



July 14, 2010

TO: Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program (A-01-10-01000)

The attached final report provides the results of our analysis of errors identified in the fiscal year 2009 Comprehensive Error Rate Testing 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>.

Please send us your final management decision, including any action plan, as appropriate, 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 Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through email at Joe.Green@oig.hhs.gov. Please refer to report number A-01-10-01000 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ANALYSIS OF ERRORS IDENTIFIED IN
THE FISCAL YEAR 2009
COMPREHENSIVE ERROR RATE
TESTING PROGRAM**



Daniel R. Levinson
Inspector General

July 2010
A-01-10-01000

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate. An error, or improper payment, is the difference between the amount that Medicare paid to a health care provider and the amount that it should have paid. Using the results of the CERT program, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims pursuant to the Improper Payments Information Act of 2002 (P.L. No. 107-300).

As part of the Medicare error rate process for fiscal year (FY) 2009, CMS's CERT contractor conducted medical record reviews of a random sample of paid claims from all types of providers. The sample consisted of 99,480 claims valued at about \$71 million. The CERT contractor found that 19,754 sampled claims resulted in improper payments valued at about \$4.7 million. Based on these sample results, the national paid claim error rate for FY 2009 was 7.8 percent (\$24.1 billion), a significant increase over the FY 2008 error rate of 3.6 percent (\$10.4 billion). According to CMS's FY 2009 *Improper Medicare Fee-for-Service Payments Report*, the increase in the error rate was attributable to substantial changes in the CERT medical record review methodologies.

OBJECTIVE

Our objective was to analyze the types of providers that caused the majority of FY 2009 improper payments and the most significant types of payment errors made by these providers.

SUMMARY OF FINDINGS

The six types of providers shown in the table below accounted for \$4.4 million, or 94 percent, of the \$4.7 million in improper payments identified by the CERT contractor.

Improper Payments by Type of Provider

Type of Provider	Improper Payments	Percentage of Improper Payments
Inpatient hospitals	\$1,912,323	40%
Durable medical equipment suppliers	1,184,505	25%
Hospital outpatient departments	584,840	12%
Physicians	313,469	7%
Skilled nursing facilities	260,381	6%
Home health agencies	185,498	4%
Subtotal	\$4,441,016	94%
All other types of providers	279,416	6%
Total	\$4,720,432	100%

The most significant types of payment errors attributable to these six provider groups were (1) insufficient documentation, e.g., missing clinical notes or test results and missing,

incomplete, or illegible physician orders, which resulted in improper payments totaling \$2.6 million; (2) miscoded claims, which resulted in improper payments totaling \$0.9 million; and (3) medically unnecessary services and supplies, which resulted in improper payments totaling \$0.8 million. These types of payment errors accounted for about 98 percent of the \$4.4 million in improper payments associated with the six types of providers.

RECOMMENDATION

We recommend that, as part of its analysis of the FY 2009 CERT improper payments, CMS use the results of our analysis in identifying the types of payment errors indicative of programmatic weaknesses and any additional corrective actions needed to strengthen the CERT program.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendation. CMS added that it would consider including the type of analysis that we made in its future improper payment reports. CMS's comments are included in their entirety as the Appendix.

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CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

INTRODUCTION

BACKGROUND

Medicare Error Rate Program

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, established the Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate. An error, or improper payment, is the difference between the amount that Medicare paid to a health care provider and the amount that it should have paid. Using the results of the CERT program, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims pursuant to the Improper Payments Information Act of 2002 (P.L. No. 107-300). On February 1, 2010, CMS issued its fiscal year (FY) 2009 *Improper Medicare Fee-for-Service Payments Report*.

Medical Reviews of Claims in the Comprehensive Error Rate Testing Program

CMS's CERT contractor is AdvanceMed, a program safeguard contractor. As part of the Medicare error rate process for FY 2009, the CERT contractor conducted medical record reviews of a random sample of paid claims from all types of providers.¹ CMS's contract requires that the CERT contractor make medical review decisions in accordance with CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08 (Integrity Manual) and applicable guidance, such as national coverage determinations (NCD), local coverage determinations (LCD), and CMS coding manuals. CMS develops NCDs to describe the circumstances for nationwide Medicare coverage of specific medical services, procedures, and devices. Medicare contractors develop LCDs to specify the clinical circumstances under which services, procedures, and devices are considered reasonable and necessary in their jurisdictions.

Fiscal Year 2009 Comprehensive Error Rate Testing Results

For FY 2009, the CERT contractor sampled 99,480 claims valued at about \$71 million. The CERT contractor found that 19,754 sampled claims resulted in improper payments valued at about \$4.7 million.² Based on these sample results, the national paid claim error rate for FY 2009 was 7.8 percent (\$24.1 billion), a significant increase over the FY 2008 error rate of 3.6 percent (\$10.4 billion). According to the FY 2009 *Improper Medicare Fee-for-Service Payments Report*, the increase in the error rate was attributable to substantial changes in the CERT medical record review methodologies.

