



February 13, 2012

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

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

**SUBJECT:** Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010  
CERT Program (A-01-11-00502)

The attached final report provides the results of our pilot project to obtain missing documentation identified in the fiscal year 2010 Comprehensive Error Rate Testing (CERT) Program.

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](mailto:Kay.Daly@oig.hhs.gov). We look forward to receiving your final management decision within 6 months. Please refer to report number A-01-11-00502 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PILOT PROJECT TO OBTAIN MISSING  
DOCUMENTATION IDENTIFIED IN THE  
FISCAL YEAR 2010 CERT PROGRAM**



Daniel R. Levinson  
Inspector General

February 2012  
A-01-11-00502

# *Office of Inspector General*

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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 improper 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 FFS claims, pursuant to the Improper Payments Information Act of 2002 (P.L. No. 107-300). The national Medicare FFS error rate for fiscal year (FY) 2010 was 10.5 percent (\$34.3 billion). Executive Order 13520 requires Federal agencies, including CMS, to reduce improper payments by “intensifying efforts to eliminate payment error, waste, fraud, and abuse in the major programs” they administer. CMS has implemented numerous corrective actions to reduce improper payments, including educating providers about the importance of submitting thorough documentation to support the medical necessity of services and items.

CMS employs three contractors to administer the CERT program: (1) the CERT documentation contractor requests and receives medical records from providers, (2) the CERT review contractor selects claims samples and reviews the medical records obtained by the documentation contractor, and (3) the CERT statistical contractor calculates error rates and the improper payment amounts based on the review contractor’s determinations.

The CERT documentation contractor requests specific medical records from providers through letters, faxes, and followup telephone calls. When a provider submits insufficient documentation in response to the initial letter, the documentation contractor sends a followup letter or fax and may attempt to telephone the provider to request additional documentation. If the provider fails to respond to the initial letter, the documentation contractor sends up to three more requests to the provider. Letters and faxes from the documentation contractor state that the provider may submit an attestation statement if a signature is illegible or missing. In addition, the CERT documentation contractor identifies referring providers (e.g., ordering physicians) and requests documentation from them to support the medical necessity for items or services ordered by billing providers (i.e., hospitals, suppliers, laboratories, and diagnostic testing facilities).

For FY 2010, the CERT review contractor sampled 79,872 claims valued at approximately \$57.8 million. The review contractor found that 20,481 sampled claims involved improper payments valued at approximately \$5.3 million. Our review covered 136 claims with improper payments greater than \$1,000 (total improper payments valued at \$510,415) that the review contractor identified during the FY 2010 error-rate process.

### **OBJECTIVE**

Our objective was to determine whether additional documentation was available to enable the CERT review contractor to overturn its claim payment denials and reduce the estimate of improper payments made in the Medicare FFS program for FY 2010.

## **SUMMARY OF FINDINGS**

We obtained additional documentation that enabled the CERT review contractor to overturn, or partially overturn, its claim payment denials for 46 of 136 claims (approximately 34 percent). The CERT review contractor overturned its claim payment denials for 46 claims because it determined that the additional medical records that we obtained were sufficient to show that the services or items billed were medically necessary. The CERT documentation contractor did not initially obtain all the necessary documentation for these 46 claims because it did not always (1) contact referring providers directly to obtain documentation to support the medical necessity of billing providers' claims, (2) redirect followup documentation requests to compliance or reimbursement personnel, or (3) seek signature attestations when signatures on clinicians' notes were illegible or missing.

For the remaining 90 claims, the CERT review contractor upheld its denials because providers did not produce requested documentation or the review contractor determined that the documentation we obtained did not sufficiently support the medical necessity of the claims.

Additional efforts to obtain missing documentation could more clearly reflect the true status of improper payments in the national Medicare FFS error rate estimate. Based on our results, the CERT statistical contractor estimated that additional documentation to overturn claim payment denials would have reduced the FY 2010 error rate estimate from 10.5 percent to 10.2 percent, which would have reduced the estimate of improper payments by approximately \$956 million.

