DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

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

FROM: Dennis J. Duquette
Deputy Inspector General for Audit Services

SUBJECT: Oversight and Evaluation of the Fiscal Year 2003 Hospital Payment Monitoring Program (A-03-03-00015)

Attached is a copy of our final report on the results of our oversight and evaluation of the Hospital Payment Monitoring Program (HPMP). The Centers for Medicare & Medicaid Services (CMS) developed the HPMP to establish the Medicare fee-for-service paid claims error rate for inpatient acute care hospital services on a State and national level and to provide statistical and administrative data for use in reducing improper admissions and payments.

As part of the HPMP, CMS hired two contractors (AdvanceMed and DynKePRO), called Clinical Data Abstraction Centers (CDACs), to screen the medical records for inpatient acute care paid claims. For a sample of claims, the CDACs screened the inpatient admissions for medical necessity and determined whether the claims identified the appropriate diagnoses and procedures and were accurately coded. The Quality Improvement Organizations (QIOs) reviewed claims that failed the CDAC process, as well as a sample of claims that passed.

Our objectives were to determine whether (1) the CDACs followed established HPMP error rate review policies and procedures and (2) the HPMP internal quality control process ensured the reliability of the CDAC claims review process.

Our review of 90 inpatient hospital claims found that the CDACs generally followed established policies and procedures. In addition, our review of 45 claims subject to the HPMP internal quality control process showed that controls were generally operating effectively. However, we noted the following procedural problems:

- For 2 of the 90 sampled claims, one CDAC did not send followup letters requesting medical records. Under HPMP procedures, the CDACs were to send followup requests if they did not receive medical records within 15 days of the initial request. Despite the lack of followup, the providers submitted the medical records within 30 days of the initial request.

- For 1 of the 45 claims subject to quality control reviews, a quality control procedure was not followed. The two CDACs differed on the allowability of this hospital admission. Consistent with HPMP review procedures, the CDAC that failed the admission sent the claim to the QIO for additional review. However, CMS did not clarify to the CDACs the final medical determination on this case. This clarification is necessary to ensure consistency in future screening decisions.

We recommended that CMS:

- direct the CDACs to send followup requests for medical records when they do not receive the records within the established 15 days and

- promptly clarify to the CDACs the final determinations on opposing medical screening decisions.

If you have any questions, please contact me or your staff may call Joseph Vengrin, Assistant Inspector General for Financial Management Audits, at (410) 786-7103. To facilitate identification, please refer to report number A-03-03-00015 in all correspondence.

Attachment

cc:
Medicare Program Integrity Group, CMS

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2003 HOSPITAL PAYMENT MONITORING PROGRAM

November 2003
A-03-03-00015

Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the Hospital Payment Monitoring Program (HPMP) to establish the Medicare fee-for-service paid claims error rate for inpatient acute care hospital services on a State and national level and to provide statistical and administrative data for use in reducing improper admissions and payments.

As part of the HPMP, CMS hired two contractors, called Clinical Data Abstraction Centers (CDACs), to screen medical charts for inpatient acute care paid claims. For a sample of claims, the CDACs screened the inpatient admissions for medical necessity and determined whether the claims identified the appropriate diagnoses and procedures and were accurately coded. The Quality Improvement Organizations (QIOs) reviewed claims that failed the CDAC screening process, as well as a sample of claims that passed.

OBJECTIVES

Our objectives were to determine whether (1) the CDACs followed established HPMP error rate review policies and procedures and (2) the HPMP internal quality control process ensured the reliability of the CDAC claims review process.

SUMMARY OF FINDINGS

Our review of 90 inpatient acute care hospital claims found that the CDACs generally followed established HPMP error rate review policies and procedures. In addition, our review of 45 claims subject to the HPMP internal quality control process showed that controls were generally operating effectively. However, we noted the following procedural problems:

- For 2 of the 90 sampled claims, one CDAC did not send followup letters requesting medical records. Under HPMP procedures, the CDACs were to send followup requests if they did not receive medical records within 15 days of the initial request. Despite the lack of followup, the providers submitted the medical records within 30 days of the initial request.