¹ For FY 2008 and prior years, inpatient hospital claims were reviewed under the Hospital Payment Monitoring Program, and other Medicare fee-for-service claims were reviewed under the CERT program. For FY 2009, CMS consolidated the two reviews under the CERT program.

² The amount of improper payments is calculated by adding total overpayments to the absolute value of total underpayments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to analyze the types of providers that caused the majority of FY 2009 improper payments and the most significant types of payment errors made by these providers.

Scope

Our review covered the 19,754 sampled claims with \$4.7 million in improper payments identified by the CERT contractor during the FY 2009 error rate process.

We limited our review of internal controls to obtaining an understanding of CMS's written policies regarding medical reviews.

We performed our fieldwork from November 2009 through February 2010.

Methodology

To accomplish our objective, we:

- reviewed Medicare requirements regarding medical reviews,
- reviewed the CERT contractor's medical review determinations and classifications of improper payments, and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

The six types of providers shown in the table on the next page accounted for \$4.4 million, or 94 percent, of the \$4.7 million in improper payments identified by the CERT contractor.

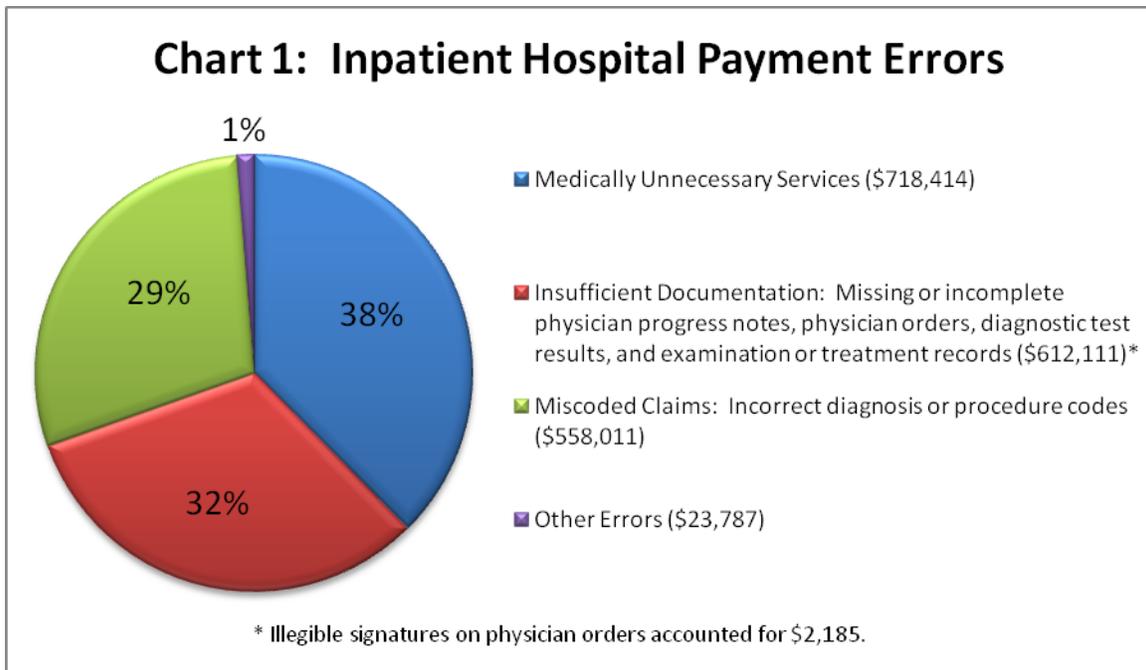
Improper Payments by Type of Provider

Type of Provider	Improper Payments	Percentage of Improper Payments
Inpatient hospitals	\$1,912,323	40%
Durable medical equipment (DME) suppliers	1,184,505	25%
Hospital outpatient departments	584,840	12%
Physicians	313,469	7%
Skilled nursing facilities (SNF)	260,381	6%
Home health agencies (HHA)	185,498	4%
Subtotal	\$4,441,016	94%
All other types of providers	279,416	6%
Total	\$4,720,432	100%

The most significant types of payment errors attributable to these six types of providers were (1) insufficient documentation, e.g., missing clinical notes or test results and missing, incomplete, or illegible physician orders, which resulted in improper payments totaling \$2.6 million; (2) miscoded claims, which resulted in improper payments totaling \$0.9 million; and (3) medically unnecessary services and supplies, which resulted in improper payments totaling \$0.8 million. These types of payment errors accounted for about 98 percent of the \$4.4 million in improper payments associated with the six types of providers.

