NOV 10 2005

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 2005 Comprehensive Error Rate Testing Program (A-03-05-00006)

The attached final report provides the results of our oversight and evaluation of the fiscal year (FY) 2005 Comprehensive Error Rate Testing (CERT) program. The Centers for Medicare & Medicaid Services (CMS) developed the CERT program primarily to establish the Medicare fee-for-service paid claims error rate for all types of services other than inpatient short term acute-care and long term care hospital services. The Hospital Payment Monitoring Program (HPMP) was established to produce an error rate for inpatient acute care hospital claims. When aggregated, those error rates produce an overall Medicare fee-for-service paid claims error rate. CMS includes the error rate results in its annual report on erroneous payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a CERT Tracking and Reporting Database 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, for the FY 2005 error rate, whether (1) CMS and AdvanceMed had appropriate controls to ensure that AdvanceMed followed established procedures in making medical review decisions and adequately maintained, updated, and reported the results of those reviews; (2) CMS and AdvanceMed had implemented a prior recommendation to complete the CERT quality assurance program; and (3) CMS had ensured consistency and coordination of the error rate programs.

A summary of our results follows:

- CMS and AdvanceMed generally had appropriate controls to ensure that AdvanceMed made medical review decisions in accordance with established procedures and that it adequately maintained, updated, and reported the results of those reviews. However, AdvanceMed did not always make follow-up phone calls to providers that did not respond to requests for medical records. We are not making any recommendations on this issue because CMS has contracted with another company to make follow-up requests for the FY 2006 CERT review.

- AdvanceMed had implemented the recommendation from our prior review to improve the completeness of quality assurance reviews. During FY 2005, AdvanceMed completed all 4,325 of the required quality assurance reviews.

- CMS could do more to ensure consistency and coordination of the error rate programs. Sampling periods were not consistent, and management of the programs was decentralized.

We recommend that CMS (1) work to establish CERT and HPMP sample periods that are more consistent with each other and more closely aligned with the FY and (2) consider centralizing the management of the error rate programs under a single office for consistency in methodology and uniformity in reporting.

In its comments on our draft report, CMS concurred with our findings and recommendations.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact 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-03-05-00006 in all correspondence.

Attachments

cc:
Kimberly Brandt
Director, Program Integrity Group

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2005 COMPREHENSIVE ERROR RATE TESTING PROGRAM

Daniel R. Levinson
Inspector General

NOVEMBER 2005
A-03-05-00006

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

In fiscal year (FY) 2000, the Centers for Medicare & Medicaid Services (CMS) initiated two programs to develop a fee-for-service Medicare error rate. The Comprehensive Error Rate Testing (CERT) program, which is the primary subject of this report, was established to produce an error rate for all provider claims other than inpatient acute care hospital claims.[1] The Hospital Payment Monitoring Program (HPMP), the subject of another Office of Inspector General report (A-03-05-00007), was established to produce an error rate for inpatient acute care hospital claims. When aggregated, those error rates produce an overall Medicare fee-for-service paid claims error rate. CMS includes the results of these programs in its annual report on erroneous payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

For the FY 2005 error rate, CMS contracted with AdvanceMed to serve as the CERT contractor, to operate the CERT Operations Center, and to develop a CERT Tracking and Reporting Database 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.

For the FY 2006 error rate, CMS contracted with AdvanceMed to continue as the CERT review contractor and with Livanta to become the CERT documentation contractor. AdvanceMed would continue to perform all medical reviews and document the results of those reviews. Livanta would request all medical records from providers and affiliated contractors and make follow-up requests.

OBJECTIVES

Our objectives were to determine, for the FY 2005 error rate, whether:

- CMS and AdvanceMed had appropriate controls to ensure that AdvanceMed followed established procedures in making medical review decisions and adequately maintained, updated, and reported the results of those reviews;

- CMS and AdvanceMed had implemented a prior recommendation to complete the CERT quality assurance program; and

- CMS had ensured consistency and coordination of the error rate programs.

[1]Inpatient hospital claims include short term and long term acute-care claims but exclude critical access, psychiatric, and rehabilitation hospital claims.

SUMMARY OF FINDINGS

CMS and AdvanceMed generally had appropriate controls to ensure that AdvanceMed made medical review decisions in accordance with established procedures and that it adequately maintained, updated, and reported the results of those reviews. However, AdvanceMed did not always make follow-up phone calls to providers that did not respond to requests for medical records. We are not making any recommendations on this issue because Livanta, rather than AdvanceMed, is responsible for follow-up requests for the FY 2006 CERT review.

