



March 9, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010 (A-01-11-00504)

The attached final report provides the results of our review of CERT (Comprehensive Error Rate Testing) errors overturned through the appeals process for fiscal years 2009 and 2010.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted 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 Kay L. Daly, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at Kay.Daly@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-01-11-00504 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF CERT ERRORS
OVERTURNED THROUGH THE
APPEALS PROCESS FOR
FISCAL YEARS 2009 AND 2010**



Daniel R. Levinson
Inspector General

March 2012
A-01-11-00504

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 national Medicare fee-for-service (FFS) error rate. An erroneous payment amount is the difference between the amount that Medicare paid a health care provider and the amount that it should have paid. Using the results of the CERT program, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare FFS claims, pursuant to the Improper Payments Information Act of 2002 (P.L. No. 107-300).

Medicare Appeals Process

Providers have the right to appeal claim payment denials made by the CERT review contractor. The Medicare appeals process has five levels, but the majority of overturned CERT claim payment denials occur during the first three levels, which are (1) Medicare Administrative Contractor redeterminations, (2) Qualified Independent Contractor reconsiderations, and (3) Administrative Law Judge hearings.

Reported Error Rates for Fiscal Years 2009 and 2010

The error rates for fiscal years (FY) 2009 and 2010 were 7.8 percent (\$24.1 billion) and 10.5 percent (\$34.3 billion), as reported in CMS's *Agency Financial Report* for the respective years. The FY 2009 *Improper Medicare Fee-for-Service Payments Report* states that appeal decisions made after the cutoff period for determining the error rate are not reflected in improper payments report estimates.

OBJECTIVE

Our objective was to determine the effect that CERT claim payment denials overturned after the cutoff date would have had on the Medicare FFS error rates that CMS reported for FYs 2009 and 2010.

SUMMARY OF FINDINGS

CERT claim payment denials overturned after the cutoff date for determining the Medicare FFS error rate for each FY would have reduced the reported error rates from 7.8 percent to 7.2 percent for FY 2009 and from 10.5 percent to 9.9 percent for FY 2010. Approximately 5.5 percent of the CERT claim payment denials for FY 2009 and 7.6 percent for FY 2010 were overturned during one of the first three levels of the appeals process. If these overturned CERT claim payment denials had been included in the initial error-rate calculations, the estimated value of reported errors for FYs 2009 and 2010 would have decreased by approximately \$2 billion each year. CMS could improve the accuracy of the reported estimate of improper payment error rates by including an adjustment for overturned CERT claim payment denials.

RECOMMENDATION

We recommend that CMS develop a reliable methodology for adjusting the Medicare FFS error rate, incorporating the outcome of appeal decisions for CERT claim payment denials, to make CMS's estimate of the value of reported errors more accurate.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our findings and outlined steps for implementing our recommendation. CMS's comments, excluding a technical comment that we addressed as appropriate, are included as Appendix B.

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INTRODUCTION

BACKGROUND

Medicare Error Rate Program

The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program to produce a national Medicare fee-for-service (FFS) error rate. An erroneous payment amount is the difference between the amount that Medicare paid a health care provider and the amount that it should have paid. Using the results of the CERT program, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare FFS claims, pursuant to the Improper Payments Information Act of 2002 (P.L. No. 107-300). The annual estimate does not reflect all errors that are overturned during the appeals process. As a result, the reported estimate may overstate the actual amount of improper payments.

CERT Contractors' Roles

CMS contracts with three entities to administer the CERT program: (1) the documentation contractor requests and receives medical records from providers; (2) the review contractor selects claim samples, reviews the medical records obtained by the documentation contractor, and accepts or denies the claims; and (3) the statistical contractor calculates error rates and the improper payment amounts based on the review contractor's determinations.