INPATIENT HOSPITALS

Improper payments totaling more than \$1.9 million for 400 inpatient hospital claims accounted for 40 percent of the \$4.7 million in improper payments. As shown in Chart 1, the most significant types of inpatient hospital payment errors that the CERT contractor found were medically unnecessary services, insufficient documentation, and miscoded claims.



Medically Unnecessary Services

The CERT contractor determined that 123 inpatient claims with improper payments totaling \$718,414 were for medically unnecessary services:

- For 119 claims with improper payments totaling \$704,394, the services could have been performed in a less intensive setting, such as a hospital outpatient department.
- For 4 claims with improper payments totaling \$14,020, the services were provided only so that the beneficiaries could qualify for placement in SNFs.

For example:

A hospital was paid \$2,923 to treat a beneficiary for chest pain as an inpatient. According to the CERT contractor, the beneficiary's condition was relatively stable, as evidenced by her normal vital signs and EKG. The CERT contractor concluded that the beneficiary could have been treated in the hospital observation area as an outpatient and did not require admission to an inpatient hospital. As a result, the CERT contractor denied the total payment.

Insufficient Documentation

The CERT contractor determined that for 91 inpatient claims with improper payments totaling \$612,111, the medical records did not include sufficient documentation to make an informed decision that the services billed were medically necessary. These improper payment determinations related to missing or incomplete:

- physician progress notes, diagnostic test results, and/or discharge summaries for 63 claims with improper payments totaling \$453,227;
- results of examinations or treatments and/or emergency room records for 23 claims with improper payments totaling \$131,799; and
- physician orders and other documentation for 5 claims with improper payments totaling \$27,085.

For example:

A hospital was paid \$10,433 for total hip replacement surgery. The CERT contractor concluded that the documentation in the beneficiary's medical record was insufficient to support the need for the surgery. Specifically, the record did not contain information on the types of treatment that had been tried before surgery, a pathology note to support statements in the record, or a preoperative x-ray documenting the extent of osteoarthritis of the hip. As a result, the CERT contractor denied the total payment.

Miscoded Claims

The CERT contractor determined that 182 inpatient claims with improper payments totaling \$558,011 included miscoded diagnoses or procedures. Specifically, using the correct diagnosis or procedure code, the CERT contractor:

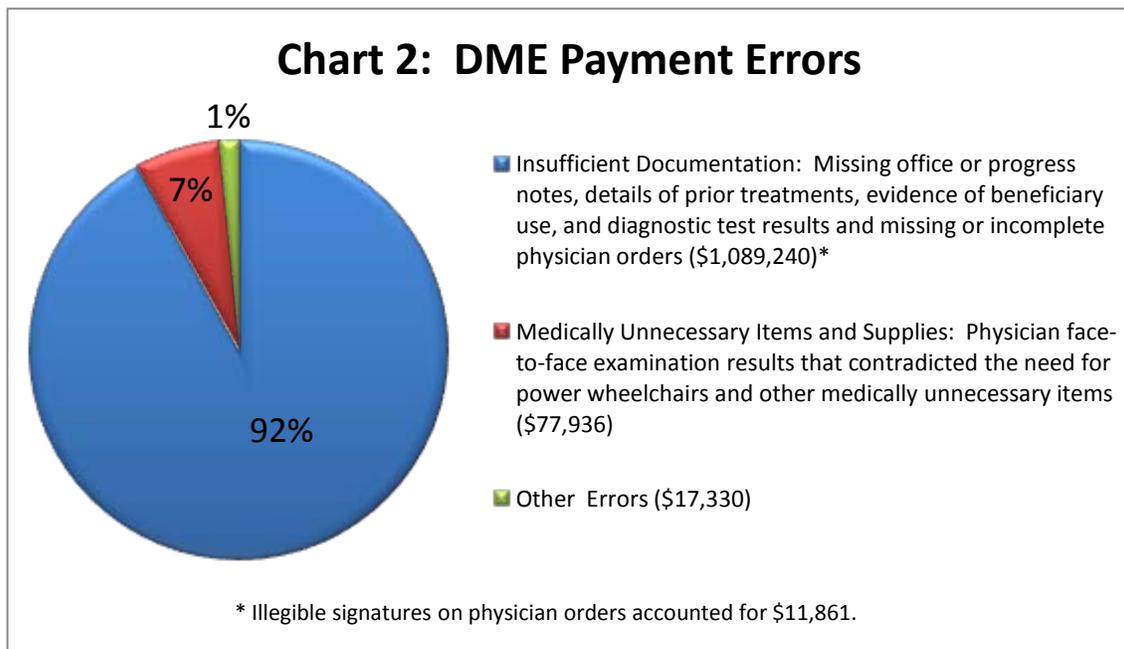
- reduced the payments for 123 claims by \$362,213 and
- increased the payments for 59 claims by \$195,798.

For example:

A hospital was paid \$17,283 for an excision and debridement procedure. The CERT contractor concluded from the documentation in the medical record that the hospital performed a less complex surgical procedure than the one coded by the hospital. The CERT contractor's correction of the procedure code reduced the payment by \$11,237.

