



SEP 29 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Independent Contractor's Review of Fiscal Intermediary and Carrier Claims From the Fiscal Year 2008 Comprehensive Error Rate Testing Program (A-01-09-00511)

The attached final report provides the results of our audit of an independent contractor's review of fiscal intermediary and carrier claims from Medicare's fiscal year (FY) 2008 Comprehensive Error Rate Testing (CERT) program.

To help determine the annual Medicare error rate, the Centers for Medicare & Medicaid Services' (CMS) CERT contractor conducts medical reviews of a sample of paid claims. CMS requires the CERT contractor to make medical review decisions in accordance with CMS's written policies, including those in its "Program Integrity Manual."

To provide assurance that the reported FY 2008 error rates were accurate, CMS contracted with SafeGuard Services, LLC (SGS) to perform a random, independent review of the CERT contractor's payment determinations. SGS's review consisted of a subsample of 852 paid claims from the sample of 57,966 fiscal intermediary and 51,559 carrier claims that the CERT contractor had reviewed in determining the FY 2008 fiscal intermediary and carrier error rates. CMS's contract required SGS to follow guidance in national coverage determinations (NCD), local coverage determinations (LCD), and CMS manuals, and to use the same documentation that the CERT contractor had used to assess whether claim payments met Medicare medical necessity, reasonableness, documentation, coding, and reimbursement requirements.

Our objectives were to determine whether (1) SGS complied with the CMS contract in performing medical reviews of a subsample of claims from the FY 2008 CERT sample and (2) SGS's results provided CMS with assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate.

SGS complied with its CMS contract in performing medical reviews of a subsample of claims from the FY 2008 CERT samples. Using the same documentation that the CERT contractor had used, SGS followed the protocols in the applicable NCDs, LCDs, and CMS manuals to determine

whether the services in the subsample were medically necessary, reasonable, adequately documented, correctly coded, and reimbursed.

SGS's results may not have provided CMS with assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate. Specifically, of the 852 sampled claims, SGS found 194 erroneous claims, whereas the CERT contractor found 87 erroneous claims (including 78 that SGS also found in error). Thus SGS found an additional 116 erroneous claims that the CERT contractor had not initially found erroneous.

SGS's review results differed from those of the CERT contractor because (1) for 46 of the disputed claims, the CERT contractor and SGS differed in their professional judgment as to how they interpreted the medical documentation and how much documentation they required to determine medical necessity; (2) for 42 claims, the CERT contractor used available medical records and beneficiary claim histories rather than the physician's order required by Medicare as evidence of the physician's intent to order the test; and (3) for 28 claims, the CERT contractor subsequently agreed with SGS that the documentation was insufficient to support the medical necessity requirements.

We were unable to quantify the statistical effect of SGS's results on the FY 2008 fiscal intermediary and carrier error rates. However, SGS's results may not strengthen CMS's confidence that these error rates are accurate.

We recommend that CMS:

- clarify documentation policies to reduce the number of differences in professional judgment,
- require the CERT contractor to obtain physician orders to support the medical necessity for diagnostic tests in accordance with Medicare requirements, and
- require the CERT contractor to develop a corrective action plan to reduce its number of incorrect determinations.

In comments on our draft report, CMS concurred with our findings and recommendations and outlined the steps it has taken to begin implementing our recommendations.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, the final report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at Joe.Green@oig.hhs.gov. Please refer to report number A-01-09-00511 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INDEPENDENT CONTRACTOR'S
REVIEW OF
FISCAL INTERMEDIARY AND
CARRIER CLAIMS FROM THE
FISCAL YEAR 2008
COMPREHENSIVE ERROR RATE
TESTING PROGRAM**



Daniel R. Levinson
Inspector General

September 2009
A-01-09-00511

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate. Using the results of the CERT program, 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 (P.L. No. 107-300).

Fiscal intermediaries process Medicare Part A claims for inpatient hospital, skilled nursing, home health, and hospice services and Medicare Part B claims for outpatient hospital services. Carriers process Medicare Part B claims for physician, laboratory, ambulance, and ambulatory surgical center services.

To determine the error rate, CMS's CERT contractor conducts medical record reviews of a random sample of paid claims. CMS's contract requires that the CERT contractor make medical review decisions in accordance with CMS's written policies, including those in its "Program Integrity Manual."