Medicare Appeals Process

Providers have the right to appeal the review contractor's determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). In this report, we refer to these determinations as CERT claim payment denials. The Medicare appeals process has five levels, but the majority of overturned CERT claim payment denials occur during the first three:

1. Medicare Administrative Contractor (MAC) redeterminations of Medicare A and B: A provider has 120 days from the date of receipt of the initial claim determination to file an appeal requesting that the MAC examine the claim. A minimum monetary threshold is not required to request a redetermination.
2. Qualified Independent Contractor (QIC) reconsiderations of Medicare A and B: A provider dissatisfied with the MAC redetermination may request a reconsideration. The QIC reconsideration allows for an independent review of medical necessity issues by a panel of health care professionals. A minimum monetary threshold is not required to request reconsideration.
3. Administrative Law Judge (ALJ) hearings: If the value in dispute meets the threshold for obtaining an ALJ hearing following the QIC's decision, a provider may request an ALJ hearing within 60 days of receipt of the reconsideration. The ALJ will generally issue a decision within 90 days of receipt of the hearing request.

In general, providers may submit additional documentation for the first three levels of appeal. The fourth level is a review by the Medicare Appeals Council within the Departmental Appeals Board, and the fifth level is a review by the United States District Court.

Fiscal Years 2009 and 2010 Error Rates

The error rates for fiscal years (FY) 2009 and 2010 were 7.8 percent (\$24.1 billion) and 10.5 percent (\$34.3 billion), as reported in CMS's *Agency Financial Report* for the respective years.¹ The FY 2009 *Improper Medicare Fee-for-Service Payments Report* states that appeal decisions made after the cutoff date for determining the error rate are not reflected in its estimates.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the effect that CERT claim payment denials overturned after the cutoff date would have had on the Medicare FFS error rates that CMS reported for FYs 2009 and 2010.

Scope

Our review focused on the CERT claim payment denials that were fully or partially overturned² during one of the first three levels³ of the appeals process and after the cutoff dates for determining the error rates. We limited our review to FYs 2009 and 2010 because the number of CERT claim payment denials appealed had increased significantly from the number in FYs 2007 and 2008. This may be due, in part, to the CERT program's change to a more stringent medical record review methodology in FY 2009.

We limited our review of internal controls to obtaining an understanding of (1) the first three levels of the appeals process and (2) CMS's written policies regarding medical reviews, its methodology for calculating error rates, and its involvement in the appeals process.

We performed our fieldwork from December 2010 through August 2011.

¹ In the FY 2010 *Agency Financial Report*, CMS stated that the error rate of 7.8 percent noted in the FY 2009 report represents a combination of review results from two methodologies, one of which was newer and more stringent. CMS also stated that the error rate for FY 2009 based on a subsample of claims using the newer methodology was 12.4 percent (\$35.4 billion).

² We received the FYs 2009 and 2010 CERT claim payment denials overturned on March 15, 2011, and June 8, 2011, respectively, from the QIC. Claim payment denials overturned after these dates were not included in our results.

³ We excluded the fourth and fifth levels of the appeals process because providers rarely appealed CERT claim payment denials beyond the third level. Providers appealed a total of 5 claim payment denials beyond the third level in FYs 2009 and 2010.

Methodology

To accomplish our objective, we:

- reviewed the applicable Medicare criteria used to adjudicate claims for the first three levels of the appeals process;
- determined the number and amounts of CERT claim payment denials overturned during the first three levels of the appeals process;
- contacted the QIC and the Department of Health and Human Services, Office of Medicare Hearings and Appeals, for information on how they track and report appealed CERT claim payment denials;
- provided data for the statistical contractor to use in determining the effect that CERT claim payment denials overturned through appeals would have had for each FY's reported error rate; 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 objective.

FINDINGS AND RECOMMENDATION

CERT claim payment denials overturned after the cutoff date for determining the Medicare FFS error rate for each fiscal year would have reduced the reported error rates from 7.8 percent to 7.2 percent for FY 2009 and from 10.5 percent to 9.9 percent for FY 2010. Approximately 5.5 percent of the CERT claim payment denials for FY 2009 and 7.6 percent for FY 2010 were overturned during one of the first three levels of the appeals process. If these overturned CERT claim payment denials had been included in the initial error-rate calculations, the estimated value of reported errors for FYs 2009 and 2010 would have decreased by approximately \$2 billion each year. CMS could improve the accuracy of the reported estimate of improper payment error rates by including an adjustment for overturned CERT claim payment denials.