- For 1 of the 45 claims subject to quality control reviews, a quality control procedure was not followed. The two CDACs differed on the medical necessity of this hospital admission. Consistent with HPMP review procedures, the CDAC that failed the admission sent the claim to the QIO for additional review. However, CMS did not clarify to the CDACs the final medical determination on this case. This clarification is necessary to ensure consistency in future screening decisions.

RECOMMENDATIONS

We recommend that CMS:

- direct the CDACs to send followup requests for medical records when they do not receive the records within the established 15 days and

- promptly clarify to the CDACs the final determinations on opposing medical screening decisions.

TABLE OF CONTENTS

LIST OF ACRONYMS

CDAC	Clinical Data Abstraction Center
CMS	Centers for Medicare & Medicaid Services
DRG	diagnosis-related group
FY	fiscal year
HPMP	Hospital Payment Monitoring Program
OIG	Office of Inspector General
QIO	Quality Improvement Organization

INTRODUCTION

BACKGROUND

Medicare Program

Medicare, established by title XVIII of the Social Security Act, as amended, is a broad health insurance program that covers persons 65 years of age and older, along with those under 65 who are disabled or who have end stage renal disease. CMS administers the program.

Medicare Error Rate

The Office of Inspector General (OIG) initiated annual Medicare fee-for-service paid claims error rate reviews in fiscal year (FY) 1996 because a preliminary assessment identified Medicare benefit payments as a high-risk area. That assessment was based on the complexity of CMS's policies and reimbursement systems, the decentralized structure of the Medicare program, and reported instances of fraud and abuse.

The purpose of OIG's error rate reviews was to determine whether Medicare benefit payments were made in accordance with the provisions of title XVIII and, specifically, whether services were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

In FY 2000, in response to an OIG recommendation to develop its own error rate process, CMS initiated two programs. The HPMP, which is the subject of this report, was established to produce an error rate for inpatient acute care hospital claims.[1] The Comprehensive Error Rate Testing program, the subject of another OIG report (A-03-03-00014), was developed to produce an error rate for all other provider claims. When aggregated, these error rates produce an overall Medicare fee-for-service paid claims error rate similar to the one developed by OIG. Beginning in FY 2003, CMS assumed responsibility for error rate development.

Hospital Payment Monitoring Program

The goals of HPMP are to establish the Medicare paid claims error rate for inpatient acute care hospitals on a State and national level and to provide statistical and administrative data for use in reducing improper admissions and payments.
Each month, CMS provides a sample of several thousand claims to its CDACs (DynKePRO and AdvanceMed) to screen medical charts for inpatient acute care paid claims. The CDACs obtain

[1] Before August 2002, HPMP was known as the Payment Error Prevention Program.

the related medical records from the health care providers and perform an admission-necessity screening and a diagnosis-related group (DRG) validation screening for Medicare discharges.

- During the admission-necessity process, nonphysician medical personnel use standardized, commercially available, clinical decision software to screen the first 24 hours of the medical records. This software contains measurable clinical indicators to assess the appropriateness of hospitalization.

- During the DRG validation process, coding specialists review diagnostic and procedural information and the discharge status shown in the medical records to determine the appropriate DRG. For Maryland claims, the coding specialists perform length-of-stay reviews because those claims are not paid based on DRGs.

Claims that fail one or both of the CDAC screenings are forwarded to the Quality Improvement Organizations (QIOs) for a complete review and final determination. The QIOs also review a 10-percent quality control sample of claims for which the CDAC screenings found no errors. For each claim reviewed, the QIO evaluates the medical necessity, quality, and appropriateness of services provided using professionally developed criteria on providing care, diagnosis, and treatment. If it identifies an error in the inpatient admission or treatment, the QIO notifies the fiscal intermediary to make a financial adjustment to the claim reimbursement.

As part of the HPMP quality control process, each CDAC selects a quarterly sample of 30 claims for review by the other CDAC. The CDACs compare their individual results and, if they agree, close the claim. If they do not reach agreement, CMS, in coordination with the two CDACs, makes the final determination.

To calculate the Medicare inpatient paid claims error rate, CMS collates and analyzes the data collected by the CDACs and the QIOs.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether**:**

- the CDACs followed established HPMP error rate review policies and procedures and

- the HPMP internal quality control process ensured the reliability of the CDAC claims review process.