To strengthen its confidence in the CERT review findings and provide assurance that the reported fiscal year (FY) 2008 error rate was accurate, CMS contracted with SafeGuard Services, LLC (SGS), an independent medical review organization, to perform a random, independent review of the CERT contractor's payment determinations. SGS is a program safeguard contractor for CMS with experience in medical review, data analysis, complaint resolution, and investigative activities for various types of Medicare claims. SGS's review consisted of a subsample of 852 paid claims from the sample of 57,966 fiscal intermediary and 51,559 carrier claims that the CERT contractor had reviewed in determining the FY 2008 fiscal intermediary and carrier error rates. CMS's contract required SGS to follow guidance in national coverage determinations (NCD), local coverage determinations (LCD), and CMS manuals and to use the same documentation that the CERT contractor had used to assess whether claim payments met Medicare medical necessity, reasonableness, documentation, coding, and reimbursement requirements.

OBJECTIVES

Our objectives were to determine whether (1) SGS complied with the CMS contract in performing medical reviews of a subsample of claims from the FY 2008 CERT sample and (2) SGS's results provided CMS with assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate.

SUMMARY OF FINDINGS

SGS complied with its CMS contract in performing medical reviews of a subsample of claims from the FY 2008 CERT samples. Using the same documentation that the CERT contractor had used, SGS followed the guidance in the applicable NCDs, LCDs, and CMS manuals to determine whether the services in the subsample were medically necessary, reasonable, adequately documented, and correctly coded and reimbursed.

SGS's results may not have provided CMS with assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate. Specifically, of the 852 subsampled claims, SGS found 194 erroneous claims, whereas the CERT contractor found 87 erroneous claims (including 78 that SGS also found in error). Thus SGS found an additional 116 erroneous claims that the CERT contractor had not initially determined to be in error.

SGS's review results differed from those of the CERT contractor because:

- For 46 of the 116 erroneous claims, the CERT contractor and SGS differed in professional judgment as to how they interpreted the medical documentation and how much documentation was required to determine medical necessity.
- For 42 of the 116 erroneous claims, the CERT contractor used available medical records and beneficiary claim histories rather than the physician orders required by Medicare as evidence of physician intent to order the tests.
- For 28 of the 116 erroneous claims, the CERT contractor subsequently agreed with SGS that the documentation was insufficient to support the medical necessity requirements.

CMS reviewed SGS's results and concurred that the different determinations for the 46 claims were due to differences in professional judgment. CMS agreed with SGS that the remaining 70 (42 plus 28) claims were erroneous.

This review identified numerous differences between the CERT contractor's and SGS's determinations. We were unable to quantify the statistical effect of SGS's results on the FY 2008 fiscal intermediary and carrier error rates because CMS subsampled from the CERT sample. As a result, any estimate would be applicable only to the CERT sample. Extrapolating the results to all fiscal intermediary and carrier claims covered by the FY 2008 CERT error rate would thus not be valid. However, the SGS review identified enough incorrect determinations by the CERT contractor to warrant further corrective action by CMS to improve the Medicare error rate process. In addition, this review identified opportunities for CMS to reduce differences in professional judgment by clarifying its documentation policies.

RECOMMENDATIONS

We recommend that CMS:

- clarify documentation policies to reduce the number of differences in professional judgment,
- require the CERT contractor to obtain physician orders to support the medical necessity for diagnostic tests in accordance with Medicare requirements, and
- require the CERT contractor to develop a corrective action plan to reduce its number of incorrect determinations.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our findings and recommendations and outlined the steps it has taken to begin implementing our recommendations.

CMS's comments are included in their entirety as the Appendix.

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CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

INTRODUCTION

BACKGROUND

Medicare Error Rate Program

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, established the Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate. An error is the difference between the amount that Medicare paid to a health care provider and the amount that it should have paid. Medicare will pay only for items and services that are medically necessary. Using the results of the CERT program, 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 (P.L. No. 107-300).

Medicare Contractors

Fiscal intermediaries process Medicare Part A claims for inpatient hospital, skilled nursing, home health, and hospice services and Medicare Part B claims for outpatient hospital services. Carriers process Medicare Part B claims for physician, laboratory, ambulance, and ambulatory surgical center services. As required by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS is replacing its current claim payment contractors with new contract entities called Medicare Administrative Contractors (MAC) that process both fiscal intermediary and carrier claims. At the time of our audit, some claim processing activities had transitioned to MACs.

