Improper Medicare Fee-For-Service Payments Report - November 2009 Report

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Findings

National Medicare FFS Error Rate

The national paid claims error rate in the Medicare FFS program for this reporting period is 7.8% (which equates to $24.1 B). The 95% confidence interval for the Medicare FFS program paid claims error rate was 7.3% - 8.4%. The 90% confidence interval (required to be reported by IPIA) was 7.3% - 8.3%.

Based on both the recommendations contained in recent OIG audit reports and those of CMS' advisory medical staff, CMS modified the medical review process for the November 2009 Improper Payments report. CMS implemented three separate revisions to the CERT review criteria based on these recommendations. Approximately 99,500 claims completed the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria. The national paid claims error rate for those claims reviewed under the strictest criteria, when applied to the entire year, is 12.4% or $35.4 billion. However, CMS consulted with the OIG concerning the limited time period covered by these claims, and determined that reporting the error rate for this subset of claims only would not be in compliance with IPIA requirements.

Table 3b summarizes the overpayments, underpayments, improper payments, and error rates by contractor type.

Table 3b: Error Rates and Projected Improper Payments by Contractor Type

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Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier/MAC	$78.7B	$7.6B	9.7%	$0.1B	0.2%	$7.8B	9.9%
DME MAC	$10.4B	$5.4B	51.9%	$0B	0.0%	$5.4B	51.9%
FI/MAC - Non-Inpatient	$108.2B	$4B	3.7%	$0.2B	0.2%	$4.2B	3.9%
FI/MAC - Inpatient	$111.2B	$6.1B	5.5%	$0.8B	0.7%	$6.8B	6.1%
All Medicare FFS	**$308.4B**	**$23B**	**7.5%**	**$1.1B**	**0.4%**	**$24.1B**	**7.8%**

(2)

The DME MAC (51.9%) error rate was much higher than that of the Carrier/MAC (9.9%), FI/MAC Non-Inpatient (3.9%) and FI/MAC Inpatient (6.1%) rates because CMS' stricter adherence to policies disproportionally affected DME claims. More DME claims were determined to be paid in error because of the more strict enforcement of documentation requirements rather than allowing for clinical review judgment. In the past, reviewers applied clinical review judgment to claims to fill in the gaps of knowledge where documentation was missing. Once CMS clarified that clinical review judgment may not override documentation requirements, more errors were found on DME items. Additionally, it is often more difficult for DME contractors to obtain the proper documentation because they request documentation from the supplier who billed for the item, not the medical professional who ordered the item. The supplier then is responsible for submitting documentation to CMS that they have collected from the ordering provider. The involvement of multiple parties can cause a delay in documentation receipt and incomplete documentation. CMS also recently clarified that documentation produced by the supplier alone is insufficient to warrant payment of the claim.

As previously stated, the national paid claims error rate for FY 2009 is 7.8% or $24.1 B. Last year's error rate was 3.6% or $10.4 B. The increase in the error rate can be attributed to several programmatic changes. These changes and their impacts are further discussed below.

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Consolidation of HPMP and CERT

Differences in error rate measurement methodology in the HPMP and CERT programs resulted in an increased error rate for inpatient hospital claims. HPMP sampled claims three months after month of discharge which allowed time for adjustment bills. CERT reviews the iteration of the claim that was randomly selected, even if the provider subsequently submitted an adjustment claim. HPMP allowed appeals to be submitted and adjudicated before calculating the error rate. The CERT program includes only appeals that have been adjudicated by a designated cutoff date in the error rate calculations. Therefore, the CERT program counts fewer appeal overturns. Additionally, CERT more strictly applied all national and local policies when reviewing inpatient claims.

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Documentation Requirements

Many of the new errors resulted from a strict adherence to policy documentation requirements. In the past, the CERT contractor requested physician medical records but if all documentation was not submitted, the reviewers considered all available information (medical records, supplier notes, beneficiary payment history, etc.) and applied clinical review judgment to determine if sufficient information was available to make a payment decision. Now, CERT requires that physician records be present and doesn't consider additional available information until all of the documentation requirements are met. Consider for example, a bill submitted by a supplier for an oxygen concentrator. The supplier documentation includes a Certificate of Medical Necessity (CMN) which lists the oxygen saturation at rest and during exercise as required by the local coverage determination (LCD). The LCD also requires that the information on the CMN be supported by the ordering/referring physician's medical records. If the physician's medical record documentation is not submitted to the review entity, the supplier claim is denied.

