

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CARRIER MEDICAL REVIEW
PROGRESSIVE CORRECTIVE
ACTION**



Daniel R. Levinson
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OBJECTIVES

To determine whether Medicare carriers have implemented medical review progressive corrective action strategies for physicians in accordance with guidance issued by the Centers for Medicare & Medicaid Services (CMS).

To determine whether progressive corrective action is achieving desired results, which are to reduce physician error rates and to modify the behavior of physicians.

BACKGROUND

In fiscal year (FY) 2000, CMS revised its Program Integrity policy to include a new process for conducting medical review. In general, this revised strategy uses progressive corrective action approaches such as preliminary data analysis, probe medical reviews, and the calculation of billing error rates to correct billing problems through targeted education and training. The ultimate goal of these strategies is to reduce billing and payment errors.

Progressive corrective action strategies have taken on increased significance under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 921 of the MMA highlights the importance of providing effective education and training to Medicare participating providers. It provides increased funding to improve the accuracy of billing and coding claims data and the timeliness of contractor responses.¹ In addition, effective October 1, 2005, the MMA requires Medicare contractors to use claims payment error rate information as “an incentive to implement effective education and outreach programs.”²

Under progressive corrective action strategies, carriers are instructed to: (1) conduct preliminary data analysis to identify inappropriate, unnecessary, or excessive provider claims billed to the Medicare program; (2) complete a medical review of a probe sample of provider claims to determine the severity of the billing problem; (3) consider indicators such as the individual provider error rate when deciding how

¹ MMA, section 921(d)(2).

² MMA, section 921(b)(1).

to address a problem; (4) conduct medical review activities that are appropriate to the identified problem; and (5) provide education and training to all providers identified as aberrant billers.

In addition, carriers are required to have a tracking system and document the following five items: all educational contacts made as a result of actions to correct identified problems; the results of quarterly reassessments for all providers; the date a provider is put on a provider-specific edit; the date edits are turned off; and the results of appealed medical review decisions.

For this inspection, we conducted a document review of carrier manual instructions and program memoranda, reviewed 18 Medicare Part B carriers' tracking systems for all physicians who were first identified for progressive corrective action during the first two quarters of FY 2003, and collected information from staff at CMS and 18 Part B carriers.

FINDINGS

Carriers are generally implementing progressive corrective action strategies consistent with CMS guidance. Our examination of the data from carriers' tracking systems for Medicare participating physicians leads us to conclude that carriers are generally implementing progressive corrective action strategies consistent with CMS guidance. Even though carriers are not required to document their approaches in all cases, there is evidence in their tracking systems that they are implementing the five progressive corrective action approaches. Specifically,

- sixteen carriers have evidence in their tracking systems that their decision to conduct medical review is based on the results of preliminary data analysis,
- all eighteen carriers have information indicating that they conduct pre-or postpayment probes to validate suspected aberrant billing behavior for at least some of the physicians identified for corrective action,
- sixteen carriers include error rate calculations in their tracking systems for at least some of the identified physicians, which indicates that carriers consider error rates when deciding how to address a given billing problem,

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- all eighteen carriers have information documenting that they take steps to subject physicians to reasonable amounts of medical review, and
- seventeen carriers have information in their system documenting that they provide education and training to at least some of the physicians identified for progressive corrective action.

In addition, in our interviews with the 18 carriers, they confirm that they are implementing corrective action strategies, and they provide explanations of how they carry out each of the 5 approaches.

However, carriers are not following all tracking requirements.

Carriers are required to have a tracking system and document five specific progressive corrective action elements. We found that while all carriers have a tracking system, none of the carriers document all the required elements. They are most commonly missing the results of quarterly reassessments and information on contacts made to correct identified problems.

Little information exists to determine whether progressive corrective action strategies are achieving desired results.

We found that carriers calculated baseline and subsequent error rates for an average of 8 percent of the 2,316 physicians identified for corrective action during the first two quarters of FY 2003, which is too small a sample to determine whether or not progressive corrective action strategies are effective. Additionally, CMS relies primarily on compliance-based oversight mechanisms that do not address progressive corrective action outcomes. As a result, we cannot determine whether progressive corrective action strategies reduce individual physician error rates and/or modify the behavior of physicians.

RECOMMENDATIONS

The MMA highlights the importance of providing effective education and training to Medicare participating providers. However, CMS does not currently have any method that measures the effectiveness of progressive corrective action strategies and whether the strategies reduce individual physician error rates and/or modify the behavior of physicians.

