New Scrutiny on Improper Payments: Federal Government Heightens Focus on Estimating Error

by Sue Bowman, RHIA, CCS

CMS Proposes Mandatory State Reporting of Medicaid and SCHIP Payment Errors

The Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the August 27 *Federal Register* that would require state agencies to estimate improper payments in the Medicaid program and State Children's Health Insurance Program (SCHIP). Under the Improper Payments Information Act of 2002, federal agencies are required to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payment, and report those estimates to Congress. If necessary, the agency is also required to submit a report on actions taken to reduce erroneous payments.

Under this act, improper payment is defined as any payment made that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. Any payment to an ineligible recipient, for an ineligible service, for services not received, or any duplicate payment or payment that does not account for credit for applicable discounts is included under this definition.

To comply with the act, the secretary of Health and Human Services (HHS) must estimate improper payments made under Medicare, Medicaid, and SCHIP. Although CMS has estimated improper payments in the Medicare program since 1996, no systematic means of measuring overall program payment errors at the state and national levels currently exist for Medicaid and SCHIP. Since Medicaid and SCHIP are administered by state agencies according to each state's unique program characteristics, state involvement in estimating improper payments is necessary for the HHS secretary to comply with the provisions of the Improper Payments Information Act.

The proposed rule would require that states provide the HHS secretary with the information needed to monitor performance of Medicaid and SCHIP by measuring improper payments and providing state-level improper payment estimates to calculate a national level improper payment estimate.

CMS believes that the Payment Accuracy Measurement (PAM) model being pilot-tested by a number of states can be implemented nationwide. It would effectively provide all states with the method needed to produce state-specific improper payment estimates, which can be used as a basis for determining national improper payment estimates. The PAM model uses a claims-based sample and review methodology and is designed to estimate a state-specific payment error rate that is within 3 percent (plus or minus) of the true population error rate with 95 percent confidence.

Following the initial estimation of the error rate and improper payments, states would be required to address problem areas that result in improper payments. Improvement will be tracked over time through the states' annual payment error estimates. States will also be required to submit an annual payment error rate measurement report listing the identified errors (identifying which amounts were overpayments, underpayments, and payments for ineligible individuals and services), explain the causes of the errors, and explain the actions taken to address those errors and reduce improper payments.

The review procedures for estimating improper payments for fee-for-service claims would cover processing validation, eligibility, and medical review. Each line item on the claims included in the review sample would be reviewed to validate that it was processed correctly based on the information on the claim. The eligibility review would verify that the beneficiary was eligible for Medicaid or SCHIP at the time the service was received through case record review and field investigation. Medical review would be conducted via mail requests for copies of medical records. At a minimum, the medical review would include review of the guidelines and policy related to the claim, medical record documentation, medical necessity, and coding accuracy.

For capitated payments, each capitation and premium payment would be reviewed to validate that it was processed correctly. The eligibility review of recipients on whose behalf a capitated payment or premium was paid would be the same as that for recipients for fee-for-service claims.

CMS plans to release guidance addressing any immediate questions states may have after reviewing the provisions of the final regulations within 60 days of the effective date of the regulation. They also plan to provide detailed instructions describing the methods and procedures for estimating the payment error rate as necessary.

OIG Monitors Steps to Lower CERT Non-Response Rate

From fiscal years 1996 through 2002, the HHS Office of Inspector General (OIG) estimated the rate of error in Medicare fee-for-service paid claims. In fiscal year 2000, CMS established the Comprehensive Error Rate Testing (CERT) program to produce an error rate for all provider claims except inpatient acute care hospital claims. The Hospital Payment Monitoring Program produces an error rate for inpatient acute care hospital claims. When the error rates from these two programs are combined, CMS produces an overall Medicare fee-for-service error rate similar to the one produced by the OIG.

Beginning in fiscal year 2003, CMS assumed responsibility for developing the error rate for Medicare fee-for-service paid claims. Each month, a contractor hired by CMS to operate the CERT program randomly selects about 200 claims from each Medicare fiscal intermediary, carrier, and durable medical equipment regional carrier (referred to as "affiliated contractors"). For the sampled claims, the contractor requests medical records from providers or affiliated contractors.

For fiscal year 2003, CMS experienced a significant, unexpected problem with providers who did not respond to requests for medical records under the CERT program. More than half of the initial error rate reported by CMS was attributable to nonresponders. According to CMS, nonresponses are comprised of instances where the CERT contractor received no documentation from the provider. Responses included no response from the provider, provider could not find record, record destroyed, provider did not treat beneficiary, provider believes releasing the record is a HIPAA privacy violation, and the cost of providing the record is too great.[1]

Subsequently, CMS implemented several corrective actions to improve the fiscal year 2004 CERT process for obtaining medical records. The CERT management staff gave presentations to the affiliated contractors to educate them on the role of the CERT contractor and to assist them in responding to questions from providers. CMS also directed the affiliated contractors to contact providers that did not submit medical records when requested. The medical record request letters were revised to highlight the CERT contractor's authorization to obtain medical records from providers. This authorization allows the CERT contractor to request medical records for Medicare claims without obtaining prior beneficiary authorization. Providers are also now given the option to submit the requested medical records via fax to reduce providers' costs and processing time. CMS also improved the procedures for following up with providers who fail to respond to the initial request.

An Internet-based claims tracking system has been developed to provide CMS, the CERT contractor, and the affiliated contractors with the weekly status of the review process. This tracking system provides a useful way to identify providers who have not submitted requested medical records. CMS has requested funding to support an electronic medical record submission pilot to facilitate the process and timeliness of submitting medical records.[2]

The chairman of the Senate Committee on Finance and several members of the House of Representative were concerned about the large number of providers that did not supply requested medical records. The OIG was asked to monitor the implementation of CMS's corrective actions to improve the CERT process for obtaining medical records. The OIG report on the interim results of its review of the adequacy of CMS's corrective actions was published in June 2004 and concluded that CMS's actions increased providers' responsiveness to requests for medical records. The provider nonresponse rate for fiscal year 2004 claims decreased significantly when compared with fiscal year 2003.

As of April 8, 2004, the nonresponse rate was about 2 percent based on the total number of sampled claims for the first three quarters of fiscal year 2004 and about 3 percent based on the total dollar value of claims for the same period. The final fiscal year 2003 nonresponse rate was about 8 percent of the total number of sampled claims and 7 percent of the total dollar value of claims.

As a result of its evaluation, the OIG did not make any specific recommendations because the effects of CMS's corrective actions were still relatively new. However, the OIG was concerned that providers still failed to provide medical records

supporting 2,239 claims, despite the CERT contractor's repeated efforts. The OIG has initiated an in-depth review to determine why these providers failed to respond. It also plans to further assess the impact of CMS's corrective actions. The OIG indicated in its report that CMS officials responsible for the Medicare error rate process concurred with its audit results and conclusions.

Notes

1. Centers for Medicare and Medicaid Services. "Improper Medicare Fee-for-Service Payments—Fiscal Year 2003." Available online at www.cms.hhs.gov/cert/reports.asp.
2. Ibid.

Sue Bowman *(sue.bowman@ahima.org) is director of coding policy and compliance at AHIMA.*

Article citation:
Bowman, Sue. "New Scrutiny on Improper Payments: Federal Government Heightens Focus on Estimating Error." *Journal of AHIMA* 75, no.10 (Nov-Dec 2004): 18-19.