CERT CLAIM PAYMENT DENIALS OVERTURNED

In FY 2009, 1,092 of the 2,060 appealed CERT claim payment denials were overturned, and for FY 2010, 1,557 of the 3,256 appealed CERT claim payment denials were overturned. The majority of appealed CERT claim payment denials that were overturned occurred during the first level of appeal. (See the table.)

Denials Overturned at the First Three Levels of Appeal

	FY 2009	FY 2010
Number of Denied Claims Overturned	1,092	1,557
1. MAC Redeterminations	1,036	1,496
2. QIC Reconsiderations	22	47
3. ALJ Hearings	34	14

See Appendix A for additional information regarding CERT claim payment denials that were overturned and their effect on error rates.

Examples of the rationales for overturning CERT claim payment denials for Medicare A and B during the first three levels of appeal included the following:

1. The MAC overturned a CERT claim payment denial because the provider submitted additional medical records that supported the payment of the claim.
2. The QIC overturned a CERT claim payment denial because it determined that the patient's medical records supported the services billed.
3. The ALJ overturned a CERT claim payment denial because testimony by third-party consultants that was supported by medical records established that the claimed services were reasonable and necessary.

CERT claim payment denials overturned through the appeals process had a total value of approximately \$6.1 million. Institutional providers, including inpatient hospitals, accounted for 89 percent of the overturned appeals. The average value for each of these claims was approximately \$5,800.

FISCAL YEARS 2009 AND 2010 ERROR-RATE REDUCTIONS

According to CMS officials, appeal decisions made after the cutoff period for determining error rates have not been reflected in past reported error rates. If CMS had included the overturned CERT claim payment denials that we discuss in this report in the *Agency Financial Reports* and *Improper Medicare Fee-for-Service Payments Reports*, the published error rates would have been reduced from 7.8 percent to 7.2 percent, or approximately \$2 billion, for FY 2009 and from 10.5 percent to 9.9 percent, or approximately \$2 billion, for FY 2010.

After we discussed the results of our review with CMS officials, CMS refined its error-rate estimation methodology to reflect the receipt of additional documentation and the outcome of appeal decisions that occurred after CMS's cutoff date for determining the error rate. According to CMS officials, this reduced the FY 2010 error rate to 9.1 percent, or 0.8 percent less than the 9.9 percent we identified in this report. Using the actual appeal results and the submission of late documentation received after the cutoff date for FY 2010, CMS adjusted the FY 2011 error rate. We have not reviewed in detail the adjustment methodology that CMS used, but we have

concerns about the reliability of an adjustment methodology that is based on 1 year's data. In general, an adjustment based on the results of several years of activity would be more reliable than one based on 1 year's activity. For example, a moving average that reflects the outcome of appeal decisions over 3 to 5 years would generally enhance the adjustment's reliability.

RECOMMENDATION

We recommend that CMS develop a reliable methodology for adjusting the Medicare FFS error rate, incorporating the outcome of appeal decisions for CERT claim payment denials, to make CMS's estimate of the value of reported errors more accurate.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our findings and outlined steps for implementing our recommendation. CMS's comments, excluding a technical comment that we addressed as appropriate, are included as Appendix B.