AdvanceMed had implemented the recommendation from our prior review to improve the completeness of quality assurance reviews. During FY 2005, AdvanceMed completed all 4,325 of the required quality assurance reviews.

In addition, CMS could do more to ensure consistency and coordination of the error rate programs. Sampling periods were not consistent, and management of the programs was decentralized.

RECOMMENDATIONS

We recommend that CMS:

- work to establish CERT and HPMP sample periods that are more consistent with each other and more closely aligned with the FY and

- consider centralizing the management of the error rate programs under a single office for consistency in methodology and uniformity in reporting.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S COMMENTS

CMS concurred with the findings and recommendations. CMS's comments are included as an appendix to this report.

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INTRODUCTION

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established Medicare as 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 Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Error Rate

In fiscal year (FY) 2000, CMS initiated two programs to develop a fee-for-service Medicare error rate. The Comprehensive Error Rate Testing (CERT) program, which is the primary subject of this report, was established to produce an error rate for all provider claims other than inpatient acute care hospital claims.[1] The Hospital Payment Monitoring Program (HPMP), the subject of another Office of Inspector General report (A-03-05-00007), was established to produce an error rate for inpatient acute care hospital claims. When aggregated, those error rates produce an overall Medicare fee-for-service paid claims error rate. An error is the difference between the amount that Medicare paid to a provider and the amount that it should have paid.

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 pursuant to the Improper Payments Information Act of 2002 (Public Law 107-300). Implementing guidance from the Office of Management and Budget requires that the Department of Health and Human Services include the estimate in the Performance and Accountability Report for each FY.

Comprehensive Error Rate Testing Program

CMS designed the CERT program 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. The FY 2005 CERT error rate is based on payments for claims submitted to the affiliated contractors (carriers, fiscal intermediaries, and durable medical equipment regional carriers) during calendar year 2004. Each month, the CERT contractor randomly selects for medical review about 200 claims from each affiliated contractor. For the sampled items, the CERT contractor requests medical records from providers and the affiliated contractors. If a provider fails to respond to the initial request within 14 days, the CERT contractor must make a series of follow-up 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

[1]Inpatient hospital claims include short term and long term acute-care claims but exclude critical access, psychiatric, and rehabilitation hospital claims.

contractors' local medical review policies. In the absence of written criteria, the CERT medical review specialists apply their clinical expertise.

CMS requires that the CERT contractor conduct quality assurance reviews to help assure CMS and contractor management that medical review results were accurate, consistent, and documented in accordance with CERT procedures. 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. CMS includes the agreed-upon results of the CERT quality assurance reviews in its CERT error rate calculations.

For the FY 2005 CERT review, CMS contracted with AdvanceMed to operate the CERT Operations Center and to develop a CERT Tracking and Reporting Database System. For the FY 2006 CERT review, AdvanceMed continues as the medical review contractor; however, CMS transferred all functions related to obtaining medical records and making follow-up requests to Livanta. Livanta did not provide any services for the FY 2005 CERT sample.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine, for the FY 2005 error rate, whether:

- CMS and AdvanceMed had appropriate controls to ensure that AdvanceMed followed established procedures in making medical review decisions and adequately maintained, updated, and reported the results of those reviews;

- CMS and AdvanceMed had implemented a prior recommendation to complete the CERT quality assurance program; and

- CMS had ensured consistency and coordination of the error rate programs.

Scope

For the FY 2005 CERT error rate review, CMS selected for review by AdvanceMed 143,263 of the 1,123,620,433 claims submitted by providers during calendar year 2004. Those claims included outpatient hospital, home health, skilled nursing facility, carrier, and medical equipment claims, as well as critical access, psychiatric, and rehabilitation inpatient hospital claims. AdvanceMed selected 4,325 of the 143,263 claims for internal quality assurance reviews.

We judgmentally selected 57 claims, of which 15 had received a medical review and 42 had received both a medical review and a quality assurance review, to test whether the reviews were adequately documented and the medical review decisions were properly entered in the CERT Tracking and Reporting Database System.

We limited our review of controls 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. We did not independently evaluate CERT medical review decisions.

We performed the review from April through September 2005 at CMS headquarters in Baltimore, MD, and at AdvanceMed in Richmond, VA.