DURABLE MEDICAL EQUIPMENT SUPPLIERS

Improper payments totaling almost \$1.2 million for 6,874 DME supplier claims accounted for 25 percent of the \$4.7 million in improper payments that the CERT contractor identified. As shown in Chart 2, the most significant types of DME supplier payment errors that the CERT contractor found were insufficient documentation and medically unnecessary items and supplies.



Insufficient Documentation

The CERT contractor determined that for 6,385 DME supplier claims with improper payments totaling about \$1.1 million, the medical records did not include sufficient documentation to make an informed decision that the items and supplies billed were medically necessary. These improper payment determinations related to:

- missing physician office or progress notes, details of prior treatments, evidence of beneficiary use, and/or results of diagnostic tests for 4,531 claims with improper payments totaling \$761,156;
- missing, unsigned, undated, or incomplete physician orders for 1,509 claims with improper payments totaling \$262,953;
- missing or unsigned plans of care for 134 claims with improper payments totaling \$28,770;
- no documentation for 82 claims with improper payments totaling \$14,571;
- illegible physician orders for 68 claims with improper payments totaling \$11,861; and
- missing or unsigned certificates of medical necessity (CMN) for 61 claims with improper payments totaling \$9,929.

For example:

A DME supplier was paid \$1,293 for a power wheelchair. The CERT contractor concluded that the documentation in the medical record was insufficient because it did not show that the beneficiary was able to transfer to and from the power wheelchair and maintain stability while operating the wheelchair in the home. The record also did not document that the home had adequate access between rooms or that the beneficiary's weight did not exceed the weight capacity of the wheelchair. In addition, the record did not include the results of a required physician face-to-face examination. As a result, the CERT contractor denied the total payment.

Medically Unnecessary Items and Supplies

The CERT contractor determined that 343 DME supplier claims with improper payments totaling \$77,936 were for medically unnecessary items and supplies:

- For 13 claims with improper payments totaling \$38,932, physician face-to-face examination results contradicted the need for power wheelchairs.
- For 113 claims with improper payments totaling \$11,951, medical necessity requirements in the applicable LCDs were not met.

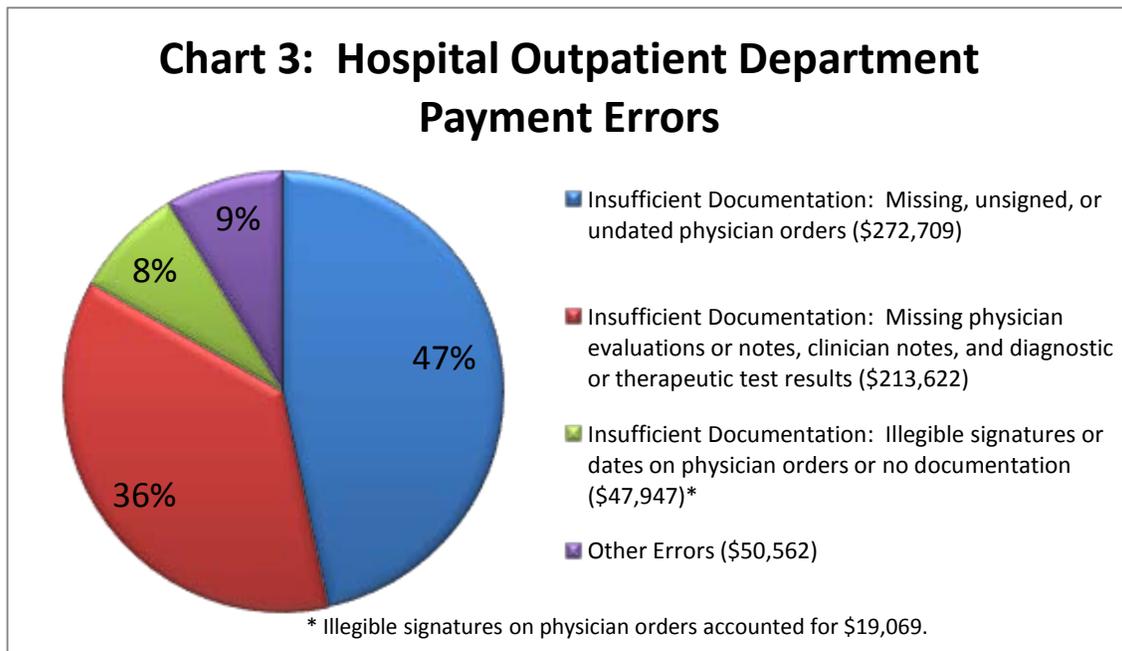
- For 102 claims with improper payments totaling \$9,866, the diabetic testing supplies dispensed to the beneficiaries exceeded the amounts specified in the physician orders.
- For 22 claims with improper payments totaling \$2,329, items and supplies were not needed, could not be used in the home, or were not used by the beneficiaries.
- For 93 claims with improper payments totaling \$14,858, items and supplies were medically unnecessary for other reasons.