Claim Review Activities

CMS's "Medicare Program Integrity Manual," Pub. No. 100-08 (Integrity Manual), chapter 3, section 3.4.5, defines three types of claim review activities: automated prepayment review (performed by computers), routine prepayment and postpayment reviews (performed by nonmedical professionals), and complex prepayment and postpayment medical reviews (performed by licensed medical professionals). Only a complex medical review requires that a licensed medical professional evaluate medical records to determine whether a service or an item is covered and medically necessary. Pursuant to the Integrity Manual, a medical reviewer who performs a complex medical review must follow national coverage determinations (NCD) and local coverage determinations (LCD)¹ and must consider the beneficiary's clinical condition as indicated by the beneficiary's medical records.

¹CMS develops NCDs to describe the circumstances for nationwide Medicare coverage of specific medical services, procedures, and devices. Medicare contractors develop LCDs to specify the clinical circumstances under which services are considered reasonable and necessary in their jurisdictions.

Medical Reviews of Claims in the Comprehensive Error Rate Testing Program

CMS's CERT contractor is AdvanceMed, a program safeguard contractor (PSC). As part of the Medicare error rate process, the CERT contractor conducts medical record reviews of a random sample of paid claims. CMS's contract requires that the CERT contractor make medical review decisions in accordance with the Integrity Manual; section 7 of the PSC Umbrella Statement of Work; and applicable guidance, such as NCDs, LCDs, and CMS coding manuals.

We issued two previous reports on the medical review of durable medical equipment claims in the CERT program.² Both of these reports highlighted differences between the CERT contractor's medical review methodology and the methodology that an independent medical review contractor used to make medical necessity determinations. CMS generally agreed with the recommendations in our reports, which included requiring the CERT contractor to review all available medical records necessary to determine compliance with applicable medical necessity requirements. CMS stated that it had initiated corrective actions.

Independent Medical Review Contractor

In September 2008, CMS contracted with SafeGuard Services, LLC (SGS), to perform an independent review of a subsample of Medicare Parts A and B claims that the CERT contractor had reviewed as part of the fiscal year (FY) 2008 fiscal intermediary and carrier error rate process. The purpose of SGS's review, as stated in the "CMS Financial Report, Fiscal Year 2008," was to "strengthen our confidence in the CERT review findings and assure the accuracy of the reported error rate." SGS is a PSC for CMS with experience in medical review, data analysis, complaint resolution, and investigative activities for various types of Medicare claims.

CMS's contract required SGS to follow guidance in NCDs; LCDs; and CMS manuals, including the Integrity Manual, and to use the same documentation that the CERT contractor had used to assess whether claim payments met Medicare medical necessity, reasonableness, documentation, coding, and reimbursement requirements. With the exception of the requirement that SGS use the same documentation that the CERT contractor used, these review requirements are consistent with the definition of a complex medical review in the Integrity Manual.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether (1) SGS complied with the CMS contract in performing medical reviews of a subsample of claims from the FY 2008 CERT sample and (2) SGS's results provided CMS with assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate.

²"Medical Review of Claims for the Fiscal Year 2006 Comprehensive Error Rate Testing Program" (A-01-07-00508, August 22, 2008) and "Independent Contractor's Review of Durable Medical Equipment Claims From the Fiscal Year 2008 Comprehensive Error Rate Testing Program" (A-01-09-00500, May 12, 2009).

Scope

Our review covered SGS's evaluation of a subsample of 852 paid claims from the sample of 57,966 fiscal intermediary³ and 51,559 carrier claims that the CERT contractor had reviewed in determining the FY 2008 fiscal intermediary and carrier error rates.

We limited our review of internal controls to obtaining an understanding of CMS's written policies regarding medical reviews and of SGS's adherence to those policies.

We performed our fieldwork at SGS in Camp Hill, Pennsylvania, and AdvanceMed in Richmond, Virginia, during January and April 2009, respectively.

Methodology

To accomplish our objectives, we:

- reviewed Medicare requirements and CMS's policies regarding medical reviews, including the requirements detailed in the Integrity Manual and the PSC Umbrella Statement of Work;
- reviewed CMS's contracts with both the CERT contractor and SGS;
- interviewed SGS officials to obtain an understanding of their medical review procedures;
- compared SGS's results with the CERT contractor's results;
- met with SGS, CMS, and the CERT contractor to discuss differences in medical review determinations;
- calculated the payment effect of SGS's review determinations; and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

³During the period of our review, inpatient hospital claims were reviewed under the Hospital Payment Monitoring Program (HPMP) and were thus excluded from the subsample. Subsequently, HPMP was merged with the CERT program.