## **RECOMMENDATIONS**

We recommend that CMS:

- continue to educate providers on the documentation required to support the medical necessity of services and items billed to Medicare;
- assess the improper payments identified by the CERT review contractor and the overturned denials of claim payments noted in this report to identify the population of claim payment denials that would benefit from additional requests for medical records; and
- ensure that the CERT documentation contractor follows established procedures in seeking signature attestations when signatures on clinicians' notes are illegible or are missing and clarify existing procedures, including:
  - contacting referring providers directly to obtain documentation, when applicable, to support the medical necessity of billing providers' claims and
  - redirecting followup documentation requests, when necessary, to compliance or reimbursement personnel.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In written comments on our draft report, CMS neither agreed nor disagreed with our first recommendation and did not agree with our second and third recommendations.

Regarding our first recommendation, CMS stated that it conducts many activities to educate providers on Medicare documentation requirements. CMS disagreed with our second recommendation and stated that throughout 2011, it had intensified efforts to obtain documentation for claims that have the greatest impact on the error rate, and it plans to continue improving this process. With regard to our third recommendation, CMS stated that it “disagrees that additional contractor monitoring activities are necessary.” According to CMS, the documentation contractor consistently follows the guidelines and practice standards in its statement of work. However, CMS stated that it is conducting an independent verification and validation of the CERT internal processes, including a detailed review of the documentation contractor’s processes to improve its rate of success.

In addition, CMS provided technical comments, which we addressed in this report as appropriate. CMS’s comments, excluding its technical comments, are included as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Regarding CMS’s comments on our first recommendation, we acknowledge CMS’s efforts to educate providers on Medicare documentation requirements. However, for more than one-third of the claims in our review, we were able to obtain additional and necessary medical records that the CERT documentation contractor did not obtain. Therefore, we encourage CMS to continue its efforts to educate providers on the documentation requirements needed to support the medical necessity of services and items billed to Medicare.

Regarding CMS’s comments on our second recommendation, we continue to recommend that CMS assess the improper payments identified by the CERT review contractor and the overturned claim payment denials noted in this report to identify the population of claim payment denials that would benefit from additional requests for medical records. Analyzing claim payment denials would enhance CMS’s efforts to focus on claims that have the greatest impact on the error rate.

Regarding CMS’s comments on our third recommendation, the CERT documentation contractor did not always take steps to obtain missing documentation, including signature attestations. Therefore, we continue to recommend that CMS ensure that the CERT documentation contractor follow established procedures for seeking attestations and clarify existing procedures on contacting referring providers and redirecting followup documentation requests to compliance or reimbursement personnel.

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## **INTRODUCTION**

### **BACKGROUND**

#### **Medicare Error Rate Program**

The Centers for Medicare & Medicaid Services (CMS) administers Medicare and established the Comprehensive Error Rate Testing (CERT) program to produce a national Medicare fee-for-service (FFS) error rate. An improper 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 FFS claims, pursuant to the Improper Payments Information Act of 2002 (P.L. No. 107-300) as amended by the Improper Payments Elimination and Recovery Act of 2010 (P.L. No. 111-204). The national Medicare FFS error rate for fiscal year (FY) 2010 was 10.5 percent (\$34.3 billion).

#### **Executive Order 13520**

Executive Order 13520, issued on November 20, 2009, requires Federal agencies, including CMS, to reduce improper payments by “intensifying efforts to eliminate payment error, waste, fraud, and abuse in the major programs” they administer while continuing to ensure that the programs serve their intended beneficiaries. CMS has implemented numerous corrective actions to reduce improper payments, including educating providers about the importance of submitting thorough documentation to support the medical necessity of services and items. CMS has also stated that it plans to analyze the improper payment data from the CERT program and make changes in areas that show programmatic weakness.

#### **CERT Contractors’ Roles**

CMS employs three contractors to administer the CERT program: (1) the CERT documentation contractor requests and receives medical records from providers, (2) the CERT review contractor selects claims samples and reviews medical records obtained by the documentation contractor, and (3) the CERT statistical contractor calculates error rates and improper payment amounts based on the review contractor’s determinations.

#### **Medical Record Collection Process**

CMS requires the CERT documentation contractor to collect medical records from providers. The documentation contractor requests specific medical records from providers through letters, faxes, and followup telephone calls. When a provider submits insufficient documentation in response to the documentation contractor’s initial letter, the documentation contractor sends a followup letter or fax and may attempt to telephone the provider to request additional documentation. If the provider fails to respond to the initial letter, the documentation contractor sends up to three more requests to the provider. The final request informs the provider that actions may be taken to deny and recover payment for all services billed on the claim if the provider does not respond to the request for medical records within 15 days. Letters and faxes

from the documentation contractor state that the provider may submit an attestation statement if a signature in the documentation is illegible or missing.<sup>1</sup> In addition, the documentation contractor identifies and contacts referring providers (e.g., ordering physicians) to request documentation to support the medical necessity for items or services ordered that support claims from billing providers (i.e., hospitals, suppliers, laboratories, and diagnostic testing facilities).

