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

**SUBJECT:** Oversight and Evaluation of the Fiscal Year 2004 Comprehensive Error Rate Testing Program (A-03-04-00007)

Attached is a copy of our final report on the results of our oversight and evaluation of the fiscal year (FY) 2004 Comprehensive Error Rate Testing (CERT) program. The Centers for Medicare & Medicaid Services (CMS) developed CERT primarily to establish the Medicare fee-for-service paid claims error rate for all types of Medicare services other than inpatient acute care hospital services. The CMS includes the results of the CERT program in its annual report on erroneous payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

The CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a tracking and reporting database and system. The CERT contractor is responsible for obtaining information from health care providers and the affiliated contractors (fiscal intermediaries, carriers, and durable medical equipment regional carriers) to determine whether the affiliated contractors have met CMS's goal of paying Medicare claims correctly.

Our objectives were to determine whether (1) the CERT contractor had appropriate controls to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported and (2) the CERT quality assurance program ensured the reliability of the claims review process.

The CERT contractor generally had appropriate controls to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported. However, we found two instances in which the contractor did not perform procedures timely. Despite the lack of timeliness, the CERT contractor identified those problems, took corrective action, and completed the review and the Medicare error rate calculations by the required due date.

The quality assurance program did not provide full assurance of the reliability of the claims review process. The CERT contractor completed only 984 of the required 2,587 FY 2004 quality assurance reviews by July 30, 2004. Personnel from CERT stated that because of an overwhelming backlog of initial medical record reviews, management reallocated resources to complete those reviews and delayed the completion of the required quality assurance reviews.

We identified a similar problem with the quality assurance program during our FY 2003 CERT review.

We recommend that CMS direct the CERT contractor to schedule and complete the required number of quality assurance reviews throughout the year.

In informal comments on a draft of this report, CMS officials agreed with the audit results and the recommendation.

If you have any questions, please contact me, or your staff may call David M. Long, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at david.long@oig.hhs.gov. Please refer to report number A-03-04-00007 in all correspondence.

Attachment

cc:
Ms. Kimberly Brandt

**Department of Health and Human Services**

**OFFICE OF INSPECTOR GENERAL**

# OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2004 COMPREHENSIVE ERROR RATE TESTING PROGRAM


**November 2004**
**A-03-04-00007**

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# EXECUTIVE SUMMARY

## BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the Comprehensive Error Rate Testing (CERT) program primarily to establish the Medicare fee-for-service paid claims error rate for all types of Medicare services other than inpatient acute care hospital services. The CMS includes the results of the CERT program in its annual report on erroneous payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

The CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a tracking and reporting database and system. The CERT contractor is responsible for obtaining information from health care providers and the affiliated contractors (fiscal intermediaries, carriers, and durable medical equipment regional carriers) to determine whether the affiliated contractors have met CMS's goal of paying Medicare claims correctly.

## OBJECTIVES

Our objectives were to determine whether (1) the CERT contractor had appropriate controls to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported and (2) the CERT quality assurance program ensured the reliability of the claims review process.

## SUMMARY OF RESULTS

The CERT contractor generally had appropriate controls to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported. However, we found two instances in which the contractor did not perform procedures timely. Despite the lack of timeliness, the CERT contractor identified those problems, took corrective action, and completed the review and the Medicare error rate calculations by the required due date.

The quality assurance program did not provide full assurance of the reliability of the claims review process. The CERT contractor completed only 984 of the required 2,587 fiscal year (FY) 2004 quality assurance reviews by July 30, 2004. Personnel from CERT stated that because of an overwhelming backlog of initial medical record reviews, management reallocated resources to complete those reviews and delayed the completion of the required quality assurance reviews. We identified a similar problem with the quality assurance program during our FY 2003 CERT review.

## RECOMMENDATION

We recommend that CMS direct the CERT contractor to schedule and complete the required number of quality assurance reviews throughout the year.

## CMS COMMENTS

In informal comments on a draft of this report, CMS officials agreed with the audit results and the recommendation.

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# 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. The CMS administers the program.

### Medicare Error Rate

In FY 2000, CMS initiated two programs to develop a fee-for-service Medicare error rate. The CERT program, which is the subject of this report, was established to produce an error rate for all provider claims other than inpatient acute care hospital claims. The Hospital Payment Monitoring Program, the subject of another Office of Inspector General (OIG) report (A-03-04-00008), was established to produce an error rate for inpatient acute care hospitals. When aggregated, those error rates produce an overall Medicare fee-for-service paid claims error rate similar to the one previously developed by OIG.