FINDINGS AND RECOMMENDATIONS

SGS complied with its CMS contract in performing medical reviews of a subsample of claims from the FY 2008 CERT samples. Using the same documentation that the CERT contractor had used, SGS followed the guidance in the applicable NCDs, LCDs, and CMS manuals to determine whether the services in the subsample were medically necessary, reasonable, adequately documented, and correctly coded and reimbursed.

SGS's results may not have provided CMS with assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate. Specifically, of the 852 subsampled claims, SGS found 194 erroneous claims, whereas the CERT contractor found 87 erroneous claims (including 78 that SGS also found in error). Thus SGS found an additional 116 erroneous claims that the CERT contractor had not initially determined to be in error.

SGS's review results differed from those of the CERT contractor because:

- For 46 of the 116 erroneous claims, the CERT contractor and SGS differed in professional judgment as to how they interpreted the medical documentation and how much documentation was required to determine medical necessity.
- For 42 of the 116 erroneous claims, the CERT contractor used available medical records and beneficiary claim histories rather than physician orders required by Medicare as evidence of physician intent to order the tests.
- For 28 of the 116 erroneous claims, the CERT contractor agreed with SGS after further review that the documentation was insufficient to support the medical necessity requirements.

CMS reviewed SGS's results and concurred that the different determinations for the 46 claims were due to differences in professional judgment. CMS agreed with SGS that the remaining 70 (42 plus 28) claims were erroneous.

This review identified numerous differences between the CERT contractor's and SGS's determinations. We were unable to quantify the statistical effect of SGS's results on the FY 2008 fiscal intermediary and carrier error rates because CMS subsampled from the CERT sample. As a result, any estimate would be applicable only to the CERT sample. Extrapolating the results to all fiscal intermediary and carrier claims covered by the FY 2008 CERT error rate would thus not be valid. However, the SGS review identified enough incorrect determinations by the CERT contractor to warrant further corrective action by CMS to improve the Medicare error rate process. In addition, this review identified opportunities for CMS to reduce differences in professional judgment by clarifying its documentation policies.

PROGRAM REQUIREMENTS

Medicare Payment Requirements

Section 1833(e) of the Social Security Act (the Act) precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member.

Physician Orders for Diagnostic Tests

Pursuant to 42 CFR § 410.32(a), all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.

According to CMS's "Medicare Benefit Policy Manual," Pub. No. 100-02 (the Policy Manual), chapter 15, section 80.6.1, an order is a communication from the treating physician requesting that a diagnostic test be performed for a beneficiary. Although Medicare does not require the physician to sign the order, "the physician must clearly document, in the medical record, his or her intent that the test be performed."

Physician Evaluation and Management Services

CMS's 1995 and 1997 publications entitled "Documentation Guidelines for Evaluation and Management Services" provide documentation guidelines for the three key elements for evaluation and management services—history, examination, and medical decisionmaking. When billing Medicare for a patient visit or consultation, the physician must select a Current Procedural Terminology (CPT) code that best represents the level of evaluation and management service performed (e.g., straightforward, low, moderate, or high level of medical decisionmaking). The physician is responsible for ensuring that the documentation supports the level of services furnished and that the CPT codes selected reflect those services.

ASSURANCE OF ERROR RATE ACCURACY

SafeGuard Services' Error Determinations

SGS's results may not provide assurance that the FY 2008 fiscal intermediary and carrier error rates were accurate. SGS found that 194 of the 852 subsampled claims were in error. These errors resulted in overpayments of \$43,949, or 11 percent of the total \$399,046 in payments for the subsampled claims. In contrast, the CERT contractor found 87 erroneous claims (including 78 that SGS also found in error) that resulted in overpayments of \$7,592, or 1.9 percent of the total payments for the subsampled claims. Thus SGS found more than twice the number of erroneous claims and more than five times the percentage of overpayments for the subsampled claims than the CERT contractor found.

Response to SafeGuard Services' Additional Error Determinations

Because of the significant number of differences between SGS's determinations and the CERT contractor's determinations, we participated in a dispute resolution process with medical review staff from SGS, the CERT contractor, and CMS. CMS asked SGS to review the CERT contractor's written responses to SGS's additional error determinations. The CERT contractor reversed its initial decision on only 28 of the 116 differences. However, SGS maintained that all of these claims had been paid in error.

CAUSES OF DIFFERENCES IN REVIEW DETERMINATIONS

SGS's review results differed from those of the CERT contractor because of (1) differences in professional judgment, (2) the CERT contractor's lack of adherence to Medicare requirements for physician orders, and (3) the CERT contractor's incorrect medical necessity determinations.