To address these issues, we recommend that CMS:

- Institute outcome-based program measures to better determine whether progressive corrective action strategies reduce individual physician error rates and/or modify the behavior of physicians.
- Conduct reviews of carrier tracking systems to ensure that carriers are complying with requirements.

AGENCY COMMENTS

CMS concurred with our recommendations. CMS further commented that it has already taken steps to include reviews of carrier tracking systems as part of its annual SAS-70 reviews. The full text of CMS's comments is included in Appendix A.

CMS also commented that it will “continue to require its contractors to evaluate the effectiveness of corrective actions taken.” It noted that there are a number of methods that can be employed to identify progressive corrective action outcomes. CMS commented that error rates, as well as analysis of claims data, may be sufficient to determine the effectiveness of a progressive corrective action intervention.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree. However, we question whether carriers will evaluate and track the effectiveness of corrective action strategies in absence of more guidance from CMS. For example, further guidance on when to require the calculation of individual provider error rates would increase CMS's ability to determine whether progressive corrective action strategies are achieving desired results. We reiterate that, based on our review of carriers' tracking systems, we found that none of the 18 carriers tracked the results of quarterly reassessments for all physicians identified for corrective action during our sampling timeframe, as required by CMS.



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To determine whether progressive corrective action is achieving desired results, which are to reduce physician error rates and to modify the behavior of physicians.

BACKGROUND

In fiscal year (FY) 2000, CMS revised its Program Integrity policy to include a new process for conducting medical review. In general, this revised strategy uses progressive corrective action approaches such as preliminary data analysis, probe medical reviews, and the calculation of billing error rates to correct billing problems through targeted education and training. The ultimate goal of these strategies is to reduce billing and payment errors.

Progressive corrective action strategies have taken on increased significance under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 921 of the MMA highlights the importance of providing effective education and training to Medicare participating providers. It provides increased funding to improve the accuracy of billing and coding claims data and the timeliness of contractor responses.³ In addition, effective October 1, 2005, the MMA requires Medicare contractors to use claims payment error rate information as “an incentive to implement effective education and outreach programs.”⁴

Medical Review and Progressive Corrective Action

Section 1862(a)(1)(A) of the Social Security Act states that Medicare covers services that are included in a Medicare benefit category, are not statutorily excluded, and are reasonable and necessary. Federal statute sets forth broad categories of benefits covered by Medicare, but does not provide a comprehensive list of services that are reasonable and necessary for beneficiaries’ medical care. CMS and the contractors

³ MMA, section 921(d)(2).

⁴ MMA, section 921(b)(1).

I N T R O D U C T I O N

(including Medicare Part B carriers) are responsible for reviewing, processing, and adjudicating claims to determine whether services provided are reasonable and necessary, and are therefore covered under Medicare.

In an effort to minimize fraud, waste, and abuse in Medicare, CMS requires Part B carriers to review claims submitted for payment.⁵ Specifically, under the Program Integrity medical review function, carriers are instructed to review submitted claims to determine whether they are reasonable and necessary and are correctly coded. When conducting medical review, carriers are instructed to apply progressive corrective action strategies.

CMS program memorandum AB-00-72, dated August 7, 2000, provides Medicare carriers with written instructions on progressive corrective action strategies. CMS describes these instructions as “. . . further guidance, underlying principles and approaches to be used in deciding how to deploy resources and tools for medical review.” These instructions require some specific activities, but also allow carriers flexibility in the approaches they may use when carrying out progressive corrective action.

CMS instructs carriers to perform preliminary data analysis to identify inappropriate, unnecessary, or excessive provider claims billed to the Medicare program. In addition, carriers must complete a medical review of a probe sample of provider claims to determine the degree of severity of the billing problem.⁶ When problems are identified, carriers are to conduct medical review activities that are appropriate to the problem. Carriers must also provide education and training to all providers who are identified as aberrant billers. See the chart on the next page for a primer on progressive corrective action approaches, which are outlined in CMS program memorandum AB-00-72.

⁵ CMS, “Medicare Program Integrity Manual,” June 2000.

⁶ With the exception of not exceeding a probe sample size of 20-40 claims, currently CMS does not require carriers to use a specific sampling methodology (e.g., a random sample) for the probe medical review.