## **Medical Review Error Codes**

The CERT review contractor uses the following descriptions to classify most of the improper payments for its medical reviews of claims:

- No-documentation improper payments are for claims for which the CERT documentation contractor receives no documentation after it completes its request process.
- Insufficient-documentation improper payments are for claims for which a provider submits some documentation, but the CERT review contractor determines that it is not sufficiently conclusive to support the provided service.<sup>2</sup>
- Incorrectly coded improper payments are for claims that are billed and paid based on a procedure code that the CERT review contractor determines does not accurately reflect the service provided.
- Medically unnecessary improper payments are for claims for which there is sufficient documentation in a medical record to allow the CERT review contractor to conclude that the services are not medically necessary.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether additional documentation was available to enable the CERT review contractor to overturn its claim payment denials and reduce the estimate of improper payments made in the Medicare FFS program for FY 2010.

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<sup>1</sup> CMS Transmittal No. 327, issued on March 16, 2010, and retroactive for the FY 2010 CERT error rate, clarifies and updates previous provider signature requirements in the *Medicare Program Integrity Manual*. This policy stipulates that medical review contractors shall accept a signature attestation from the author of the medical record entry if the signature is illegible or missing from medical documentation, unless the signature is missing from an order.

<sup>2</sup> This error code includes instances of inadequate documentation. For example, the review contractor has a complete medical record, but the clinician's notes are not detailed enough for medical reviewers to determine medical necessity. In such cases, the medical records are available but cannot support the billed services.

## Scope

For FY 2010, the CERT review contractor sampled 79,872 claims valued at approximately \$57.8 million. The review contractor found that 20,481 sampled claims involved improper payments valued at approximately \$5.3 million. Our review covered 136 claims with improper payments greater than \$1,000 (total improper payments valued at \$510,415) that the review contractor identified during the FY 2010 error-rate process.<sup>3</sup> The review contractor confirmed that these claims were missing sufficient documentation for it to make an informed decision that the services or items billed were medically necessary.

We limited our review of internal controls to obtaining an understanding of CMS's written policies regarding medical reviews. We performed our fieldwork from February through April 2011.

## Methodology

To accomplish our objective, we:

- reviewed CMS requirements regarding the CERT process for obtaining documentation for medical record review;
- identified 136 claims with improper payments greater than \$1,000 for which we attempted to obtain missing documentation by:
  - contacting billing providers through telephone calls, letters, or onsite visits;
  - contacting referring providers, as necessary, to obtain medical records that supported billing providers' claims;
  - requesting and receiving clinician attestation statements for certain medical records that were not signed or had illegible signatures; and
  - locating providers by searching the Internet and contacting postal authorities;
- provided medical records to the CERT review contractor so it could determine whether the documentation would change its decisions to deny claim payment;
- recalculated the review contractor's partially overturned claims to determine the revised value of the claims;

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<sup>3</sup> The CERT review contractor determined that 228 claims with improper payments greater than \$1,000 had insufficient or no documentation. We identified 71 additional claims that we reclassified from medically unnecessary to insufficient documentation. Of these 299 claims, we excluded 163 claims: 87 claims with inadequate initial documentation, 75 claims under provider appeal, and 1 claim for which the CERT documentation contractor received adequate documentation after the start of our review.

- worked with the CERT statistical contractor to estimate the impact of the additional documentation that we obtained on the FY 2010 national Medicare FFS error rate;<sup>4</sup> 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 RECOMMENDATIONS**

We obtained additional documentation that enabled the CERT review contractor to overturn, or partially overturn, its claim payment denials for 46 of 136 claims (approximately 34 percent). The CERT review contractor overturned its claim payment denials because it determined that the additional medical records that we obtained were sufficient to show that the services or items billed were medically necessary. The CERT documentation contractor did not initially obtain all the necessary documentation for these 46 claims because it did not always (1) contact referring providers directly to obtain documentation to support the medical necessity of billing providers' claims, (2) redirect followup documentation requests to compliance or reimbursement personnel, or (3) seek signature attestations when signatures on clinicians' notes were illegible or were missing.