For example:

A DME supplier was paid \$4,483 for a power wheelchair. The CERT contractor determined that the physician face-to-face examination results clearly documented that the beneficiary had adequate upper extremity strength and no arthritis in the upper extremities. Further, the medical record did not indicate that the beneficiary was unable to self-propel. As a result, the CERT contractor denied the total payment.

HOSPITAL OUTPATIENT DEPARTMENTS

Improper payments totaling \$584,840 for 4,810 hospital outpatient department claims accounted for 12 percent of the \$4.7 million in improper payments. As shown in Chart 3, the most significant type of hospital outpatient department payment error that the CERT contractor found was insufficient documentation.



The CERT contractor determined that for 4,040 hospital outpatient department claims with improper payments totaling \$534,278, the medical records did not include sufficient

documentation to make an informed decision that the services billed were medically necessary. These improper payment determinations related to:

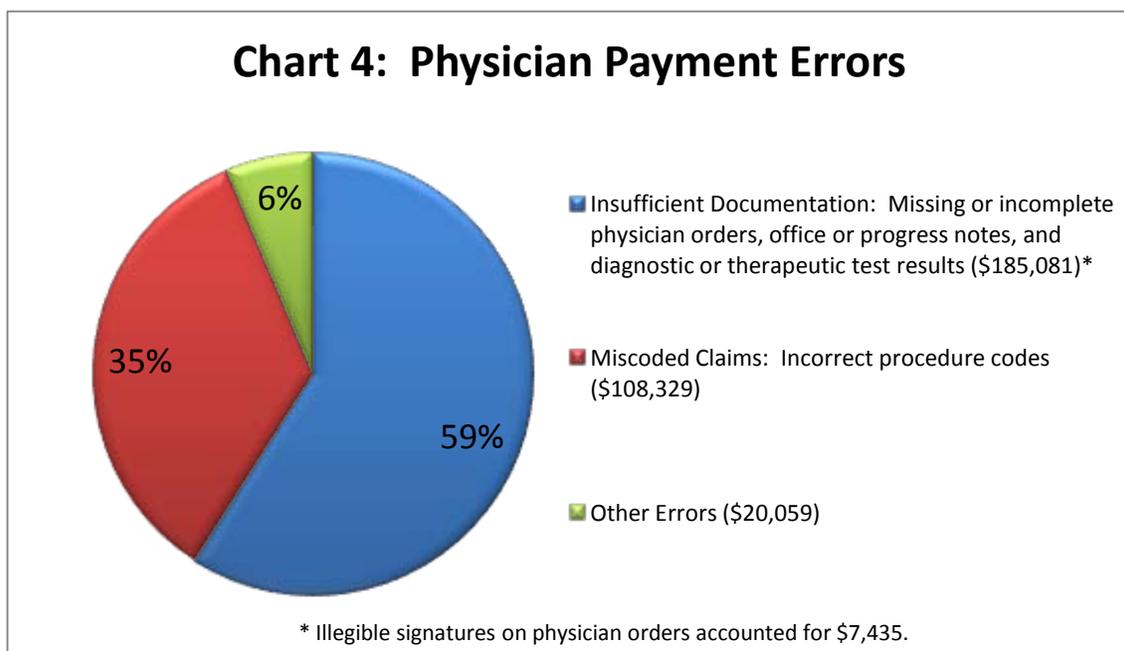
- missing, unsigned, or undated physician orders for 3,041 claims with improper payments totaling \$272,709;
- missing physician evaluations, physician notes, clinician notes, and/or diagnostic or therapeutic test results for 843 claims with improper payments totaling \$213,622;
- no documentation for 36 claims with improper payments totaling \$28,878; and
- illegible signatures or dates on physician orders for 120 claims with improper payments totaling \$19,069.

For example:

A hospital was paid \$127 for an ultrasound. The documentation in the medical record included a requisition, detailed bill, and test results. The CERT contractor concluded that the documentation was insufficient because it did not include a physician order for the test. As a result, the CERT contractor denied the total payment.

PHYSICIANS

Improper payments totaling \$313,469 for 4,440 physician claims accounted for 7 percent of the \$4.7 million in improper payments. As shown in Chart 4, the most significant types of physician payment errors that the CERT contractor found were insufficient documentation and miscoded claims.