Primer on Progressive Corrective Action Approaches and Activities		
Recommended Approach	Underlying Principle	Specific Activities
<i>The decision to conduct medical review should be data driven.</i>	Preliminary data analysis determines whether patterns of claims submission and payments indicate potential problems.	Activities may include simple identification of aberrancies in billing patterns or claims; provider referrals; reports from CMS; and/or comparisons between peer groups, for example, how identified physicians' billing patterns compare to billing patterns of peers in the same specialty.
<i>Validate potential problems by conducting probe reviews.</i>	Probe sample reviews validate the existence of billing errors.	Carriers should select a sample (either prepayment or postpayment) that generally does not exceed more than 20 to 40 claims for any individual provider problem, or 100 claims or services from a wider universe of providers.
<i>The provider error rate is an important consideration.</i>	Information such as provider billing or payment error rates guide carriers in how to address the billing problem.	Carriers should consider the error rate. They are also encouraged to consider the total value of the problem, the past history of the provider, and/or whether the severity of the problem is determined to be minor, moderate, or significant in nature.
<i>Subject providers only to the amount of medical review necessary.</i>	Medical review resources are allocated to providers or services where the Medicare Trust Fund is at greatest risk.	Carriers should target problems that are high cost, likely to have adverse impact on beneficiaries, and/or are problems that have become progressively worse.
<i>Provider feedback and education is an essential part of solving problems.</i>	Education and feedback is a core step in solving billing problems.	Carriers should provide education and training to <u>all</u> providers identified for medical review. This education can be in the form of direct one-on-one contacts, through telephone or conference calls, and/or through group meetings. These are referred to as types of interventions.

Source: CMS, Medical Review Progressive Corrective Action Program Memoranda Transmittal AB-00-72, August 2000.

In addition, carriers are required to have a tracking system that documents the following five items:

- all educational contacts made as a result of actions to correct identified billing problems. This information may include dates when educational letters were mailed out or when telephone or onsite meetings were held,
- results of quarterly reassessments to determine if behavior changed after the provider received necessary education and training,
- date a provider is put on a provider-specific edit,⁷
- date a provider is taken off an edit, and
- results of appealed medical review decisions.

National Paid Claims Error Rate

Currently, CMS contracts with the program safeguard contractor, AdvanceMed, to calculate the national paid claims error rate through the Comprehensive Error Rate Testing (CERT) program.⁸ The goal of this work is to improve the accuracy of payment decisions made by Medicare contractors. Based on local and national coverage policies, a medical review team reviews information the carrier used to make its decision “to verify that decisions regarding the claims were accurate and based on sound policy.” In FY 2003, CMS found that carriers paid 7.3 percent of all Medicare Part B claims in error.⁹ It is CMS’s expectation that progressive corrective action intervention efforts will contribute to a reduction in the national paid claims error rate.¹⁰

CMS Oversight

In FY 2003, CMS initiated the Self-Assessment, Performance Oversight, and Comprehensive Error Rate Testing and Educational program (SPACE) and began using it to conduct oversight of carrier activities,

⁷ Edits are software-based controls used to prevent an overutilization of codes, upcoding to a higher reimbursement rate, or inappropriate frequencies of services billed for the same beneficiary. Edits are put in place to flag any group of claims that does not follow Medicare coverage guidelines and may serve to delay or reject payments.

⁸ From fiscal year 1996 to fiscal year 2002, the Office of Inspector General calculated the national Medicare paid claims error rate. In fiscal year 2003, CMS assumed this responsibility.

⁹ This estimate excludes nonresponse claims.

¹⁰ CMS, “FY 2003 Improper Medicare Fee For Service Payments Report,” November 2003.

including those activities associated with progressive corrective action interventions. The SPACE program consists of the following:

- **Self-Assessment** —“Certification Package for Internal Controls”- A carrier’s self-assessment to identify and correct any weakness within an operational area;
- **Performance Oversight** —“Statement on Auditing Standards Number 70” (SAS-70) — An audit of a Medicare contractor’s operational areas conducted by an independent auditing firm. Among other elements, auditors measure whether internal controls and objectives for medical review are in place and based on CMS instructions;
- **Comprehensive Error Rate Testing** — A program safeguard contractor-run program that measures carriers’ paid claims error rates; and
- **Educational Training Program** — An educational interaction between CMS staff and carriers based on potential or current areas of contractor vulnerability. Educational interventions may be based on findings from SAS-70 audits or other CMS concerns.