For the remaining 90 claims, the CERT review contractor upheld its denials because providers did not produce requested documentation or the review contractor determined that the documentation we obtained did not sufficiently support the medical necessity of the claims. We determined that 5 of the 90 claims may have involved billing fraud. We referred these claims to the Office of Inspector General (OIG), Office of Investigations (OI).

Although the CERT documentation contractor has a rigorous record-collection process, additional efforts to obtain missing documentation could more clearly reflect the true status of improper payments in the national Medicare FFS error rate estimate. Based on our results, the CERT statistical contractor estimated that additional documentation to overturn claim payment denials would have reduced the FY 2010 error rate estimate from 10.5 percent to 10.2 percent, which would have reduced the estimate of improper payments by approximately \$956 million.<sup>5</sup>

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<sup>4</sup> The CERT statistical contractor recalculated the error rate estimate using the revised overpayment amounts.

<sup>5</sup> Because of OIG's statutory authority, some providers may have been more responsive to our requests for documentation than they would have been to similar requests from the CERT documentation contractor.

## DENIALS OVERTURNED

The CERT review contractor overturned its denials for 46 claims because the medical records we obtained were sufficient to allow it to conclude that the services or items billed were medically necessary.<sup>6</sup> For example:

- For a hospital inpatient claim for the treatment of a postoperative infection, we contacted the referring provider to obtain the physician's order for scheduled intravenous medications. We gave the CERT review contractor this documentation. Using this new information, the review contractor overturned its denial of \$20,332.
- For a durable medical equipment (DME) supplier's claim for a prosthetic limb, we contacted the referring provider to obtain the ordering physician's clinical documentation that included the patient's functional abilities, history of prior prosthetic use, the patient's desire to walk, and the clinical assessment of the patient's rehabilitation potential. We gave the CERT review contractor this documentation. Using this new information, the review contractor determined that the claim was reasonable and necessary and overturned its denial of \$3,716.
- For a hospital outpatient claim for chemotherapy drugs, we provided the CERT review contractor with the physician's order. After several unsuccessful attempts to obtain the physician's order from the hospital's medical records department, we redirected our request to the reimbursement manager, who provided the physician's order. Using this new information, the review contractor determined that 17 of 23 lines of service on the claim were reasonable and necessary and overturned \$2,399 of its denial of \$2,762.
- For a physician claim for a chest procedure, we provided the CERT review contractor with a signature attestation that the medical record entry for the date of service accurately reflected the physician's signature made in his capacity as a medical doctor. Using this new information, the review contractor overturned its denial of \$1,476.

The CERT documentation contractor did not obtain these records because it did not always:

- contact referring providers directly to obtain documentation to support the medical necessity of billing providers' claims,
- redirect followup documentation requests to compliance or reimbursement personnel, or
- seek signature attestations when signatures on clinicians' notes were illegible or were missing.<sup>7</sup>

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<sup>6</sup> For 30 claims, the CERT review contractor changed initial claim payment denials to full payments. For the remaining 16 claims, the review contractor changed initial claim payment denials to partial payments.

<sup>7</sup> According to CMS, the CERT documentation contractor attempted to obtain all of the attestations for claims denied based on missing signatures, but the contractor was unable to obtain all attestations within the allowed period because of time constraints.

## **DENIALS UPHELD**

The CERT review contractor upheld its denials for 90 claims because providers did not produce requested documentation or the review contractor determined that the documentation did not sufficiently support the medical necessity of the claims. For example:

- For a hospital inpatient claim for a urinary tract infection, we provided the CERT review contractor with the patient's history and physical, an emergency department assessment, a patient care form documenting the patient's interhospital transport, and other records. However, the review contractor upheld its denial because the physician's admission order for inpatient care was missing, and we could not obtain it.
- For a hospital inpatient psychiatric facility claim for the treatment of substance abuse, we provided the CERT review contractor with the entire medical record, including documentation on the hospital admission, any evaluation reports, and the patient's progress. However, the review contractor determined that the records showed the inpatient hospital admission was not required because the beneficiary was stable. Pursuant to section 1862(a)(1)(A) of the Social Security Act and 42 CFR §§ 412.27(a) and 482.61, the review contractor reclassified this improper payment from "insufficient documentation" to a "medically unnecessary" inpatient admission because patient care could have been provided on an outpatient basis.

