Room for Improvement: CMS Reports 2004 Payment Error Rate Findings; OIG Publishes Recommendations for Hospital Compliance Programs

by Sue Bowman, RHIA, CCS

Two recent developments highlight the need for improvement in medical record documentation, coding, and hospital compliance programs.

CMS Fails to Meet 2004 Payment Error Rate Performance Goal

One of the Centers for Medicare and Medicaid Services' (CMS) Medicare performance goals for FY 2004 was to reduce the improper payments made under the fee-for-services (FFS) program to 4.8 percent net (5.6 percent gross) or less, a goal that was not met. The national paid claims error rate in the Medicare FFS program for 2004 was 10.1 percent gross (overpayments plus underpayments) and 9.3 percent net (overpayments minus underpayments). This means that of the $213.5 billion paid by the Medicare FFS program, $21.7 billion gross ($19.9 billion net) was paid incorrectly.

The breakdown of the payment error rate is shown in "Medicare FFS Payment Errors," below.

Medicare FFS Payment Errors

	Percentage of Net Errors	Net Errors as a Percentage of Total Dollar Amount Sampled
Insufficient documentation	43.7	4.1
Nonresponse	29.7	2.8
Incorrect coding	17.2	1.6
Medically unnecessary	7.7	0.7
Other	1.6	0.2

"Insufficient documentation" means that providers did not include pertinent patient facts in the submitted medical record documentation. In some, it was clear that patients received services, but the physician's orders or documentation supporting the beneficiary's medical condition were incomplete. The carrier-billed service with the highest insufficient documentation error rate was follow-up inpatient consultations. The intermediary-billed service with the highest insufficient documentation error rate was inpatient skilled nursing facility services.

"Nonresponse" means that the provider did not submit any documentation to support the services provided. CMS attributed nonresponse to several factors, including lack of familiarity with the Comprehensive Error Rate Testing (CERT) program contractor, concerns about HIPAA compliance, and lack of documentation. In some instances, the documentation was located at a third party. If providers failed to contact the third party or the third party failed to submit the documentation, CMS counted the claim as a nonresponse error.

"Incorrect coding" involves either upcoding (documentation supports a lower-paying code than the code submitted) or undercoding (documentation supports a higher-paying code than the code submitted). Upcoding accounted for most of the identified coding errors. In an undercoding special study, CMS determined that most of the undercoding involved claims billed to carriers for evaluation and management services. Since facilities undercoded only .05 percent of the claims submitted to fiscal intermediaries, CMS feels that these errors represent random billing errors. CMS believes that in order to lower the error

rates related to incorrect coding, it must focus on the rate of undercoded or upcoded services, not the dollar-weighted rate associated with these payment errors.

"Medically unnecessary services" include situations where the review staff identified enough medical record documentation to make an informed decision that the services billed to Medicare were not medically necessary.

"Other errors" include instances in which providers' claims did not meet benefit category requirements or other billing requirements.

Corrective Actions

General corrective actions that CMS has taken, or plans to take, include educational programs by contractors; requiring contractors to develop annual medical review strategies to reduce error rates; development and installation of new correct coding edits; and encouragement of contractors to address provider billing and payment questions more consistently. Some of the corrective actions CMS has initiated to reduce future error rates in the specific error rate categories include:

Insufficient Documentation

- Conducting a special study to better understand the causes of insufficient documentation
- Releasing a list of overused codes
- Extending the time that providers have to respond to documentation requests
- Hiring a second CERT contractor to assume responsibility for requesting and receiving all requested medical records
- Modifying the medical record request letters to clarify the components of the record needed for CERT review
- Providing a second opportunity to supply additional documentation if the initial documentation is deemed insufficient
- Educating providers about the importance of submitting thorough and complete documentation

Nonresponse

- Revising medical record request letters to emphasize that faxing is the most effective way of submitting medical records
- Implementing an appeals tracking system
- Conducting an electronic health record submission pilot to determine whether accepting computerized and imaged medical records would improve efficiency and lower the error rate

Incorrect Coding

- Encouraging the American Medical Association to improve clinical examples and other documentation guidelines to assist physicians in understanding how to correctly code evaluation and management services
- Educating physicians about the importance of billing correctly to avoid upcoding and undercoding