Related Work

The Government Accountability Office (GAO) issued a report entitled “Recent CMS Reforms Address Carrier Scrutiny of Physicians’ Claims for Payment” in May 2002.¹¹ This report describes the progressive corrective action strategy and its use of provider education in combination with medical review, as well as its effects on physician paid claims. GAO found that only a small percentage of total physician claims are ever selected for medical review, which can limit progressive corrective action’s influence on reducing the national paid claims error rate.

SCOPE

This inspection determines the extent to which carriers have implemented progressive corrective action strategies consistent with CMS guidance. It does not determine the effectiveness of any individual carrier’s use of progressive corrective action strategies. In addition, this

¹¹ GAO-02-693, May 2002.

inspection focuses solely on physicians and excludes other types of providers that may be identified for corrective action.

METHODOLOGY

We obtained information for this inspection from a number of sources: a document review of carrier manual instructions and transmittals, a review of 18 Medicare Part B carriers' tracking systems, telephone interviews and onsite discussions with carrier staff, and telephone and in-person interviews with key CMS regional and central office staff.

Document Review

We reviewed the "Medicare Program Integrity Manual" and CMS Program Memoranda transmittals pertaining to progressive corrective action and other relevant documents.¹² These documents were primarily used to determine the approaches and recommended activities under progressive corrective action.

Tracking System and Error Rate Analysis

We contacted 18 Medicare Part B carriers and requested a description of the variables listed in their tracking system. We also asked for data for all physicians who were first identified for progressive corrective action during the first or second quarters of FY 2003. For all identified physicians, we requested that carriers submit the following information:

- all education and training activities in FY 2003;¹³
- error rates prior to progressive corrective action intervention, i.e., "baseline error rates," and error rates after receiving progressive corrective action intervention, i.e., "subsequent error rates" that were calculated in FY 2003; and
- any information regarding the status of appealed medical review decisions.

We developed an instrument to review and analyze the variables and data in the carriers' tracking system. Specifically, we determined whether each carrier documented both the required information and any other information regarding recommended progressive corrective

¹² CMS, "Medicare Program Integrity Manual," June 2000.

¹³ Carriers had a reasonable amount of time during the course of fiscal year 2003 to provide education and/or training and conduct at least one quarterly reassessment, as required by CMS guidance.

action approaches and/or activities. Note that we did not independently verify the accuracy of any of the data in the tracking systems.

We also analyzed the error rate information provided by carriers. Specifically, we determined the extent to which carriers calculated baseline and subsequent error rates for the physicians identified for progressive corrective action.

Carrier Onsite Discussions and Telephone Interviews

We conducted site visits with three carriers to determine their understanding of progressive corrective action strategies and objectives. We also conducted structured telephone interviews with the supervising staff at each of the 18 Medicare Part B carriers involved in conducting progressive corrective action activities.¹⁴ During telephone interviews, we gathered information about carriers' experiences implementing progressive corrective action, which included:

- the extent to which carriers have implemented the strategies,
- the extent to which progressive corrective action has achieved desired results, and
- how CMS oversees carriers' performance related to progressive corrective action.

CMS Central Office and Regional Office Interviews

We conducted structured in-person interviews with key staff at CMS central office who are responsible for Program Integrity, medical review oversight. We also conducted telephone interviews with each of the eight CMS regional offices.¹⁵ Our questions focused on the following:

- the extent to which carriers have implemented the strategies,
- the extent to which progressive corrective action strategies have achieved desired results, and
- the oversight mechanisms CMS currently uses to determine carrier performance with regard to progressive corrective action.

¹⁴ We excluded Triple-S, the carrier for Puerto Rico and the Virgin Islands.

¹⁵ At the time we collected data for this inspection, CMS had 10 regional offices throughout the United States, and for its medical review work, had combined regions 8, 9, and 10 into a consortium.

LIMITATIONS

Although CMS guidance instructs carriers to consider individual provider error rates when deciding how to address a billing problem, it does not explicitly require the carriers to calculate baseline or subsequent billing and/or payment error rates. As we discuss in more detail later, carriers had limited information on baseline and subsequent error rates in their tracking systems. As a result, we were unable to determine whether progressive corrective action strategies reduce billing and/or payment errors.

STANDARDS

This inspection was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency.