## **REFERRALS OF POTENTIAL FRAUD**

Of the 90 claim payment denials that were upheld by the review contractor, we determined that 5 may have involved billing fraud. For three of these claims, we determined the potential fraud through unannounced visits to the offices of the billing suppliers and ordering physicians. We could not locate these suppliers at their last known addresses or elsewhere. The physicians either had no record of these beneficiaries or stated that they did not order the items billed by the suppliers. For one claim, the physician identified as the ordering physician stated that he did not order the DME supplies. For another claim, the owner of a DME company that we were unable to contact had already been charged with health care fraud. We referred these claims to OI. The CERT documentation contractor did not have reason to suspect these five claims were potentially fraudulent because the suppliers provided requested documentation.

## **ADDITIONAL EFFORTS COULD REDUCE ERROR RATE**

Although the CERT documentation contractor has a rigorous record-collection process, additional efforts to obtain missing documentation could more clearly reflect the true status of improper payments in the national Medicare FFS error rate estimate. Our additional efforts included (1) contacting referring providers directly to obtain documentation to support the medical necessity of billing providers' claims, (2) redirecting followup documentation requests to compliance or reimbursement personnel, or (3) seeking signature attestations when signatures on clinicians' notes were illegible or were missing.

The CERT statistical contractor recalculated the FY 2010 error rate based on the 46 overturned claims payment denials. The revised error rate was 10.2 percent, reducing the error rate by 0.3 percent and the estimate of improper payments by approximately \$956 million.

## **RECOMMENDATIONS**

We recommend that CMS:

- continue to educate providers on the documentation requirements needed to support the medical necessity of services and items billed to Medicare;
- assess the improper payments identified by the CERT review contractor and the overturned denials of claim payments noted in this report to identify the population of claim payment denials that would benefit from additional requests for medical records; and
- ensure that the CERT documentation contractor follows established procedures in seeking signature attestations when signatures on clinicians' notes are illegible or are missing and clarify existing procedures, including:
  - contacting referring providers directly to obtain documentation, when applicable, to support the medical necessity of billing providers' claims and
  - redirecting followup documentation requests, when necessary, to compliance or reimbursement personnel.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In written comments on our draft report, CMS neither agreed nor disagreed with our first recommendation and did not agree with our second and third recommendations.

Regarding our first recommendation, CMS stated that it conducts many activities to educate providers on Medicare documentation requirements. CMS disagreed with our second recommendation to identify the population of claims that would benefit from additional requests for medical records. CMS stated that throughout 2011, it had intensified efforts to obtain documentation for claims that have the greatest impact on the error rate, and it plans to continue improving this process. With regard to our third recommendation, CMS stated that it "disagrees that additional contractor monitoring activities are necessary." According to CMS, the documentation contractor consistently follows the guidelines and practice standards in its statement of work. However, CMS stated that it is conducting an independent verification and validation of the CERT internal processes, including a detailed review of the documentation contractor's processes to improve its rate of success.

In addition, CMS provided technical comments, which we addressed in this report as appropriate. CMS's comments, excluding its technical comments, are included as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Regarding CMS's comments on our first recommendation, we acknowledge CMS's efforts to educate providers on Medicare documentation requirements. However, for more than one-third of the claims in our review, we were able to obtain additional and necessary medical records that the CERT documentation contractor did not obtain. Therefore, we encourage CMS to continue its efforts to educate providers on the documentation requirements needed to support the medical necessity of services and items billed to Medicare.

Regarding CMS's comments on our second recommendation, we continue to recommend that CMS assess the improper payments identified by the CERT review contractor and the overturned claim payment denials noted in this report to identify the population of claim payment denials that would benefit from additional requests for medical records. Analyzing claim payment denials would enhance CMS's efforts to focus on claims that have the greatest impact on the error rate.

Regarding CMS's comments on our third recommendation, the CERT documentation contractor did not always take steps to obtain missing documentation, including signature attestations. Therefore, we continue to recommend that CMS ensure that the CERT documentation contractor follow established procedures for seeking attestations and clarify existing procedures on contacting referring providers and redirecting followup documentation requests to compliance or reimbursement personnel.