Medically Unnecessary Services

- Developing a tool that generates state-specific hospital billing reports to help quality improvement organizations (QIOs) analyze administrative claims data
- Developing projects with QIOs that address state-specific hospital billing reports to help QIOs analyze administrative claims data

OIG Issues Supplement to Compliance Program Guidance for Hospitals

Earlier this year, the Office of Inspector General (OIG) published its "Supplemental Compliance Program Guidance (CPG) for Hospitals," which is intended to supplement, not replace, the OIG's 1998 Compliance Program Guidance for Hospitals. The supplemental CPG contains new compliance recommendations and an expanded discussion of risk areas, taking into account recent changes to hospital payment systems and regulations, evolving industry practices, current enforcement priorities, and lessons learned in the area of corporate compliance.

New fraud and abuse described in the supplemental CPG include:

Outpatient procedure coding: The implementation of the Medicare outpatient prospective payment system (PPS) increased the importance of accurate procedure coding for hospital outpatient services. Because incorrect procedure coding may lead to overpayments and subject a hospital to liability for the submission of false claims, hospitals need to pay close attention to coder training and qualifications. Hospitals should also review their outpatient documentation practices to ensure that claims are based on complete medical records and that the medical records support the levels of service claimed.

A hospital's evaluation and management coding guidelines should ensure that services are medically necessary and sufficiently documented and that the codes accurately reflect the intensity of hospital resources required to deliver the services.

Use of information technology: The implementation of the outpatient PPS increased the need for hospitals to pay particular attention to their computerized billing, coding, and information systems. Information technology presents new opportunities to advance healthcare efficiency, but also new challenges to ensuring the accuracy of claims and the information used to generate claims. Prudent hospitals will take steps to ensure that they thoroughly assess all new computer systems and software that impact coding, billing, or the generation or transmission of information related to federal healthcare programs or their beneficiaries.

In addition to addressing new risk areas, the supplemental CPG also discusses the importance of hospitals' self-assessment of the effectiveness of their compliance programs. Hospitals should regularly review the implementation and execution of their compliance program elements. Although measurement of various outcomes indicators is a common method of assessing compliance program effectiveness, the OIG noted that reliance on these indicators alone may cause an organization to miss crucial underlying weaknesses. Hospitals should examine program outcomes and assess the underlying structure and process of each compliance program element. Factors identified by the OIG that may be useful when evaluating the effectiveness of basic compliance program elements fall into the following categories:

- Designation of a compliance officer and compliance committee
- Development of compliance policies and procedures (including standards of conduct)
- Opening lines of communication
- Appropriate education and training
- Internal monitoring and auditing
- Response to detected deficiencies
- Enforcement of disciplinary standards

Examples of some of the factors the OIG recommends that hospitals include in their evaluation of their compliance programs include:

- Has the hospital developed a risk assessment tool, which is reevaluated on a regular basis, to assess and identify weaknesses and risks in operations?
- Has the hospital evaluated its training and education program on an annual basis and determined that the content is appropriate and sufficient to cover the range of issues confronting its employees?
- Has the hospital kept up to date with any changes in federal healthcare program requirements and adapted its education and training program accordingly?
- Does the audit plan include an assessment of billing systems, in addition to claims accuracy, in an effort to identify the root cause of billing errors?
- Is the role of the auditors clearly established? Are coding and audit personnel independent and qualified, with the requisite certifications?
- Does the audit include a review of all billing documentation, including clinical documentation, in support of the claim?
- Are corrective action plans developed that take into account the root causes of each potential violation?

A point of interest is the recommendation that corrective action plans take into account the root causes of each potential violation. For example, if the root cause of an identified problem is incomplete medical record documentation, the corrective action plan should include steps to improve the documentation rather than "workarounds" (such as coder education) that do not address the underlying cause.

References

Centers for Medicare and Medicaid Services. “Improper Medicare Fee-for-Service Payments—Fiscal Year 2004.” Available online at www.cms.hhs.gov/cert/reports.asp.

Office of Inspector General. “The Supplemental Compliance Program Guidance for Hospitals.” Available online at www.access.gpo.gov/su_docs/fedreg/a050131c.html.

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