► FINDINGS

Carriers are generally implementing progressive corrective action strategies consistent with CMS guidance

Our examination of the data from carriers' tracking systems for Medicare participating physicians

leads us to conclude that carriers are generally implementing progressive corrective action strategies consistent with CMS guidance. Even though carriers are not required to document their approaches in all cases, there is evidence in their tracking systems that they are implementing the five progressive corrective action approaches.¹⁶ Additionally, in our interviews with the 18 carriers, they confirm that they are generally implementing corrective action strategies, and they provide explanations of how they carry out each of the 5 specific approaches.

The decision to conduct medical review should be data driven.

Sixteen of the eighteen carriers have evidence in their tracking system that their decision to conduct medical review is based on the results of preliminary data analysis. Carriers' tracking systems have information such as indications that a given physician appeared to be upcoding for a particular service and indications that a given physician billed for significantly higher amounts than other physicians in the same area of specialization.

In addition, in our interviews with the carriers, all 18 report that their decision to conduct medical review is based on the results of preliminary data analysis. Specifically, all carriers report that they analyze provider billing information to identify aberrant billing patterns for both physician specific and service specific data prior to conducting medical review.¹⁷ When asked to provide further detail, 10 carriers explain that they compare national, State, and local data across provider peer groups to determine where aberrancies exist.

Validate potential problems by conducting "probe reviews." All 18 carriers have information in their tracking systems indicating that they conduct prepayment or postpayment probes to validate suspected aberrant billing behavior. Specifically, carriers' tracking systems include

¹⁶ CMS, "Medial Review Progressive Corrective Action," Program Memoranda Transmittal AB-00-72, August 2000.

¹⁷ Physician specific data analysis generally involves comparing individual physicians' billing practices with billing practices of other, comparable physicians. Service specific analysis generally involves comparing the billing of particular services with local or national trends data.

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information such as the sample size of a given probe, the number of claims reviewed, the type of probe action taken, and the date that a given probe was closed.

Furthermore, in our interviews with the carriers, all 18 report that they use the results of prepayment or postpayment probe medical reviews to validate a potential billing problem. Seven carriers report that probe reviews are one of the most effective progressive corrective action practices. One carrier notes, “The concept of the probe review has been very effective. It can validate that the issue is valid before over-working the provider.”

The provider error rate is an important consideration in deciding how to address the problem. Sixteen of the eighteen carriers have error rate calculations in their tracking systems for at least some physicians who were identified for progressive corrective action during the first two quarters of FY 2003. Further, in our interviews, 17 of the 18 carriers report that they consider the individual physician error rate when deciding how to address a physician’s billing problem.

Subject providers only to the amount of medical review necessary to address the nature and the extent of the identified problems. All 18 carriers have information in their tracking system indicating that they consider factors such as the dollar value of the billing problem, the history of the physician’s billing patterns and/or the physician’s billing or payment error rate when deciding how to address a given billing problem.

In our interviews with the carriers, all 18 confirm that they take steps to ensure that physicians are subjected only to reasonable amounts of medical review. For example, all carriers explain that they determine the severity of a problem by examining the dollar value of the identified problem, and/or the past billing history of the physician. Eight carriers also report using the results of probe reviews to determine the level of a given billing problem. This severity level information is then used to determine the type of corrective action.

Provider feedback and education is an essential part of solving problems. Seventeen of eighteen carriers have information in their tracking systems documenting that they provided education and training to at least some of the physicians identified for progressive corrective action during the first two quarters of FY 2003. The tracking systems have indications that educational letters were sent to at least some physicians or that education was provided on a given date. The extent

to which carriers meet the requirement to track this information for all physicians identified for progressive corrective action is discussed in greater detail in the next section.¹⁸

Additionally, in our interviews with the carriers, all 18 report that they use feedback and education to solve billing problems. Specifically, all 18 carriers explain that they provide education and training on a one-on-one and/or group basis. They also report providing training through written materials or electronically.

However, carriers are not following all tracking requirements

Carriers are required to have a tracking system and document five specific elements. We found

that all carriers have a tracking system; however, none of the carriers document all the required elements. (See Table 1 on the next page.)

Carriers are instructed to “identify all individual providers and track all contacts made as a result of actions to correct identified problems.”