# **APPENDIX**

**APPENDIX: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

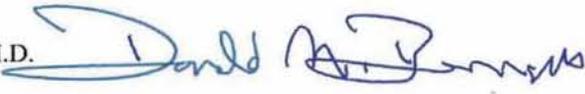
DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** NOV 23 2011

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

**FROM:** Donald M. Berwick, M.D.   
Administrator

**SUBJECT:** Office of Inspector General (OIG) Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 Comprehensive Error Rate Testing Program (A-01-11-00502)

Thank you for the opportunity to review and comment on this OIG pilot project. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG invested in determining that additional documentation is available to overturn many claim payment denials, which may ultimately reduce the incidence of improper payments in the Medicare Fee for Service (FFS) program and result in a more accurate calculation of the error rate. In this particular study, the OIG was able to obtain additional documentation that enabled the Comprehensive Error Rate Testing (CERT) review contractor to partially, or completely, overturn 34 percent of the 136 claims sampled. CMS is committed to reporting an accurate estimate of improper payments and continuously looked for ways to improve the error rate measurement processes. We recognize the importance of obtaining all available medical record documentation when making improper payment determinations. In fact, prior to the receipt of the OIG recommendations, CMS had already implemented the activities recommended by the OIG as part of our ongoing process improvements. We look forward to continuing work with the OIG to decrease improper payments and more accurately reflect the incidence of improper payments in the Medicare FFS program.

We reviewed the report and our responses to your recommendations are below.

**OIG Recommendation**

Continue to educate providers on the documentation requirements needed to support the medical necessity of services and items billed to Medicare.

**CMS Response**

The CMS currently conducts many activities to educate providers on the Medicare documentation requirements. First, CMS publishes quarterly Provider Compliance Newsletters, located at

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[http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf). CMS began publishing this newsletter in October 2010. Second, CMS distributes Comparative Billing Reports (CBRs) to a select number of providers in designated specialties. The goal of the CBR is to show providers what their billing patterns are in comparison to their peers and to help providers identify potential errors in their billing practice. Third, CMS conducts regular provider outreach calls nationally and within Medicare claims processing contractor local areas. Fourth, Medicare claims processing contractors regularly publish articles on Local Coverage Determination policies and present information regarding the CERT program and documentation requirements on their websites.

Many insufficient documentation errors are due to situations where the provider who submits a claim for an item or service is not the ordering or referring physician (e.g., durable medical equipment (DME) or laboratory services). It is often a challenge to obtain proper medical record documentation from the medical professional who ordered the item or service since it is not their payment that is under review. CMS implemented a process to notify the ordering physician when one of these items or services is selected for CERT review. The notification reminds physicians of their responsibility to maintain documentation of medical necessity and submit requested documentation. In addition, CMS is educating physicians on documentation requirements for DME and laboratory services.

#### **OIG Recommendation**

Assess the improper payments identified by the CERT review contractor and the overturned denials of claim payments identified in this report to identify the population of claim payment denials that would benefit from additional requests for medical records.

#### **CMS Response**

The CMS respectfully disagrees that this process is necessary to identify the population of claims CMS will focus on for additional documentation requests. In 2010, CMS established a process to make additional calls to secure documentation from providers and suppliers. Throughout 2011, CMS continued this effort and refined it to focus on claims that have the greatest impact on the error rate. We believe this refined process makes the best use of CMS and contractor resources. CMS has been successful in obtaining additional documentation and we plan to continue and improve this process.

#### **OIG Recommendation**

Ensure that the CERT documentation contractor follows established procedures in seeking signature attestations when signatures on clinicians' notes are illegible or are missing and clarify existing procedures, including: contacting referring providers directly to obtain documentation, when applicable, to support the medical necessity of billing providers' claims and redirecting follow up documentation requests, when necessary, to compliance or reimbursement personnel.

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**CMS Response**

The CMS respectfully disagrees that additional contractor monitoring activities are necessary. The CMS established processes to continuously monitor the CERT contractors' activities. We found that the CERT documentation contractor consistently follows the guidelines and practice standards within its statement of work. In addition, we closely monitor the documentation contractor through monthly onsite visits and weekly status meetings. Lastly, we are currently conducting an independent verification and validation of the CERT internal processes, which includes a detailed review of the documentation contractor's processes. We will continue to monitor its process and make suggestions to improve its rate of success.