Monitoring Improper Medicare Payments: New CMS Programs Build on OIG Methods to Report Errors

by Rita A. Scichilone, MHSA, RHIA, CCS, CCS-P, CHC

The Office of Inspector General (OIG) issued its last improper Medicare fee-for-service payment error rate report in January. Does this mean that all claims problems have been fixed? Have healthcare providers finally become 100 percent compliant?

Unfortunately, the answer is no. From fiscal year 2003 and forward, the Centers for Medicare & Medicaid Services (CMS) will publish a national error rate developed through its Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program (HPMP), formally known as the Payment Error Prevention Program (PEPP). CMS initiated these programs, which build on OIG methods to report errors in the future.

This article will discuss the 2002 OIG Audit Report (A-17-02-02202) and provide a glimpse of the CERT and HPMP programs of the future. The full audit report is available for downloading from the OIG Web site.

Gathering Data

The primary objective of the OIG annual audit has been to determine whether Medicare fee-for-service benefit payments were made in accordance with the applicable statutes. There are three key areas of review and a determination was made if the services were:

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

A total of 4,985 claims worth $6.2 million dollars were reviewed from a statistically derived sample involving 610 beneficiaries. All claims processed for payment for each selected beneficiary were reviewed during a three-month period to determine if:

- the contractor paid, recorded, and reported the claim correctly
- the beneficiary and the provider met all Medicare eligibility requirements
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations

Noncompliant Claims Drop

Medical review staff from Medicare contractors and quality improvement organizations (QIOs) analyzed the medical records. QIOs applied the appropriate coverage guidelines in the process, including use of the Medicare carrier and fiscal intermediary manuals.

The results showed that 1,030 claims did not comply with Medicare laws and regulations (almost 21 percent), and the report describes these instances of noncompliance as improper payments. This report includes a comparison to the previous OIG audit reports for fiscal years 1996-2001 of the same type for a seven-year look at improvement and work yet to be done. Due to compliance programs and educational efforts, the amount of improper payments has fallen from $23.2 billion in the 1996 report to $13.3 billion in the 2002 report. This still represents 6.3 percent of the $212.7 billion dollars in processed fee-for-service payments reported by CMS. Improper payments have decreased, but there is still room for more improvement.

According to the report, there were more than 40 million beneficiaries enrolled in the Medicare program with a total of $254.5 billion paid out in benefits. The fee-for-service amount comprises approximately 84 percent of the total benefits.

Categorizing Improper Payments

Improper payments are categorized by type: documentation errors, medically unnecessary services, coding errors, and noncovered/other.

The fiscal year 2002 report shows a percentage decrease from the previous years in all categories except the medically unnecessary services category, which has been the largest category in four of the last seven years. Unsupported and medically unnecessary services have been pervasive problems over the seven-year review period, comprising more than 80 percent of the total improper payments. The report states that "CMS upheld over 90 percent of the overpayments identified in our FY's 1996-2001 samples and recovered the bulk of them."[1]

Documentation errors have represented the largest category in three of the seven years reviewed using this process. In 2002, the dollar amount of this type of error decreased by nearly 26 percent compared to fiscal year 2001. Even with this improvement, documentation problems still represent an estimated $3.8 billion in improper payments for Medicare beneficiary services. This category includes those cases with both insufficient documentation and no documentation at all.

Compared to the other categories, medical necessity comprised more than half of the improper payments at 57.1 percent, or $7.6 billion of the total. The report indicates that hospital inpatient prospective payment system claims accounted for 52 percent of those errors this year.

The coding error category decreased in 2002 to 14.3 percent of the total, from 17 percent in 2001. For most of the coding errors found, the medical reviewers determined that documentation submitted by providers supported a lower reimbursement code, primarily in physician service evaluation and management reporting. CPT codes 99233, Subsequent hospital care, and 99214, Office or other outpatient visit, have specific review details illustrated within the report showing variances between reported codes and codes considered to be in error by the medical reviewers.

The $13.3 billion error rate reported for fiscal year 2002 is higher than the fiscal year 2001 rate of $12.1 billion, which is due partially to an increase in Medicare expenditures for this review period. More than 92 percent of Medicare fee-for-service payments since fiscal year 1998 have contained no errors. The government can conclude that the majority of providers that submit claims to Medicare do so for medically necessary and correctly coded billed services supported by appropriate documentation.