Using the results of its error rate programs, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims in accordance with the Improper Payments Information Act of 2002.

### Comprehensive Error Rate Testing Program

The CERT program is designed to determine the underlying reasons for claim errors and to develop appropriate action plans to improve compliance with payment, claims processing, and provider billing requirements. CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a tracking and reporting database system.

Each year, the CERT contractor reviews the medical records for approximately 120,000 claims processed by the affiliated contractors. The CERT contractor randomly selects about 200 claims from each affiliated contractor each month. For the sampled items, the CERT contractor requests medical records from providers and the affililiated contractors. If a provider fails to respond to the initial request within 19 days, the CERT contractor makes a series of followup phone calls and letter requests.

In reviewing claims and medical records, the CERT contractor follows Medicare regulations, national coverage decisions, coverage provisions in interpretive manuals, and affiliated contractor local medical review policies and articles. In the absence of written policies or articles, the CERT medical review specialists apply their clinical expertise.

Each month, the CERT quality assurance program selects and reviews a random sample of 200 claims for which medical review specialists found no errors and an additional 10 percent random

sample of claims for which medical review specialists found errors. Quality assurance reviews are intended to help assure management that medical review decisions were accurate and consistent and that medical review results were documented in accordance with CERT procedures.

### Prior Audit Coverage

The CERT program has been the subject of several OIG audits since CMS assumed responsibility for producing the Medicare error rate. The appendix of this report identifies those audits and summarizes the results and recommendations.

## OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

Our objectives were to determine whether:

- the CERT contractor had appropriate controls to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported and

- the CERT quality assurance program ensured the reliability of the claims review process.

### Scope and Methodology

To accomplish our objectives, we reviewed CMS policies and procedures related to the CERT review process, interviewed CMS and CERT contractor personnel, and performed limited testing of internal controls. We did not assess all internal controls at the CERT contractor, nor did we independently evaluate the medical review decisions.

Our review of controls was limited to observing selected aspects of the CERT medical review and reporting process, including information in the CERT database and the medical records used to support review decisions. We reviewed system reports and control logs and physically observed procedures and practices.

Our review was limited to selecting a random sample of 45 claims reviewed by medical review specialists and selected for quality assurance reviews. Providers submitted those claims during calendar year 2003. We reviewed compliance with established policies and procedures, including the documentation supporting both review decisions.

We performed our review from December 2003 to October 2004 at CMS headquarters in Baltimore, MD; CERT headquarters in Richmond, VA; and the CERT Operations Center in Baltimore.

We conducted our audit in accordance with generally accepted government auditing standards.

## RESULTS OF REVIEW

### MEDICAL RECORD REVIEWS

The CERT contractor generally had appropriate controls to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported. However, we found two instances in which the contractor did not perform procedures timely. Despite the lack of timeliness, the CERT contractor identified those problems, took corrective action, and completed the review and the Medicare error rate calculations by the required due date.

- Early in calendar year 2004, the CERT contractor temporarily lost accountability for 2,228 claims by either physically misplacing medical records or not performing the appropriate medical record request followups. Later in the year, the contractor found the records or made followup requests and completed the medical reviews in time for the results to be included in the Medicare error rate.

- Under the terms of the contract, the CERT contractor was required to establish a Web site for affiliated contractors to report the results of sampled claims adjudicated by the formal appeals process. The contract called for completing the site by November 2003 (subsequently extended to February 2004). Although the CERT contractor did not establish the Web site until September 2004, the delay did not affect the calculation of the FY 2004 error rate. CMS informed us that the CERT contractor had included the results of adjudicated claims in the final Medicare error rate.

### QUALITY ASSURANCE PROGRAM

The quality assurance program did not provide full assurance of the reliability of the claims review process. Under the terms of its contract, the CERT contractor was required to review (1) a random sample of 200 claims each month that passed the initial medical reviews and (2) a random sample of 10 percent of the claims that did not pass the medical reviews. For FY 2004, the CERT contractor was required to complete 2,587 quality assurance reviews by July 30, 2004.