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Strict Enforcement of Signature Requirements

In addition, CMS directed the CERT contractor to more strictly adhere to its policy on signatures contained in the submitted medical record. For medical review purposes, Medicare requires that services provided/ordered be authenticated by a legible identifier and stamp signatures are not acceptable. In the past, if the provider's signature was missing or illegible, and there were no other reasons for denial of the claim, the CERT contractor did not deny the claim. After consultation with the OIG, CMS issued instructions to the CERT contractor directing them to strictly adhere to the CMS policy requiring a legible identifier.

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Disallowance of Supplier Documentation

CMS determined that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim. For example, CERT reviewed a claim for enteral formula (liquid nutrition given by a feeding tube) and received a Certificate of Medical Necessity (CMN) and dietary progress notes signed by a licensed dietician. The beneficiary had oral cancer, which was treated with radiation, and a tracheostomy. However, the licensed dietician was employed by the supplier and under the new policy, CERT must deny the claim.

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Removal of Billing History as a Valid Source of Information

Based on recommendations from the OIG, CMS removed claims history as a valid source for review information. Claims that previously would have been paid based on information from claims history were then denied. For example, CERT reviewed a claim for a bedside commode. The supplier provided the treating physician's signed and dated order to the CERT Contractor indicating a 79 year old patient was recovering from a total knee replacement. A review of claims history showed the beneficiary had a Medicare covered inpatient hospital stay for total knee replacement with a comorbid diagnosis of urinary tract infection shortly before this claim. The policy states a commode is covered when the patient is physically incapable of using regular toilet facilities. The CERT Contractor would have previously determined that the total knee replacement combined with the urgency of urination associated with a urinary tract infection was sufficient to meet this requirement. Now, however, the CERT contractor may not use claims history as a basis for payment. CERT would not know the patient had urinary incontinence unless a medical record indicating the condition was also submitted.

It is likely that additional documentation, as required by the newly clarified policies, would have supported payment of the claim in many cases. For a detailed description on the types of errors and the error rate for each type, see Appendix.

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GPRA Goals

Based on the CERT results for 2007 and 2008 CMS established the following error rate goals under the Government Performance and Results Act (GPRA):

1. Reduce the National Medicare FFS Paid Claims Error Rate.

- By November 2009, reduce the percent of improper payments under Medicare FFS to 3.5%.

  Status: This goal was not met. The national paid claims error rate for the November 2009 reporting period was 7.8%. Because of the increase in the error rate, CMS is revising the goal for November 2010.

2. Reduce the Contractor-Specific Paid Claim Error Rate.

- By November 2009, 90% Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for November 2008.

  Status: Due to the reduced number of claims reviewed – 99,500 versus the 120,000 originally planned – CMS did not produce contractor-specific error rates for 2009. This goal was not calculated for 2009.

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Corrective Actions

CMS strives to eliminate improper payments in the Medicare program to maintain the Medicare trust funds and protect beneficiaries. To better account for improper payments, CMS altered the CERT process and called for a more strict enforcement of its policies. CMS will analyze the improper payment data garnered from the CERT program and make changes in areas that show programmatic weakness. CMS will also work with its contractors to ensure a more comprehensive review is done on all Medicare FFS claims. CMS plans to make several programmatic changes in order to decrease improper payments.

CMS has several correction actions in place to reduce administrative and documentation errors.

- CMS implemented improvements to the Medicare FFS error rate measurement program to ensure that providers and suppliers submit the required documentation.
  - CMS revised the medical record request letters to clarify the components of the medical record that are required for a CERT review.
  - CMS contacts third party providers to request documentation when the billing provider indicated that a portion of the medical record is possessed by a third party.
  - CMS conducts ongoing education to inform providers about the importance of submitting thorough and complete documentation of all medical records, especially those where the provider is ordering additional services or medical equipment.

CMS is dedicated to reducing authentication and medical necessity errors and is exploring the following corrective actions.

- CMS is revising Medicare FFS manuals to clarify requirements for reviewing documentation to promote uniform interpretation of our policies across all medical reviews performed by Medicare contractors.
- CMS is revising Medicare FFS manuals to address the errors related to signature requirements. CMS is currently devising a process whereby providers can attest to their signature if it is illegible or missing in a medical record under review. CMS also plans to conduct provider education related to signature requirements.
- CMS is developing comparative billing reports to help Medicare contractors and providers analyze administrative claims data.
- CMS is undertaking an automated edit demonstration to evaluate the accuracy of several commercial products that purport to deny health care claims that contain Medicare improper payments. The demonstration will determine whether these products are feasible in the Medicare FFS environment and would result in added value to the Medicare FFS program.
- CMS tasked each Carrier, FI, and MAC with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.
- CMS requires the Carriers, FIs, and MACs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce medical necessity and incorrect coding errors.
- CMS increased and refined educational contacts with providers who are billing in error.
- CMS developed and installed new correct coding edits.

CMS is expanding educational efforts to inform providers of Medicare coverage and coding rules.

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