Differences in Professional Judgment

For 46 claims in dispute, the CERT contractor and SGS differed in professional judgment as to how they interpreted the medical documentation and how much documentation they required to determine medical necessity. Nineteen of the disputed claims were for evaluation and management services for which SGS and the CERT contractor's determinations differed by one level of CPT coding. Both SGS and the CERT contractor stated that equally qualified medical reviewers often differ by one level in reviewing these claims. Such differences occur when medical reviewers select CPT codes that are one level apart (on a scale of five coding levels) based on their review of documentation submitted by providers in support of a particular level of coding. For the remaining 27 claims, SGS and the CERT contractor differed in their professional judgment for a variety of reasons. Three of these disputed claims accounted for more than 42 percent of the total value of SGS's error determinations.

Physician Order Requirements

For 42 claims in dispute, no physician orders were available to support the medical necessity of diagnostic tests, as required by Medicare. For these claims, the CERT contractor stated that it had used the available medical records (e.g., diagnostic test results initialed by the physicians after the tests) and beneficiary claim histories as evidence of physician intent to order the tests. After the dispute resolution process, CMS stated that it did not believe that a signed test result was sufficient evidence of physician intent to order a test. However, CMS also noted that the requirement for a physician order in the Policy Manual was inadvertently omitted in the Internet-only Policy Manual that the CERT contractor used to determine whether claims were medically necessary. As of January 2008, CMS revised its Internet-only Policy Manual to require that the medical documentation supporting a claim include a physician order, but the CERT contractor did not reverse its earlier determinations because of time and workload constraints.

Agreement on 28 Claims After Further Review

After further review, the CERT contractor agreed with SGS that 28 claims were in error because:

- For 25 claims, the documentation was insufficient to support the medical necessity requirements specified by the applicable criteria.
- For 3 claims, the medical records were sufficient to determine that the items were incorrectly coded.

The CERT contractor's agreement on these 28 claims more than doubled the value of its initial error determinations, from 1.9 percent to 4.2 percent of the total value of the subsampled claims. CMS stated that the CERT contractor was following CMS guidance to use clinical judgment to reasonably infer that care was provided based on available medical records and beneficiary claim histories. In March 2009, CMS provided direction to the CERT contractor that clarified that clinical judgment may not supersede documentation requirements in the CMS statute, regulations, policies, or manuals.

CENTERS FOR MEDICARE & MEDICAID SERVICES' REVIEW

CMS reviewed SGS's results and concurred that the different determinations for the 46 claims were due to differences in professional judgment. CMS agreed with SGS that the remaining 70 (42 plus 28) claims were erroneous.

CONCLUSION

The results of the SGS review identified numerous differences between the CERT and SGS medical review determinations. We were unable to quantify the statistical effect of SGS's results on the FY 2008 fiscal intermediary and carrier error rates because CMS subsampled from the CERT sample. As a result, any estimate would be applicable only to the CERT sample. Extrapolating the results to all fiscal intermediary and carrier claims covered by the FY 2008 CERT error rate would thus not be valid. However, the SGS review identified enough incorrect determinations by the CERT contractor to warrant further corrective action by CMS to improve the Medicare error rate process. In addition, this review identified opportunities for CMS to reduce differences in professional judgment by clarifying its documentation policies.

RECOMMENDATIONS

We recommend that CMS:

- clarify documentation policies to reduce the number of differences in professional judgment,
- require the CERT contractor to obtain physician orders to support the medical necessity for diagnostic tests in accordance with Medicare requirements, and

- require the CERT contractor to develop a corrective action plan to reduce its number of incorrect determinations.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our findings and recommendations and outlined the steps it has taken to begin implementing our recommendations.

CMS's comments are included in their entirety as the Appendix.

APPENDIX

*Administrator*
Washington, DC 20201

DATE: AUG 20, 2009

TO: Daniel R. Levinson
Inspector General

FROM: *Charlene Frizzera*
Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Independent Contractor's Review of Fiscal Intermediary and Carrier Claims From the Fiscal Year 2008 Comprehensive Error Rate Testing Program" (A-01-09-00511)

Thank you for the opportunity to review and comment on the OIG's draft report, "Independent Contractor's Review of Fiscal Intermediary and Carrier Claims from the Fiscal Year 2008 Comprehensive Error Rate Testing Program." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the validity of the Comprehensive Error Rate Testing (CERT) Part A and Part B error rate reviews for fiscal year (FY) 2008.