Twelve of eighteen carriers do not track this information for all physicians identified for progressive corrective action during the first two quarters of FY 2003, as required. Specifically, six carriers have this information for at least half but not all of the identified physicians. Five carriers document contact information for less than half of the identified physicians. One carrier does not track any information for any of the identified physicians.

Carriers are also required to reassess all providers on medical review quarterly to determine if their behavior has changed. The results of these reassessments must be noted in their tracking system.¹⁹ None of the 18 carriers track the results of these quarterly reviews for all physicians identified for corrective action during our sampling timeframe. One carrier tracks quarterly results for less than half of the identified physicians. While some carriers have subsequent error rate calculations for some identified physicians, there is often no indication that these rates were calculated on a quarterly basis. Further, there are no other reassessment measures, such as a downgrade from a major problem to a minor problem, recorded for all identified physicians.

¹⁸ CMS, “Medial Review Progressive Corrective Action,” Program Memoranda Transmittal AB-00-72, August 2000.

¹⁹ Quarterly reassessments included subsequent error rates or any other measure indicating that the physician’s billing behavior was reevaluated at 3-month intervals.

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Carriers are also required to document the date the provider is put on a provider-specific edit.²⁰ While not all billing problems warrant this type of information, 9 of 18 carriers do not have any dates that physicians who were identified for corrective action during the first two quarters of FY 2003 were placed on an edit. Furthermore, carriers must record the dates that edits are turned off. Eleven carriers do not have this information for any of the identified physicians.

Finally, carriers are required to “track and consider the results of appeals in their medical review activities.” Six carriers do not have this information for any of the physicians identified for progressive corrective action during the first two quarters of FY 2003.

Table 1: Number of Carriers that Follow Tracking System Requirements

Tracking Requirements	Number of Carriers Not Following Requirement	Number of Carriers Following Requirement	Number of Carriers that Track Information for at Least Some Identified Physicians
All contacts made as a result of actions to correct identified problem	12	6	17
Results of quarterly reassessments for all providers	18	0	1
Date a provider is put on provider-specific edit for medical review	9	9 ^a	9
Date edits are turned off	11	7 ^a	7
Results of appealed medical review decisions	6	12 ^b	12

Source: OIG Review of Carrier Tracking Systems, 2004.

a = Includes carriers that have information on any dates that physicians were placed on edits.

b = Includes carriers that have information on any appealed medical review decisions.

²⁰ Edits are software-based controls used to prevent an overutilization of codes, upcoding to a higher reimbursement rate, or inappropriate frequencies of services billed for the same beneficiary. Edits are put in place to flag any group of claims that does not follow Medicare coverage guidelines and could serve to delay or reject payments.

Little information exists to determine whether progressive corrective action strategies are achieving desired results

Carriers report that progressive corrective action strategies seek to reduce individual physician error rates and modify behavior of

physicians through education.²¹ We found that little information exists to determine whether progressive corrective action strategies are achieving these desired results. Specifically, carriers have limited data on physician error rates, and CMS relies on compliance-based oversight that does not measure progressive corrective action outcomes.

Carriers have limited data on physician error rates

CMS transmittals instruct carriers to consider the individual provider error rate when deciding how to address a billing problem. Carriers are not, however, explicitly required to calculate or track these error rates for each physician identified for progressive corrective action. We found that carriers calculated baseline error rates for an average of 48 percent of physicians who were identified for progressive corrective action during our sampling timeframe. Seven carriers calculated baseline error rates for less than 50 percent of physicians identified for progressive corrective action during this timeframe. Only one carrier calculated baseline error rates for all identified physicians.

Carriers calculated subsequent error rates for even fewer physicians who were identified for progressive corrective action. Specifically, carriers calculated subsequent rates for an average of 8 percent of the physicians identified for corrective action during the first two quarters of FY 2003. Twelve carriers calculated these rates for less than 10 percent of identified physicians. Again, only one calculated subsequent rates for all physicians identified for corrective action during this timeframe. See Table 2 on the next page.

²¹ Additionally, CMS guidance (*SPACE Program Guidelines: Contractor Medical Review Oversight*, p. 3, October, 2004) indicates, and carriers report, that the ultimate goal of the progressive corrective action strategies is to reduce the national paid claims error rate.