Scope and Methodology

We did not assess the complete internal control structures at the CDACs, nor did we independently evaluate the medical screening decisions. Also, the scope of this review did not include testing the statistical reliability of the Medicare paid claims error rate calculated through the HPMP process.

To accomplish our objectives, we:

- reviewed the policies and procedures related to the HPMP review process,
- interviewed CDAC personnel at DynKePRO and AdvanceMed and performed limited testing of internal controls at both CDACs, and
- reviewed and analyzed supporting decisionmaking documentation for claims we selected for detailed review.

We performed our review from March to October 2003 at DynKePRO in York, PA; AdvanceMed in Columbia, MD; and CMS headquarters in Baltimore, MD. We conducted our audit in accordance with generally accepted government auditing standards.

Screening Process Samples

We selected two random discovery samples of 45 claims each to test and evaluate the reliability of the CDACs' screenings of inpatient acute care claims submitted by hospitals. The samples included claims with discharge dates from January 1 to June 30, 2002. For the first sample of 45 claims, only the CDACs screened the claims. For the second sample of 45 claims, the CDACs determined that the claims were potentially invalid and required further review by the QIO.

We reviewed the documentation maintained in the CDAC internal tracking system, including data on the timeliness of followup requests for medical records and on medical screening decisions. We reviewed the medical records to ensure that CDAC personnel conducted the admission-necessity screening and the DRG validation screening for each claim sampled. We also reviewed the documentation supporting the length-of-stay reviews performed by the CDACs for non-DRG hospital claims in Maryland.

For the 45 claims sent to the QIO for review, the medical records were not available at the CDACs for our review. Consequently, we reviewed available documentation from the CDAC tracking system and verified that the CDACs had forwarded the claims to the QIO for an independent review. We later obtained the medical records from the QIO.

Internal Quality Control Review Sample

We selected a third random discovery sample of 45 claims for which the CDACs performed an internal quality control review from July 1 to December 31, 2002. We compared the results of the CDAC quality control reviews to determine whether the results of the original review and the quality assurance review agreed and whether differences were resolved.

FINDINGS AND RECOMMENDATIONS

Our review of 90 inpatient acute care hospital claims found that the CDACs generally followed established HPMP error rate review policies and procedures. In addition, our review of 45 claims subject to the HPMP internal quality control process showed that controls were generally operating effectively to ensure the reliability of the HPMP claims review process and the consistency of medical screening decisions. However, we noted two problems, discussed below, concerning the timeliness of requests for medical records and the quality control procedures for reviewing medical screening decisions.

REQUESTS FOR MEDICAL RECORDS

Under HPMP procedures, the CDACs were to send the initial request for medical records to the provider within 5 business days after receiving the sample claims from CMS. If the provider did not submit the medical records within 15 days of the date of the initial request, the CDACs were to send a followup request.

For 2 of the 90 sampled claims, one CDAC did not send followup letters. Despite the lack of followup, the providers submitted the medical records within 30 days of the original request, and the CDAC was able to review those claims in a timely manner. During our review, the CDAC determined that an employee's data entry error had caused the problem and took steps to resolve it.

QUALITY CONTROL PROCEDURES

The HPMP internal quality control process called for CMS, in coordination with the CDACs, to resolve any medical screening decisions disputed by the CDACs. However, this procedure was not followed for 1 of the 45 claims we reviewed. For that claim, the two CDACs disagreed on the necessity of a hospital admission. Consistent with HPMP review procedures, the CDAC that questioned the admission sent the claim to the QIO for additional review. The QIO then made the final medical determination. Although there was internal discussion within CMS and the CDACs, CMS did not clarify to the CDACs the final medical determination. This clarification is necessary to ensure consistency in future medical screening decisions.

RECOMMENDATIONS

We recommend that CMS:

- direct the CDACs to send followup requests for medical records when they do not receive the records within the established 15 days and

- promptly clarify to the CDACs the final determinations on opposing medical screening decisions.

CMS COMMENTS

To expedite the processing of this report, we obtained oral comments from CMS officials. These officials agreed with our findings and recommendations. Their comments have been incorporated in this report where appropriate.

ACKNOWLEDGEMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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