As you know, CMS established the CERT program to comply with the Improper Payments Information Act of 2002. The CERT program calculates the Medicare Fee-for-Service (FFS) error rate and an estimate of improper claim payments using a methodology approved by the OIG. The CERT methodology includes randomly selecting a sample of approximately 120,000 submitted claims, requesting medical records from providers who submitted the claims, and reviewing the claims and medical records for compliance with Medicare coverage, coding, and billing rules.

The CMS is committed to continually reviewing and refining its processes to improve the Medicare FFS error rate. This report and the earlier report "Independent Contractor's Review of Durable Medical Equipment Claims From the Fiscal Year 2008 Comprehensive Error Rate Testing Program" (A-01-09-00500) have helped identify several areas for improvement, particularly regarding CMS guidance to contractors in its manuals. Based on our own analysis and the OIG's findings, CMS has determined that we need to provide further direction to CMS contractors on our manual instructions.

Through our internal review, we determined that contractors could interpret manuals differently, especially regarding the use of clinical judgment. In fact, our internal review found that there are two distinct interpretations that could be made, which would allow a reviewer to arrive at different payment determinations. All contractors request the same types of medical record

documentation. However, CMS' Program Integrity Manual (PIM) is vague regarding how much clinical judgment contractors can use when reviewing this documentation. As a result, the CERT contractor relied more heavily on clinical judgment than other contractors when making payment determinations in accordance with one section of our manuals (*PIM, Chapter 3, §3.4.5, Section C ¶4*). For complex postpayment medical review, some carriers, fiscal intermediaries, and Medicare administrative contractors strictly applied another section of our manuals and, therefore, required more extensive medical records to be present in order to determine medical necessity (*PIM, Chapter 5, §5.7*). Both interpretations are reasonable since our manuals allow reviewers to make a determination if they believe the submitted documentation and other available information provides sufficient information to determine medical necessity. As indicated in the OIG draft report, it is likely that additional documentation would have supported the payment decision made by the CERT contractor.

Based on our internal review, we are revising our manuals to clarify requirements for reviewing documentation to promote uniform interpretation of our policies across all medical reviews performed by Medicare contractors and to reconcile any apparent conflicts between different sections of the manuals. Additionally, CMS has provided direction to the CERT contractor regarding the use of clinical review judgment. This direction clarified that clinical judgment cannot supersede documentation requirements in CMS statute, regulations, policies, or manuals. CMS plans to incorporate this clarification into the PIM.

The CMS goal is to pay the right amount to a legitimate provider, for correctly coded, medically necessary services, provided to an eligible beneficiary in an appropriate setting. In particular, CMS has set the goal of reducing the claims payment error rate to 3.5 percent for the 2009 improper payment report period. To help achieve those error rate goals, we have realigned our resources by combining three divisions – Medical Review, Recovery Audit Operations, and Error Rate Measurement into a new group – the Provider Compliance Group -- within the Office of Financial Management. This realignment will ensure those entities that have primary responsibility for complex medical review activities are applying Medicare rules consistently and accurately.

Our detailed comments on the report recommendations follow.

OIG Recommendation

Clarify documentation policies to reduce the number of differences in professional judgment.

CMS Response

The CMS concurs. CMS is in the process of revising the PIM to clarify instructions to review contractors in order to promote uniform interpretation of our policies. The revisions are in final clearance and we anticipate the release in the fall of 2009.

OIG Recommendation

Require the CERT contractor to obtain physician orders to support the medical necessity for diagnostic tests in accordance with Medicare requirements.

CMS Response

The CMS concurs. CMS clarified the policy regarding physician orders for diagnostic tests in January 2008. However, because of time and workload constraints, CMS instructed the CERT contractor not to re-review claims to retroactively enforce this policy for the 2008 improper payment report period. All diagnostic claims in the 2009 report period are being reviewed in accordance with the clarified policy.

OIG Recommendation

Require the CERT contractor to develop a corrective action plan to reduce its number of incorrect determinations.

CMS Response

The CMS concurs and has worked with the CMS contracting office to formally request the CERT contractor to develop a corrective action plan. CMS will monitor the contractor's corrective actions and its progress toward reducing incorrect determinations.

The CMS has already taken steps to improve the CERT contractor's medical review quality control process. We revised the CERT contractor's statement of work to increase the number of quality assurance reviews conducted for durable medical equipment (DME) claims. Additionally, the CERT contractor has, on its own initiative, implemented an internal quality review of DME claims included in the 2009 improper payment report period.