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Table 2: Number of Physicians Identified for Progressive Corrective Action With Baseline and Subsequent Error Rates by Carrier*

Carriers	Total Number of Physicians Identified for Progressive Corrective Action	Number of Physicians with Baseline Error Rates	Percentage of Physicians with Baseline Error Rates	Number of Physicians with Subsequent Error Rates	Percentage of Physicians with Subsequent Error Rates
A	407	162	40	0	0
B	8	7	88	1	13
C	106	52	49	2	2
D	31	16	52	0	0
E	2	0	0	0	0
F	73	47	64	29	40
G	277	177	64	14	5
H	327	224	69	4	1
I	94	35	37	15	16
J	13	13	100	13	100
K	119	59	50	5	4
L	113	50	44	3	3
M	216	168	78	77	36
N	28	19	68	2	7
O	385	24	6	4	1
P	48	0	0	0	0
Q	59	51	86	11	19
R	10	8	80	0	0
Totals	2,316	1,112	48%	180	8%

Source: OIG Review of Carrier Tracking Systems, 2004.

*Physicians were identified during the first two quarters of FY 2003.

In total, 180 physicians who were identified for progressive corrective action during the first two quarters of FY 2003 had a baseline and a subsequent error rate. Because this represents only 8 percent of the 2,316 physicians who were identified, we are unable to determine whether progressive corrective action interventions do, in fact, reduce individual physician error rates.

CMS relies on compliance-based oversight that does not address progressive corrective action outcomes

CMS central office reports that the Self-Assessment, Performance Oversight and Comprehensive Error Rate Testing and Educational program (SPACE) measures progressive corrective action outcomes. The SPACE program includes the Certification Package for Internal

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Controls (CPIC), SAS-70 audits, the Comprehensive Error Rate Testing (CERT) program, and the Educational Training program.

The majority of the SPACE program activities measure the extent to which carriers comply with progressive corrective action requirements and whether controls exist to ensure compliance. The primary goal of the self-assessment CPICs is to identify operational areas that are at risk and need improvement. The goal of the SAS-70 audits is to determine if internal controls are in place and whether they are effective. The goal of the Educational Training program is to correct areas of contractor vulnerabilities. None of these three activities measures whether progressive corrective action strategies are reducing individual error rates or modifying behavior of physicians through education.

The final component of the SPACE is the CERT program. The CERT program measures the extent to which all Medicare Part B claims were paid in error. The goal of this measure is to improve the accuracy of payment decisions made by Medicare contractors for all Medicare participating providers. In contrast, progressive corrective action strategies aim to reduce the billing or payment errors for a select group of providers who are identified as aberrant billers. Therefore, while the CERT program measures outcomes, it may not be specific enough to determine whether progressive corrective action is achieving its desired results.



R E C O M M E N D A T I O N S

While all carriers appear to be implementing progressive corrective action strategies consistent with CMS guidance, we found that none of the carriers are following all tracking requirements. In addition, we found that little information exists to determine whether progressive corrective action is achieving desired results.

The MMA highlights the importance of providing effective education and training to Medicare participating providers. However, CMS does not currently have any method that measures the effectiveness of progressive corrective action strategies and whether the strategies reduce individual physician error rates and/or modify the behavior of physicians.

To address these issues, we recommend that CMS:

- Institute outcome-based program measures to better determine whether progressive corrective action strategies reduce individual physician error rates and/or modify the behavior of physicians. To do this, CMS could:
 - Modify its SPACE program to assess progressive corrective action outcomes.
 - Revise its Medicare Carriers and Intermediaries Manuals to explicitly require the calculation of individual-provider error rates before and after progressive corrective action intervention. This information could then be used to determine whether corrective action strategies do, in fact, help reduce billing errors.
- Conduct reviews of carriers' tracking systems to ensure that carriers are complying with requirements.

AGENCY COMMENTS

CMS concurred with our recommendations. CMS further commented that it has already taken steps to include reviews of carrier tracking systems as part of its annual SAS-70 reviews. The full text of CMS's comments is included in the Appendix.

CMS also commented that it will "continue to require its contractors to evaluate the effectiveness of corrective actions taken." It noted that there are a number of methods that can be employed to identify progressive corrective action outcomes. CMS commented that error

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rates, as well as analysis of claims data, may be sufficient to determine the effectiveness of a progressive corrective action intervention.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree. However, we question whether carriers will evaluate and track the effectiveness of corrective action strategies in absence of more guidance from CMS. For example, further guidance on when to require the calculation of individual provider error rates would increase CMS's ability to determine whether progressive corrective action strategies are achieving desired results. We reiterate that, based on our review of carriers' tracking systems, we found that none of the 18 carriers tracked the results of quarterly reassessments for all physicians identified for corrective action during our sampling timeframe, as required by CMS.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 17 2005

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D. *MM*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Carrier Medical Review Progressive Corrective Action" (OEI-02-03-00300)

Thank you for the opportunity to review and comment on the above OIG draft report.