The CERT contractor completed only 984 of the required 2,587 quality assurance reviews by July 30, 2004. We selected a sample of 45 of the 2,587 claims selected for quality assurance reviews to assess the medical review results. Only 5 of the 45 claims had been subjected to a quality assurance review. The results of the five quality assurance reviews confirmed the results of the initial medical reviews.

Personnel from CERT stated that because of an overwhelming backlog of initial medical reviews, management reallocated resources to complete those reviews and delayed the completion of the required quality assurance reviews. As a result, the CERT contractor and CMS did not have full assurance that the medical review process was accurate, consistently performed, and adequately documented and that medical reviewers received timely feedback on the results. As noted in the appendix, we reported a similar problem with quality assurance reviews in our FY 2003 CERT report (A-03-03-00014).

## RECOMMENDATION

We recommend that CMS direct the CERT contractor to schedule and complete the required number of quality assurance reviews throughout the year.

## CMS COMMENTS

To expedite the processing of this report, we obtained informal comments from CMS officials. The officials agreed with the audit results and the recommendation. They stated that they had awarded a second CERT contract, which should reduce the current contractor's workload, and that both CERT contracts require comprehensive monthly reporting on quality assurance activities.

# APPENDIX

## PRIOR REPORTS

### "OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2003 COMPREHENSIVE ERROR RATE TESTING PROGRAM" (A-03-03-00014, NOV. 10, 2003)

The CERT contractor generally followed established policies and procedures for 99 of the 105 FY 2003 claims reviewed. However, the medical records for six claims were never received, and letters requesting medical records were often sent late. In addition, the CERT contractor had not performed quality assurance reviews for 22 of another 45 claims sampled, and the results of those reviews that were performed were not shared with medical review specialists.

We recommended that CMS direct the CERT contractor to:

- send requests for medical records, including followup requests, in accordance with established time schedules and

- complete all required quality assurance reviews and use the results to provide feedback and training to medical reviewers.

### "REVIEW OF CORRECTIVE ACTIONS TO IMPROVE THE COMPREHENSIVE ERROR RATE TESTING PROCESS FOR OBTAINING MEDICAL RECORDS" (A-03-04-00005, JUNE 2, 2004)

The CMS implemented several corrective actions to improve the FY 2004 CERT process for obtaining medical records, including affiliated contractor education and participation in contacting nonresponders, revised medical record request letters, improved procedures for contacting providers, and an Internet-based claims tracking system.

Those actions appeared to have increased providers' responsiveness to requests for medical records. Provider nonresponses as of April 8, 2004, represented about 2 percent of the total number and 3 percent of the total dollar value of claims selected for the FY 2004 error rate sample, compared with about 8 percent of the claims and about 7 percent of the dollar value for FY 2003. However, as of the same date, providers had failed to submit medical records for 2,239 of the 126,618 claims in the FY 2004 sample, even though CERT personnel sent 4 request letters and made 3 telephone contacts to each provider.

We did not make any recommendations because the effects of the corrective actions were still relatively new.

**"REVIEW OF PROVIDERS' RESPONSIVENESS TO REQUESTS FOR MEDICAL RECORDS UNDER THE COMPREHENSIVE ERROR RATE TESTING PROGRAM" (A-01-04-00517, SEPT. 29, 2004)**

For 505 claims that the CERT contractor considered as nonresponses during FY 2004, providers told us that they did not receive the request letters, had already provided the requested documentation, did not have direct access to medical records that were maintained at another location, or had other reasons for the nonresponses. Some providers stated that the request letters were sent to incorrect addresses, and others said that the letters were not forwarded to the appropriate people or departments. Despite this problem, we believe that subsequent telephone contacts by the CERT contractor should have elicited responses from these providers. Because the CERT contractor did not thoroughly document the results of phone calls, we were unable to determine whether the CERT contractor made the required calls.

The lack of sufficient facsimile machines may have contributed to the initial provider nonresponse problem experienced early in FY 2004. Further, the CERT contractor did not have controls to ensure that all received facsimile medical records were logged in the control system.

We concluded that CMS's diligence in obtaining medical records had reduced the nonresponse rate to less than 1 percent of the number and dollar value of claims included in the sample and that the remaining nonresponses would not have a significant impact on the reliability of CMS's estimate of the FY 2004 Medicare error rate. Nevertheless, we made several recommendations that will allow CMS to further enhance its process for ensuring that records are received timely.

# ACKNOWLEDGMENTS

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

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