Insufficient Documentation

The CERT contractor determined that for 2,005 physician claims with improper payments totaling \$185,081, the medical records did not include sufficient documentation to make an informed decision that the services billed were medically necessary. These improper payment determinations related to:

- missing physician office or progress notes and/or results of diagnostic or therapeutic tests for 1,331 claims with improper payments totaling \$132,019;
- missing, incomplete, unsigned, or undated physician orders for 482 claims with improper payments totaling \$36,607;
- illegible physician orders for 69 claims with improper payments totaling \$7,435;
- no documentation or no documentation for the specific dates of service for 83 claims with improper payments totaling \$6,934; and
- missing or unsigned plans of care or CMNs for 40 claims with improper payments totaling \$2,086.

For example:

A physician was paid \$189 for an office consultation and a urinalysis. The CERT contractor concluded that the documentation in the medical record was insufficient because it did not include office consultation notes. As a result, the CERT contractor denied the total payment.

Miscoded Claims

The CERT contractor determined that 2,207 physician claims with improper payments totaling \$108,329 contained incorrect procedure codes.

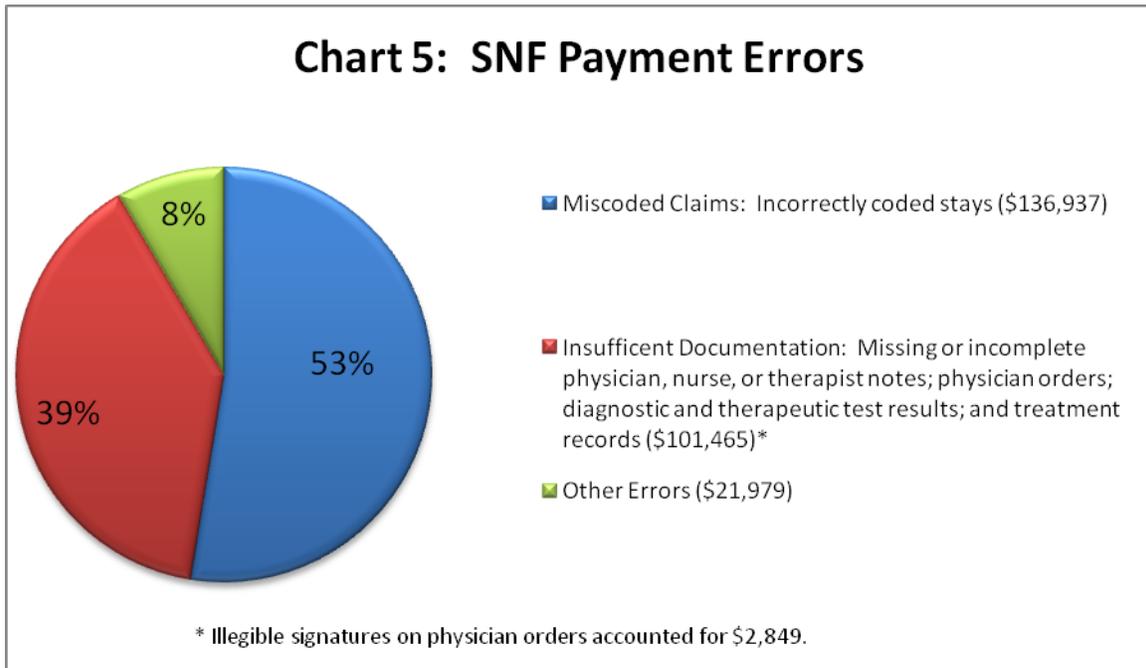
- Incorrect coding of evaluation and management services resulted in 1,333 overpayments totaling \$56,624 and 180 underpayments totaling \$5,315.
- Incorrect coding of other types of physician procedures resulted in 637 overpayments totaling \$44,904 and 57 underpayments totaling \$1,486.

For example:

A physician was paid \$50 for an evaluation and management service. The CERT contractor concluded that the documentation in the medical record supported a straightforward (minimal) level of medical decisionmaking rather than a low-complexity level of medical decisionmaking. The CERT contractor's correction of the procedure code reduced the payment by \$20.

SKILLED NURSING FACILITIES

Improper payments totaling \$260,381 for 248 SNF claims accounted for 6 percent of the \$4.7 million in improper payments. As shown in Chart 5, the most significant types of SNF payment errors that the CERT contractor found were miscoded claims and insufficient documentation.



Miscoded Claims

The CERT contractor determined that 147 SNF claims with improper payments totaling \$136,937 included miscoded stays, resulting in 127 overpayments totaling \$125,947 and 20 underpayments totaling \$10,990. These improper payment determinations related to:

- billing a higher payment code than was supported by documentation, which included late patient assessments, for 24 claims with overpayments totaling \$38,254;
- billing for the administration of intravenous medications that was not supported by documentation for 35 claims with overpayments totaling \$33,285 and not billing for the administration of intravenous medications that was supported by documentation for 6 claims with underpayments totaling \$2,508;
- billing for therapy minutes that were not supported by documentation for 41 claims with overpayments totaling \$26,746 and not billing for therapy minutes that were supported by documentation for 11 claims with underpayments totaling \$6,575; and
- making other coding errors on 27 claims with overpayments totaling \$27,662 and on 3 claims with underpayments totaling \$1,907.

