OIG Medicare Review Offers Pointers for Compliance Programs

by Sue Prophet, RHIA, CCS, CHC

With the lowest error rate to date and less money being reimbursed for improper payments, the Office of Inspector General's (OIG) 2001 review of Medicare fee-for-service claims has become a model from which to build compliance programs. The review, which was the sixth such review conducted to estimate the extent of improper payments, resulted in an estimated 6.3 percent error rate, which is less than half the 13.8 percent reported for fiscal year 1996.

HIM professionals can learn from the positive results of this audit to build a successful compliance program and, ultimately, improve the overall quality of patient care.

Vigilance Pays Off

The OIG attributes the decreased error rate to the Centers for Medicare and Medicaid Services' (CMS) continued vigilance in monitoring the error rate and developing an appropriate corrective action plan, including collaboration with provider organizations to clarify reimbursement rules and impress upon healthcare providers the importance of fully documenting services.

The OIG maintains that fraud and abuse initiatives on the part of CMS, Congress, the Department of Justice, and the OIG have also had a significant impact on improper billing practices. Since 1998, more than 90 percent of Medicare fee-for-service payments have contained no errors, according to annual audits. The errors the OIG discovered are broken down into the following categories:

Medically Unnecessary Services

Medically unnecessary services was the largest error category in 2001, totaling $5.2 billion (43.2 percent of the improper payments). Fifty-eight percent of these were attributable to inpatient prospective payment system (PPS) claims. This error category covers situations when sufficient documentation was present in the medical record for the reviewers to make an informed decision that the medical services or products received were not medically necessary.

Decisions on medical necessity were made using Medicare reimbursement rules and regulations. To a certain extent, this error category may also be reflective of documentation deficiencies, as favorable medical necessity determinations were based on the existence of supporting medical record documentation.

Documentation

Documentation errors represented the second-largest error category in 2001 and the largest error category in three of the last six years. For 2001, the dollar amount of these types of errors increased by almost 20 percent compared with 2000. They accounted for an estimated $5.1 billion in improper payments. The documentation error category includes two components:

- insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed
- no documentation to support the services provided

The dollar value of 2001 errors in the "insufficient documentation" category increased by more than 60 percent since 2000, while those in the "no documentation" category decreased by 27 percent. In previous years, many of the errors attributed to the "no documentation" category were due to lack of response to the OIG's request for submission of medical records. Over time, however, this response rate has improved, according to the OIG's review.

Medicare regulations require healthcare providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If providers failed to provide documentation or submitted inadequate documentation for the claims included in the OIG review, the Medicare contractor or OIG staff requested supporting medical records at least three times (often four or five times) before concluding that the payment was improper.

Coding

Coding errors represented the third-largest error category for 2001, with 17 percent or $2 billion of the total estimated improper payments. Over the past six years reviewed, physician and inpatient PPS claims accounted for more than 90 percent of the identified coding errors.

For most of the identified coding errors, the reviewers determined that medical record documentation supported a lower-paying code. However, a few instances of downcoding were also identified, which the OIG offset against upcoding situations.

In June 2000, the CMS administrator notified physicians that CPT codes 99233, Subsequent hospital care (requiring two of the three components of a detailed interval history, detailed examination, and medical decision making of high complexity), and 99214, Office or other outpatient visit for an established patient (requiring two of the three components of a detailed history, detailed examination, and medical decision making of moderate complexity) had accounted for a significant portion of the coding errors identified in fiscal years 1998 and 1999.

Documentation for these services often more appropriately supported CPT codes 99231, Subsequent hospital care (requiring two of the three components of a problem-focused interval history, problem-focused examination, and medical decision making of straightforward or low complexity), and 99212, Office or other outpatient visit (requiring two of the three components of a problem-focused history, problem-focused examination, and straightforward medical decision making), respectively.

The 2001 review showed continued problems with these same CPT codes. In this review, the OIG also noted a high incidence of error in CPT code 99232, Subsequent hospital care (requiring two of the three components of an expanded problem-focused interval history, expanded problem-focused examination, and medical decision making of moderate complexity).

