with DRG changes. As noted previously, we repriced all 1,396 claims with DRG changes in only 20 staff days.

OTHER MATTERS

FISCAL INTERMEDIARY PAYMENT ADJUSTMENTS

The QIOs notify fiscal intermediaries when their case reviews show that claim payment adjustments are necessary. The intermediaries are then required to make those adjustments. For the 30 claims we reviewed, the intermediaries did not make the necessary adjustments on 3 claims totaling \$5,911. The failure to make the adjustments did not affect the accuracy of the HPMP error rate. We plan to perform additional work in this area.

POTENTIALLY DUPLICATE CLAIM PAYMENTS

CMS advised us that its recovery audit contractors had identified potentially duplicate claim payments during their review process.² CMS reviewed a small number of those payments and determined that most were adjustments, not duplicates. A few of the payments for beneficiary readmissions were incorrectly paid. CMS stated that it would include a duplicate payment control in the HPMP process for future reviews. We plan to perform additional work in this area.

²Recovery audit contractors review Medicare claims to identify improper Medicare payments to health care providers.

APPENDIXES

COMPARISON OF PAYMENT AMOUNTS AND ERRORS

PRICER Error Category	Number of Claims	Payment Amount			Difference
		Original	Contractor	PRICER	
Admission necessity	1,640	\$6,932,718.14	\$0.00	\$0.00	\$0.00
Admission necessity and DRG change	197	899,703.30	0.00	0.00	0.00
Technical denial (no medical records)	98	682,938.29	0.00	0.00	0.00
DRG change - overpayment*	744	5,055,760.83	3,385,581.82	3,298,985.21	(86,596.61)
DRG change - underpayment*	646	2,885,604.97	4,340,088.77	4,648,331.51	308,242.74
DRG change - overpayment - outlier*	4	147,069.76	158,612.57	138,736.20	(19,876.37)
DRG change - underpayment - outlier*	2	26,643.28	25,200.10	39,723.72	14,523.62
Billing error**	248	1,386,647.52	332,551.42	332,551.42	0.00
Maryland length of stay**	67	538,961.75	450,676.06	450,676.06	0.00
Subtotal (errors)	3,646	\$18,556,047.84	\$8,692,710.75	\$8,909,004.12	\$216,293.37
No error	34,802	269,163,356.61	269,163,356.61	269,163,356.61	0.00
Total	38,448	\$287,719,404.45	\$277,856,067.36	\$278,072,360.73	\$216,293.37
Error Amount Category					
C Overpayment	2,967		\$11,316,377.72	\$11,422,850.70	\$106,472.98
D Underpayment	648		(1,453,040.62)	(1,775,806.98)	(322,766.36)
E Zero-dollar error**	31		0.00	0.00	0.00
Total net errors	3,646		\$9,863,337.09	\$9,647,043.72	(\$216,293.37)
C + D + E					
Total gross errors			\$12,769,418.34	\$13,198,657.68	\$429,239.34
C - D - E					

* A total of 1,396 claims had DRG changes only.

**There were 29 billing errors and 2 Maryland length-of-stay errors that did not result in payment error amounts.



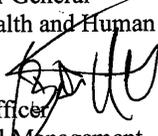
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

DATE: **NOV 08 2005**

TO: Joseph E. Vengrin
Deputy Inspector General, Audit Services
Office of Inspector General
Department of Health and Human Services

FROM: Timothy Hill 
Chief Financial Officer
Office of Financial Management

SUBJECT: CMS Comments on Oversight and Evaluation of the Fiscal Year 2005
Hospital Payment Monitoring Program (A-03-05-000007)

Thank you for the opportunity to comment on the subject report. My staff and I – as well as the leadership and staff in the Office of Clinical Standards and Quality (OCSQ) -- have reviewed the report concluding that CMS generally had appropriate controls to ensure that medical reviews performed by the Hospital Payment Monitoring Program (HPMP) Contractor were conducted in accordance with established procedures. In addition, the report found that the HPMP contractors adequately maintained, updated and reported the results of those reviews. However, there were several recommendations on which CMS wishes to comment:

1. Establish appropriate controls to select a long term care hospital sample in accordance with established criteria,
2. Use the CMS PRICER software to reprice error amounts for claims with Diagnosis Related Group (DRG) codes revised by the Quality Improvement Organizations (QIOs), and
3. Include in future error rate calculations the error amounts identified by the QIOs during their quality control reviews.

CMS comments

In an attempt to mitigate future risks of recurrence of the problems cited, CMS will take the following actions for the FY 2006 and future reports:

- **Long Term Care Hospital Sample:** The long-term acute care sample was sampled by process date rather than by the discharge date as was originally planned. To match the sampling procedure for short-term acute care claims, the

Page 2 – Joseph E. Vengrin

procedure for long-term acute care claims was changed in January 2005 after sampling for the FY 2005 estimate had completed; sampling is now done by discharge date as specified in the sampling criteria. Programming errors resulting in zero dollar payment claims and a sample size of less than the planned 1392 were also corrected in January 2005. Procedures have been put into place to prevent such programming errors. Thus, CMS has fixed the programming errors that caused the 2005 long term care hospital sample to be out of compliance with the sampling plan and has implemented procedures to identify and prevent such programming errors in the future.

- **Using PRICER:** CMS strives to produce the most precise error rate possible. However budget limitations require that we carefully consider expensive changes to the error rate measurement programs. CMS will investigate the cost benefits of the various ways of incorporating PRICER into the HPMP process and will get back to the OIG in February 2006 with our determination.

Incorporating Findings of Quality Control (QC) Reviews into the Error Rate: HPMP has included error amounts found in the 10% quality subsample in their FY 2005 estimate as directed by the OIG request and will continue to do so going forward. In addition, CMS will evaluate whether it would be more statistically valid to extrapolate these QC findings to the entire population of records

If you have questions regarding this information, please contact Jill Nicolaisen (410) 786-5873.

ACKNOWLEDGMENTS

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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