For example:

A SNF was paid \$5,727 for an 11-day episode. The CERT contractor concluded from the documentation in the medical record that the SNF provided less therapy than the amount coded by the SNF and that the record did not specify the time spent in therapy versus therapy evaluation. The CERT contractor's correction of the procedure code reduced the payment by \$1,309.

Insufficient Documentation

The CERT contractor determined that for 85 SNF claims with improper payments totaling \$101,465, the medical records did not include sufficient documentation to make an informed decision that the services billed were medically necessary. These improper payment determinations related to:

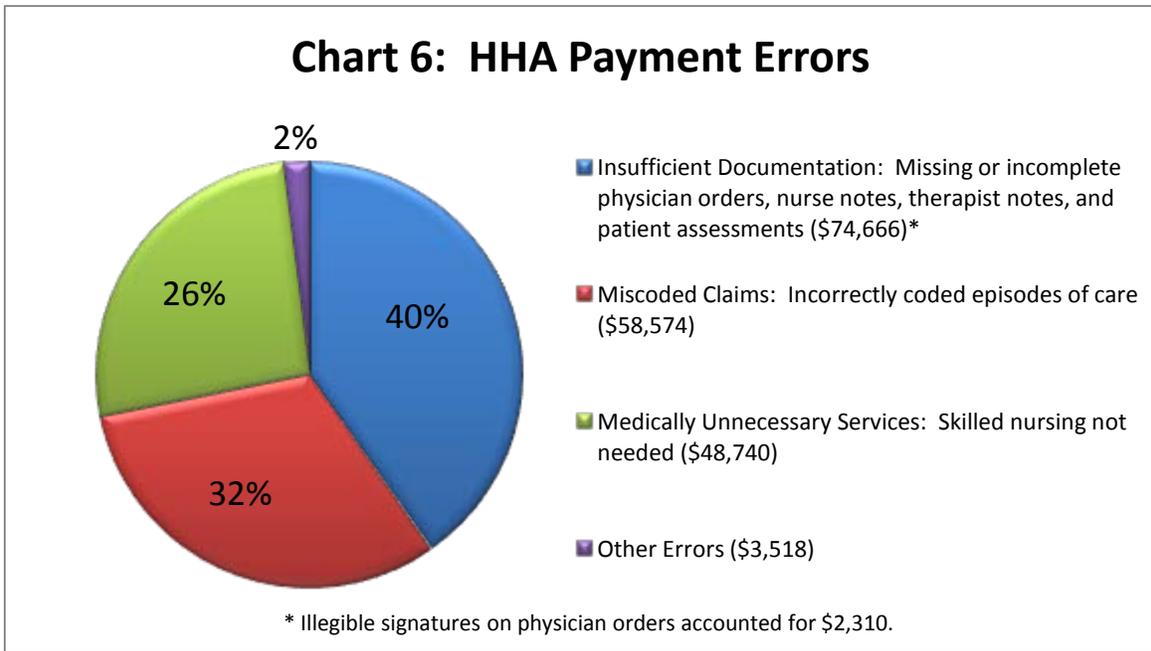
- missing physician, nurse, and/or therapist notes, results of diagnostic and therapeutic tests, and treatment records for 63 claims with improper payments totaling \$78,983;
- missing physician orders for 19 claims with improper payments totaling \$19,633; and
- illegible signatures and/or dates on physician orders for 3 claims with improper payments totaling \$2,849.

For example:

A SNF was paid \$1,138 for a 1-month episode that included daily physical therapy treatments. The CERT contractor found that the documentation in the medical record did not include daily physical therapy treatment records to support the exercises and treatments performed, the modalities used, or the units of service billed. As a result, the CERT contractor denied the total payment.

HOME HEALTH AGENCIES

Improper payments totaling \$185,498 for 193 HHA claims accounted for 4 percent of the \$4.7 million in improper payments. As shown in Chart 6 on the next page, the most significant types of HHA payment errors that the CERT contractor found were insufficient documentation, miscoded claims, and medically unnecessary services.



Insufficient Documentation

The CERT contractor determined that for 36 HHA claims with improper payments totaling \$74,666, the medical records did not include sufficient documentation to make an informed decision that the services billed were medically necessary. These improper payment determinations related to:

- missing nurse notes, therapist notes, and/or patient assessments for 22 claims with improper payments totaling \$43,353;
- missing, unsigned, or undated physician orders for 10 claims with improper payments totaling \$26,085;
- no signed plan of care for 1 claim with an improper payment of \$2,918; and
- illegible physician orders for 3 claims with improper payments totaling \$2,310.