OIG Recommendations

Based on CMS' findings, the OIG made the following recommendations:

- expand provider training on the need to maintain medical records containing sufficient documentation and proper procedure coding and billing
- refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented
- direct QIOs to identify high-risk areas and continue selected surveillance initiatives, such as hospital readmission and DRG coding reviews, to reduce medically unnecessary services and ensure continued provider integrity
- ensure that contractors recover the improper payments identified in the OIG's review

For the first time, the CERT and HPMP programs will establish baselines to measure each contractor's progress in correctly processing and paying claims. The results of these programs are intended to evaluate contractor performance and identify specific billing anomalies in the region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claim reviews, and other activities.

A New Fraud Detection Tool

CMS' Office of Financial Management Program Integrity Group developed CERT to produce national, contractor, provider type, and benefit category-specific paid claims error rates.

This program began in August 2000, gradually phasing in all Medicare contractors. Under CERT, an independent contractor (DynCorp of Richmond, VA) requests a random sample of claims from each Medicare contractor. These claims are identified as soon as they are accepted into the claims processing system. The sampled claims data are entered into a tracking and reporting database.

DynCorp follows the claims until they are adjudicated and then compares the contractor's final claims decision with its own. DynCorp's medical review staff members (including nurses, physicians, and other qualified healthcare practitioners) verify the contractor's decisions regarding the accuracy of the claims based on sound policy. Instances of incorrect processing (for example, those due to questions of medical necessity, inappropriate application of medical review policy, etc.) become targets for correction or improvement.

CMS anticipates this project will result in a paid claims error rate, a claims processing error rate, and a provider compliance rate. CMS uses the DynCorp findings to determine underlying reasons for errors in claims payments or denials and to implement appropriate corrective actions aimed toward improvement in the accuracy of claims and systems of claims processing. As part of the CERT contract, DynCorp also conducts special studies on behalf of CMS.

PROs Become QIOs

The former peer review organizations contracted by CMS were responsible for the PEPP program. These contractors, now known as QIOs, developed HPMP.

According to CMS, requirements of the QIO program are:

- improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of healthcare
- protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary and provided in the most appropriate (that is, economical) setting
- protect beneficiaries by expeditiously addressing individual cases such as beneficiary complaints, provider-issued notices of noncoverage, Federal Emergency Medical Treatment and Active Labor Act violations (dumping), and other statutory responsibilities [2]

The objective of the HPMP is to reduce payment errors for acute care hospital services and protect the Medicare Trust Fund.[3] The QIO organizations will continue the same type of work provided in the PEPP initiative, which is providing DRG validation and admission review for potential payment errors.

Many Uses for Claim Data

During the course of the DynCorp review, providers and suppliers of the sampled claims are asked to provide additional information such as medical records and certificates of medical necessity for DynCorp staff to verify that services billed were delivered, medically necessary, and appropriately processed.

For hospitals, clinical data abstraction centers will continue to request a sample of medical records from hospitals that will undergo full case review. In addition, data from this activity will be analyzed with other available data from CMS. This analysis will identify potential patterns of payment error that may require additional investigation and review. Both physician practices and hospitals are expected to continue to evaluate internal processes and compliance programs to make sure claims are accurately coded from sufficient documentation and billed correctly to prevent improper payments.

Many QIO sites contain helpful coding and documentation tips and best practices for payment error prevention. IPRO, the QIO from New York, has published helpful tips for coding the top seven DRGs.[4] Watch the CMS Web site, your local fiscal intermediary, carrier, or QIO Web sites and bulletins for the latest information concerning changes in the review process that may affect your compliance programs.

Notes

1. US Department of Health and Human Services, Office of Inspector General. "Improper Fiscal Year 2002 Medicare Fee-For-Service Payments." January 8, 2003, p. 6. Available online at www.oig.hhs.gov/ oas/reports/cms/170202202.htm.

2. Centers for Medicare & Medicaid Services. "Quality Improvement Organization Statement of Work.".

3. From the Iowa Foundation for Medical Care Web site at www.ifmc.org.

4. IPRO. "Coding for Quality: Documentation Tips for the Top 7 DRGs." 2002. For more information on IPRO, go to www.ipro.org.

Rita Scichilone *(rita.scichilone@ahima.org) is director of coding products and services at AHIMA.*

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