APPENDIXES

**APPENDIX A: CERT CLAIM PAYMENT DENIALS OVERTURNED
AND THE EFFECT ON ERROR RATES**

	FY 2009	FY 2010
Reported Error Rate	7.8%	10.5%
Error Rate After Appeals	7.2%	9.9%
Percentage of Change in Error Rate	7.7%	5.7%
Number of Reviewed Claims	99,480	79,872
Number of CERT Claim Payment Denials	19,754	20,481
Percentage of CERT Claim Payment Denials	20%	26%
Number of Denied Claims Appealed	2,060	3,256 ¹
1. Medicare Administrative Contractor (MAC) Redeterminations	1,898	3,140
2. Qualified Independent Contractor (QIC) Reconsiderations	114	102
3. Administrative Law Judge (ALJ) Hearings	48	14
Percentage of Denied Claims Appealed	10%	16%
Number of Denied Claims Overturned	1,092	1,557
1. MAC Redeterminations	1,036	1,496
2. QIC Reconsiderations	22	47
3. ALJ Hearings	34	14
Percentage of Appealed Claims Overturned	53%	48%

FY = fiscal year

CERT = Comprehensive Error Rate Testing

¹ Each level of the appeals process has statutory timeframes that provide due process to providers. Some of the claim payment denials for FY 2010 may not have completed the appeals process before the release of our report.



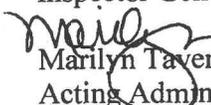
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB 10 2012

TO: Daniel R. Levinson
Inspector General

FROM: 
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010" (A-01-11-00504)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on this OIG draft report. The objective of the review was to determine the effect that appeal decisions had on the Comprehensive Error Rate Testing (CERT) program's error rates for the Medicare Fee-for-Service (FFS) as reported for FYs 2009 and 2010.

The Medicare FFS error rates for fiscal years (FY) 2009 and 2010 were 7.8 percent and 10.5 percent respectively. The reported rates do not reflect appeal decisions that were made after the cutoff date for that particular year. As stated in the draft report, CERT claim payment denials overturned after the cutoff date for each fiscal year would have reduced the reported error rates from 7.8 percent to 7.2 percent for FY 2009 and from 10.5 percent to 9.9 percent for FY 2010. If these overturned CERT claim payment denials had been included in the initial error rate calculations, the estimated value of reported errors for FYs 2009 and 2010 would have decreased by approximately \$2 billion each year.

Appeal activity is tracked by the CERT program for each claim denial to ensure the accuracy of the improper payment rate. Once a final appeal decision is made to pay or deny the claim, that decision is factored into the calculation of the Medicare FFS improper payment rate. The error rate must be published each year as part of the annual financial statement reports on November 15. However, not all of the denied claims have completed the appeal process by this date. In addition, providers can continue to submit medical documentation to support the services that were paid. While the CERT program tracks both of these activities, appeal final decisions and submission of late documentation, no adjustments are made to the error rates once they are published.

We appreciate the OIG's efforts in determining the impact that appeal decisions had on the reported error rates after the publication date. On November 15, 2011 the CMS released an adjusted error rate that incorporated the OIG's recommendation from this report. The CMS

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included for the first time an estimate for activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur after the date of the published annual improper payment rate. To account for this activity, CMS refined the error rate methodology based on historical data for actual appeal results and the submission of late documentation received after the cutoff date for 2009 and 2010. Based on the actual impact of this activity on the 2009 and 2010 error rates, CMS developed an estimate modeled after the FY 2010 actual results. This is a more conservative approach for calculating the estimate than using a blended rate from 2009 and 2010 historical data.

OIG Recommendation

The CMS should develop a reliable methodology for adjusting the Medicare FFS error rate, incorporating the outcome of appeal decisions for CERT claim payment denials, to make CMS's estimate of the value of reported errors more accurate.

CMS Response

The CMS concurs with this recommendation. In 2011, the CMS refined the CERT methodology to reflect the projected impact of late appeals and late documentation on the Medicare FFS error rate. We are encouraged by the OIG's findings and believe accounting for appeal decisions will provide for a more accurate estimate of improper payments.

Reducing improper payments is a high priority for CMS. It is important to understand the issues and areas that create improper payments and thus it is critical that CMS report the most accurate information related to the error rate. We will continue to monitor appeals and refine our approach to report the most accurate error rate by using historical data and trending information for future reporting periods.