Methodology

To accomplish our objectives, we:

- identified changes in the CERT process that CMS implemented after the FY 2004 review;

- performed limited testing and analysis of the FY 2005 CERT medical review and quality assurance processes;

- performed limited testing and analysis of the FY 2005 CERT Tracking and Reporting Database System for accuracy and completeness;

- reviewed system reports and control logs and physically observed procedures and practices, which included:

    - mailing medical record request letters,
    - screening and scanning received medical records,
    - maintaining customer service phone call logs,
    - storing medical records,
    - monitoring and documenting the affiliated contractor feedback process,
    - documenting the provider appeals process,
    - educating and training medical review personnel, and
    - updating the CERT Tracking and Reporting Database System Web site;

- reviewed actions taken by CMS to address the recommendation in our report "Oversight and Evaluation of the Fiscal Year 2004 Comprehensive Error Rate Testing Program" (A-03-04-00007, issued November 9, 2004);

- compared the FYs with the associated sample periods for both CERT and HPMP; and

- reviewed the management structure of the CERT and HPMP programs.

We performed the review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

CMS and AdvanceMed generally had appropriate controls to ensure that AdvanceMed made medical review decisions in accordance with established procedures and that it adequately maintained, updated, and reported the results of those reviews. However, AdvanceMed did not always make follow-up phone calls to providers that did not respond to requests for medical records.

AdvanceMed had implemented the recommendation from our prior review to improve the completeness of quality assurance reviews. During FY 2005, AdvanceMed completed all 4,325 of the required quality assurance reviews.

In addition, CMS could do more to ensure consistency and coordination of the error rate programs. Sampling periods were not consistent, and management of the programs was decentralized.

FOLLOW-UP PHONE CALLS

AdvanceMed did not make follow-up phone calls requesting medical records for 130,103 claims requiring such calls. Section 3.0.2 B of the "CERT Review Manual" required AdvanceMed to make a series of follow-up phone calls to providers and to record the results in the CERT Tracking and Reporting Database System.

During FY 2005, AdvanceMed made only 6,925 follow-up calls: 5,697 first calls, 1,033 second calls, and 195 third calls. We judgmentally selected 12 of the 130,103 claims for which no follow-up phone calls were recorded. Although AdvanceMed did not make all required phone calls, it later received the medical records for the 12 claims.

AdvanceMed had only a limited number of customer service representatives to make follow-up phone calls. Because customer service representatives performed many other duties, they were unable to make all required follow-up phone calls. Nevertheless, AdvanceMed received the medical records for all but 385 of the claims.

We are not making any recommendations on this issue because Livanta, rather than AdvanceMed, is responsible for follow-up requests for the FY 2006 CERT review.

CONSISTENCY AND COORDINATION OF ERROR RATE PROGRAMS

We identified two concerns that could affect the consistency and coordination of the error rate programs.

Inconsistent Sample Periods

The periods from which CMS selects sample claims for the CERT and HPMP programs differ from each other and from the FY to which the Medicare error rate applies. CMS uses sample

periods that differ from the FY to meet the annual deadline for disclosing the estimated improper Medicare payments in the Department's Performance and Accountability Report.

The following table presents, for FYs 2005 and 2006, the FY periods and the corresponding CERT and HPMP sample periods. The inconsistencies between the sample periods become more apparent in FY 2006, when half of the CERT error rate will comprise FY 2006 claim information. The HPMP error rate, on the other hand, will not comprise any FY 2006 claim information.

CERT and HPMP Sample Periods

	Start	End	Number of Sample Period Months Included in FY
FY 2005	10/1/04	9/30/05	
CERT sample	1/1/04	12/31/04	3
HPMP sample	7/1/03	6/30/04	0
FY 2006	10/1/05	9/30/06	
CERT sample	4/1/05	3/31/06	6
HPMP sample	7/1/04	6/30/05	0

Decentralized Management

The management of the CERT and HPMP programs by two separate CMS offices permits inconsistencies between the two programs. The Program Integrity Group, Office of Financial Management, manages the CERT program, while the Quality Improvement Group, Office of Clinical Standards and Quality, manages the HPMP.

We noted two program inconsistencies. First, while the CERT program includes errors identified through its quality assurance program in the error rate calculation, the HPMP initially excluded errors identified in its 10-percent quality control sample. Second, as noted above, the CERT and HPMP sample periods differ.

CMS plans to expand its error rate programs to include national rates for Medicaid, Medicare managed care, and the State Children's Health Insurance Program. While management of those error rate programs has not been finalized, CMS officials have indicated that the programs will probably be located in the Program Integrity Group, Office of Financial Management. However, the HPMP error rate program remains with the Quality Improvement Group, which is not part of the Office of Financial Management.