For example:

An HHA was paid \$2,052 for one home health episode. The CERT contractor concluded that the documentation in the medical record was insufficient to determine medical necessity because the record did not include physician orders, a plan of care, home health aide notes, or an assessment document. The record also did not include nursing notes for any date in the billed period. As a result, the CERT contractor denied the total payment.

Miscoded Claims

The CERT contractor determined that 122 HHA claims with improper payments totaling \$58,574 included miscoded episodes of care, resulting in 72 overpayments totaling \$30,669 and 50 underpayments totaling \$27,905. These improper payment determinations related to:

- billing for more therapy visits than were supported by documentation for 28 claims with overpayments totaling \$17,704 and fewer therapy visits than were supported by documentation for 8 claims with underpayments totaling \$7,986;
- billing 21 claims with overpayments totaling \$5,929 and 20 claims with underpayments totaling \$6,112 because of claim-processing errors;
- using incorrect episode dates on 12 claims with overpayments totaling \$3,759 and on 12 other claims with underpayments totaling \$6,829; and
- making other coding errors on 21 claims with improper payments totaling \$10,255.

For example:

An HHA was paid \$4,053 for 1 home health episode based on 11 physical therapy visits billed. The CERT contractor concluded that the claim was incorrectly coded because the documentation in the medical record showed that only 10 physical therapy visits were provided. The CERT contractor's correction of the procedure code reduced the payment by \$421.

Medically Unnecessary Services

The CERT contractor determined that 28 HHA claims with improper payments totaling \$48,740 were for medically unnecessary services:

- For 23 claims with improper payments totaling \$38,402, the beneficiaries did not require skilled nursing services.
- For five claims with improper payments totaling \$10,338, the beneficiaries were not homebound.

For example:

An HHA was paid \$2,468 for one home health episode. The CERT contractor concluded that the documentation in the medical record did not support the need for skilled nursing because the record did not show a change in the beneficiary's condition or treatment. The record also did not show complications related to the beneficiary's longstanding diagnosis of diabetes and indicated that the beneficiary's blood glucose levels were controlled. As a result, the CERT contractor denied the total payment.

RECOMMENDATION

We recommend that, as part of its analysis of the FY 2009 CERT improper payments, CMS use the results of our analysis in identifying the types of payment errors indicative of programmatic weaknesses and any additional corrective actions needed to strengthen the CERT program.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendation. CMS added that it would consider including the type of analysis that we made in its future improper payment reports. CMS's comments are included in their entirety as the Appendix.

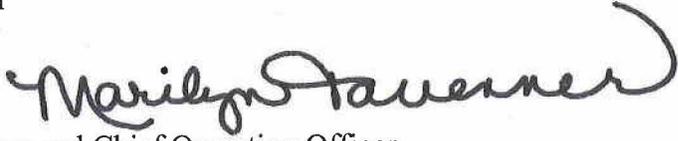
APPENDIX

*Administrator*

Washington, DC 20201

DATE: JUN - 1 2010

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner 
Acting Administrator and Chief Operating Officer

SUBJECT: Office of Inspector General (OIG) Draft Report "Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing (CERT) Program" (A-01-10-01000).

Thank you for the opportunity to comment on the subject OIG draft report regarding the analysis of improper payments identified during the Comprehensive Error Rate Testing (CERT) program reviews in 2009. We appreciate the OIG's review of the errors identified during the 2009 CERT process. CMS developed the CERT program to produce a national paid claims error rate for the entire Medicare fee-for-service program and to comply with the Improper Payments Information Act (IPIA) of 2002.

CMS appreciates the efforts and recommendations provided by the OIG – and uses those recommendations to help the CERT process. Based on these recommendations, CMS has taken aggressive actions to reflect a more complete accounting of Medicare's improper payments and provide the Agency and the OIG with more complete information about errors so the Agency can better target improper payments.

An integral part of the CERT process is the analysis of error rate data and development of error rate reduction plans to reduce improper payments and maintain the fiscal integrity of the Medicare program. The OIG's additional analysis demonstrates the utility of using CERT findings to focus on the types of providers that cause the majority of improper payments and the types of payment errors made by these providers to better focus corrective actions as we move forward.

We appreciate the OIG's work in this area and look forward to working with them as we continue to enhance the CERT process. Our response to the OIG's recommendation is below.

OIG Recommendation

We recommend that, as part of its analysis of the FY 2009 CERT improper payments, CMS use the results of our analysis in identifying the types of payment errors indicative of programmatic weaknesses and any additional corrective actions needed to strengthen the CERT program.

CMS Response

CMS concurs and will share this report with our contractors as a source of information. Also, we will consider including this type of analysis in future improper payment reports. We note, however, that because of the programming required to produce this type of detailed analysis, it cannot be done for the 2010 report, but we will include similar analysis in the 2011 report.

In addition, CMS will work internally to consider ways to incorporate this type of detailed information into future Medicare fee-for-service contractor educational efforts.