Examples of coding errors identified in the OIG review include:

- determination that the medical record documentation supported a **lower level of evaluation and management service** than the code billed
- medical record documentation supported a **different principal diagnosis** than the one reported by the hospital

Recommendations to CMS

Although the OIG identified several error categories, it is clear that the common theme is lack of complete and accurate documentation to support the services provided, billed, and coded.

While the OIG acknowledges that its six-year analysis indicates progress in reducing improper payments, its report summarizing the 2001 review shows that undocumented and medically unnecessary services have been and continue to be pervasive problems. These two error categories accounted for more than 79 percent of the total improper payments over the past six years.

The OIG noted that CMS needs to increase its work with providers to ensure that medical records support billed services. Additionally, it pointed out that medical records serve a number of valuable purposes, such as assisting providers in evaluating and planning the patient's treatment, ensuring continuity of care, and helping to ensure the correct and timely processing and payment of provider claims.

Specific recommendations from CMS include:

- increase efforts to direct Medicare contractors to **expand provider training** to further emphasize the need to maintain medical records containing sufficient documentation
- increase efforts to **use proper procedure codes** when billing Medicare for services provided

- continue to **refine Medicare regulations and guidelines** to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented
- ensure that contractors **recover the improper payments** identified in the OIG review

A Clear Message from the Government

The government has made it clear, through its audit and inspection reports, compliance program guidances, fraud alerts, and enforcement initiatives, that claims should be submitted only when appropriate documentation supporting them is present in the health record and available for audit and review. Documentation of all physician and other professional services should be proper (that is, according to regulatory standards and generally accepted documentation practices), complete, and timely to ensure that only accurate and properly documented services are billed.

HIM and compliance professionals know that compliance programs should include processes for ensuring that health record documentation is adequate and appropriate to support the coded diagnoses and procedures and the medical necessity of the services rendered. However, addressing the underlying problem of inadequate documentation can be one of the most thorny compliance issues.

It is often much easier to focus on other compliance issues, such as providing additional education to coding, billing, and registration staff. However, the success of many efforts aimed at resolving compliance problems is in jeopardy if documentation improvement activities are not included. Missing, incomplete, ambiguous, or conflicting medical record documentation is often at the root of the compliance problem.

Lessons from the Audit

What should HIM professionals learn from the OIG's audit of fiscal year 2001 Medicare fee-for-service payments? To start, they can see the positive trend in improvements in payment errors. However, as evidenced by the dollar figures involved, there is still a great deal of money being lost to improper payments. And there are still many opportunities for HIM professionals to use their expertise and resources to improve coding accuracy, record documentation practices, and quality of patient care in their own organizations.

Here are some ways to use the results of the OIG's audit in your compliance initiatives:

- use the OIG's report to **gain senior management and medical staff commitment** to endeavors directed at improving medical record documentation
- **incorporate examples** of documentation and coding errors identified in the OIG report in educational programs (for both coding staff and physicians)
- **educate physicians** on proper use of the CPT codes identified as problematic (including appropriate supporting medical record documentation)
- **use the OIG's statistics** regarding medical necessity errors in educational sessions for physicians and clinical staff (sharing facts related to actual error incidence, the financial impact, and the government's interest can often grab an audience's attention)
- ensure that problems identified in the OIG review are **addressed in your auditing and monitoring program**, because these problems can be considered high-risk areas

The OIG's report can provide a jump start to any compliance program.

Reference

The Department of Health and Human Services Office of Inspector General. "Improper Fiscal Year 2001 Medicare Fee-For-Service Payments." February 2002. Available at: http://oig.hhs.gov/oas/reports/cms/a0102002.pdf.

Reviewing the Claims

Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 6,594 fee-for-service claims processed for payment during fiscal years 2000 and 2001, the OIG found that 954 claims did not comply with Medicare laws and regulations. Improper payments made during 2001 totaled $12.1 billion.

In cases where there was insufficient or no documentation supporting Medicare claims, medical reviewers could not reach a decision on whether the services were properly authorized and medically necessary. In several cases, it was clear that Medicare beneficiaries had received services, but the physician's orders or documentation supporting the beneficiary's medical condition was missing. While these claims did not meet Medicare reimbursement rules regarding documentation, the OIG was unable to conclude that the services were not provided or unnecessary.

Sue Prophet *(sue.prophet@ahima.org) is AHIMA's director of coding policy and compliance.*

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