By way of background, in 2000 the Centers for Medicare & Medicaid Services (CMS) Division of Medical Review and Education started using the principles of Progressive Corrective Action (PCA) to inform providers about the underlying principles and approaches to medical review and to reduce billing and payment errors. The first step in the PCA process is data analysis to determine whether patterns of claims submissions and payment indicate potential problems. Once potential problems are identified, the carrier or fiscal intermediary is to deploy probe reviews of provider claims to determine the severity of the identified problem. Once the severity of the problem is identified, the contractor uses individual provider error rates to decide how to address the problem (e.g. pre-payment review, post-payment review, suspension, overpayment collections, referral to the Benefit Integrity Unit). The last part of the PCA process entails provider feedback and education that are tracked through the Provider Tracking System (PTS).

Each contractor uses a PTS to monitor and manage provider feedback and educational contacts. Instructions for the use of a PTS, which are found in the Program Integrity Manual (CMS Pub. 100-8), state:

- 1) Carriers should use the PTS to coordinate contacts with providers (e.g., medical review education contacts);
- 2) Carriers should ensure that, if a provider is to be contacted as a result of more than one problem, multiple contacts are necessary, timely and not redundant;
- 3) Carriers should also coordinate with the Benefit Integrity (BI) contractor to assure contacts are not in conflict with BI related activities;

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- 4) The PTS should contain the date a provider was placed on a provider specific edit and should reassess that provider quarterly to determine if the behavior has changed;
- 5) The Carriers must note the results of the quarterly assessment in the PTS and if the behavior has changed, the edit should be turned off with the date noted;
- 6) When a provider appeals a medical review determination to an Administrative Law Judge (ALJ), the information in the PTS should be shared with the ALJ to demonstrate corrective action taken by the carrier.

The PTS is an essential part of the PCA process as it evaluates the effectiveness of corrective actions on targeted problem areas at least every three months until there is evidence that the problem is corrected.

OIG Recommendation

The OIG recommends that CMS institute outcome-based program measures to better determine whether progressive corrective action strategies reduce individual physician error rates and/or modify the behavior of physicians.

CMS Response

We agree that the ability to measure the effectiveness of corrective actions is critical. Therefore we will continue to require that contractors evaluate the effectiveness of corrective actions taken. CMS believes there are numerous methods that can be employed to identify the outcomes of medical review interventions. Outcomes based performance measures are critical in most cases, but may not always be the most effective and least burdensome way to assess that effectiveness. In some cases, analysis of claims data may be sufficient to determine the effectiveness of an intervention. For instance, in cases where a contractor determines that the only necessary intervention is education, performing claim review to determine the outcome of the education would pose an unnecessary burden on the provider. By contrast, when a contractor places a provider on pre-payment medical review, they should calculate the provider's error rate to determine the when claims review is no longer needed and to monitor the provider's continued compliance.

OIG Recommendation

The OIG recommends that CMS conduct reviews of Medicare Carriers tracking systems to ensure that carriers are complying with requirements.

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CMS Response

We agree with this recommendation. The Statement on Auditing Standards Number 70 (SAS-70) is an audit of Medicare contractor's operational areas conducted by an independent auditing firm. The SAS-70 measures whether internal controls and objectives for medical review are in place based on CMS instructions. For the 2004 review cycle, currently underway, the SAS-70 audit was modified to assess whether or not the contractors' PTSs were effective and implemented according to the Program Integrity Manual's guidelines. This review will continue into next year's 2005 audit as well.

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A C K N O W L E D G M E N T S

This report was prepared under the direction of Jodi Nudelman, Acting Regional Inspector General for Evaluation and Inspections in the New York regional office. Other principal Office of Evaluation and Inspections staff who contributed include:

Ellen Vinkey, *Team Leader*

Christi Macrina, *Project Leader*

David Rudich, *Program Analyst*

Tricia Davis, *Director, Medicare and Medicaid Branch*

Barbara Tedesco, *Mathematical Statistician*