RECOMMENDATIONS

We recommend that CMS:

- work to establish CERT and HPMP sample periods that are more consistent with each other and more closely aligned with the FY and

- consider centralizing the management of the error rate programs under a single office for consistency in methodology and uniformity in reporting.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S COMMENTS

CMS concurred with the findings and recommendations. CMS stated that it would:

- evaluate the feasibility of making additional revisions in the sample periods of one or both of the programs to more closely align with each other and the FY and

- consider the recommendation for centralizing the management of the error rate programs under one office in CMS.

Because the CERT and HPMP programs are well into the FY 2006 review process, CMS stated that it was too late to implement the recommendations for this reporting period and would consider them for FY 2007. CMS plans to report back to us in February 2006 after it meets internally to consider the recommendations.

CMS's comments are included as an appendix to this report.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

DATE: NOV 0 8 2005

TO: Joseph E. Vengrin
Deputy Inspector General, Audit Services
Office of Inspector General
Department of Health and Human Services

FROM: Timothy Hill
Chief Financial Officer
Office of Financial Management

SUBJECT: CMS Comments on Oversight and Evaluation of the Fiscal Year 2005 Comprehensive Error Rate Testing Program (A-03-05-000006)

Thank you for the opportunity to comment on the subject report. My staff and I have reviewed the report concluding that the Comprehensive Error Rate Testing (CERT) contractor generally had appropriate controls to ensure that the medical reviews were performed in accordance with established procedures. In addition, the report found that the CERT contractor adequately maintained, updated and reported the results of those reviews. However, there were two instances in which your review found concerns that could affect the consistency and coordination of the error rate programs:

1. The periods from which CMS selects the sample claims for the CERT program and Hospital Payment Monitoring Program (HPMP) differ from each other and from the fiscal year (FY) to which the Medicare error rate applies, and

2. The management of the CERT and HPMP programs by two separate CMS offices permits inconsistencies between the two programs.

CMS comments

The CMS agrees with the findings and the recommendations. You raise good points about the need for improved consistency and coordination of the CERT and HPMP error rate programs.

Inconsistent Sample Periods: As mentioned in the report, CMS implemented changes to the CERT program that will decrease the time lag between claim sampling and error reporting for the FY 2006 reporting period. The new process allows for additional sample months from the FY to be included in the report. While we believe this will enable Medicare contractors to better target corrective

actions to reduce improper payments, it does increase the difference between the CERT and HPMP sampling periods. HPMP can move up its process by several months. CMS will evaluate the feasibility of making additional revisions in the sample periods of one or both programs to more closely align with each other and the FY.

- ***Decentralized Management:*** The report suggests that the management of the HPMP and CERT programs by two separate CMS offices contributes to the inconsistencies between the two programs. CMS believes that its primary goal is to ensure that both HPMP and CERT programs remain compliant with the Improper Payment Information Act. We will continue to evaluate the HPMP and CERT programs to identify where inconsistencies occur and determine whether steps should be taken to ensure uniformity. We will also consider your recommendation for centralizing the management of both error rate programs under one office in CMS. Since both programs are well into the review process for the FY 2006 report, it is too late to implement the significant changes you recommend for this reporting period. CMS will, however, consider the recommendations for FY 2007. We will meet internally over the next few months and report back to you in February 2006.

In addition, CMS has the following comments on the section titled FOLLOW-UP PHONE CALLS:

Though not included as a recommendation, the report identifies that AdvanceMed did not make all required follow-up phone calls for medical record requests and record the results in the CERT Tracking and Reporting Database System. Consideration should be given to the following: AdvanceMed did not implement the call application until November 2004 so 10 months of follow-up calls were not recorded in the database; to promote efficiency, AdvanceMed made one call when providers had multiple claims in the CERT sample; and AdvanceMed focused on high dollar claims first so that documentation for many of the low dollar claims were received before a call was made. It is important to note that AdvanceMed's response rate for medical record documentation was 99.5 percent. In addition, please note that CMS has removed this function from AdvanceMed and hired a new contractor, called the CERT Documentation Contractor, to perform this work. CMS is confident that the new contractor has sufficient controls in place to ensure that all follow-up phone calls are made timely and recorded in the data base.

If you have questions regarding this information, please contact Jill Nicolaisen on (410) 786-5873.

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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