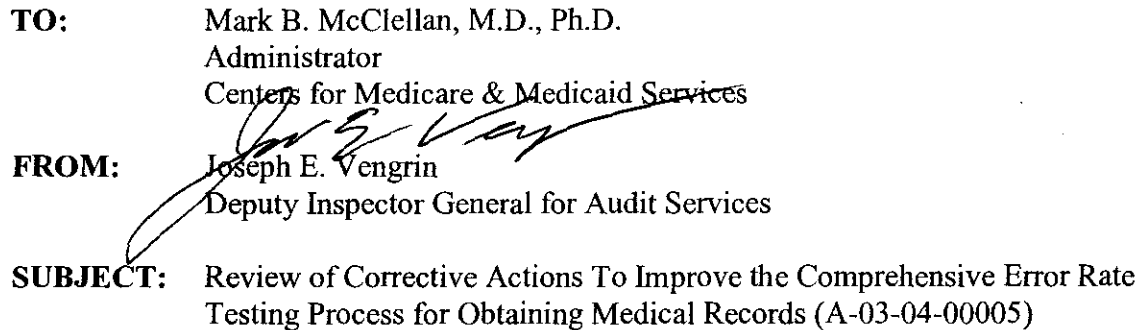
DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUN 2 2004



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

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Corrective Actions To Improve the Comprehensive Error Rate Testing Process for Obtaining Medical Records (A-03-04-00005)

Attached is a copy of our final report on the interim results of our review of the Centers for Medicare & Medicaid Services (CMS) corrective actions to improve the Comprehensive Error Rate Testing (CERT) process for obtaining medical records from health care providers.

During fiscal year (FY) 2003, CMS experienced a significant problem with providers that did not respond to requests for medical records for use in developing the Medicare payment error rate. The Chairman of the Senate Committee on Finance and other members of Congress expressed concerns with CMS's FY 2003 Medicare error rate process. The Chairman specifically requested, among other things, that we monitor the implementation of CMS's corrective actions to improve its process for obtaining medical records.

Our objective was to evaluate the adequacy of CMS's corrective actions to improve the CERT process for obtaining medical records.

CMS implemented a number of corrective actions to improve the FY 2004 CERT process for obtaining medical records. Based on our review of data for the first three quarters of the FY 2004 error rate sample, these corrective actions appear to have increased provider responsiveness to requests for medical records.

We are not making any recommendations at this time because the effects of the corrective actions are still relatively new. However, we are concerned that as of April 8, 2004, providers had failed to submit medical records supporting 2,239 of the 126,618 claims in the FY 2004 sample, despite repeated requests for the records. Therefore, we have initiated an indepth review to determine why providers failed to respond. Additionally, as part of our broader FY 2004 evaluation of the CERT program, we will further assess the impact of CMS's corrective actions.

If you have any questions, please do not hesitate to call me or your staff may contact David M. Long, Assistant Inspector General for Financial Management, Regional Operations, and Information Technology Audits, at (202) 619-1157 or through e-mail at david.long@oig.hhs.gov. Please refer to report number A-03-04-00005 in all correspondence.

Attachment

cc:
Mr. Timothy Hill
Ms. Kimberly Brandt

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CORRECTIVE ACTIONS TO IMPROVE THE COMPREHENSIVE ERROR RATE TESTING PROCESS FOR OBTAINING MEDICAL RECORDS

JUNE 2004
A-03-04-00005

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), Office of Inspector General reports are made available to members of the public to the extent the information is not subject to exemptions in the Act (see 45 CFR Part 5).

OIG FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicare Fee-for-Service Error Rate

From fiscal year (FY) 1996 through FY 2002, the Office of Inspector General (OIG) estimated the rate of error in Medicare fee-for-service paid claims. The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program in FY 2000 to produce an error rate for all provider claims other than inpatient acute care hospital claims. When aggregated with the error rate for inpatient acute care hospitals produced by the Hospital Payment Monitoring Program, CMS produces an overall Medicare fee-for-service error rate similar to the one that OIG developed. Beginning in FY 2003, CMS assumed responsibility for developing the error rate.

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—collectively referred to as the affiliated contractors. For the sampled items, the CERT contractor requests medical records from providers or from the affiliated contractors.

FY 2003 Results and Congressional Concerns

During the FY 2003 error rate review process, CMS experienced a significant problem with providers that did not respond to requests for medical records under the CERT program. CMS reported an initial error rate of 9.8 percent, of which over half was attributable to nonresponders. To report a more representative estimate, CMS adjusted the nonresponse rate to reflect OIG's 7 years of experience with nonresponders. CMS reported an adjusted error rate of 5.8 percent, of which an estimated 82 percent was due to errors other than lack of documentation and an estimated 18 percent was due to provider nonresponses to requests for medical records.

The Chairman of the Senate Committee on Finance and several other members of Congress expressed concerns about CMS's reporting of two error rates and the large number of providers that did not supply requested medical records. The Chairman asked OIG to (1) assist CMS to "get a solid number that is reliable and credible; not two numbers," (2) monitor the implementation of corrective action by CMS, and (3) examine the information obtained through the CERT review process to further target resources to rid Medicare of waste and abuse.

This review, the first of several ongoing reviews of the Medicare error rate process, responds to the Chairman's second request.

OBJECTIVE

Our objective was to evaluate the adequacy of CMS's corrective actions to improve the CERT process for obtaining medical records.

SUMMARY OF RESULTS

CMS implemented several corrective actions to improve the FY 2004 CERT process for obtaining medical records, including affiliated contractor education and participation in contacting nonresponders, revised medical record request letters, improved procedures for contacting providers, and an Internet-based claims tracking system.

Those actions appear to have increased providers' responsiveness to requests for medical records. Provider nonresponses as of April 8, 2004 represent about 2 percent of the total number and 3 percent of the total dollar value of claims selected for the FY 2004 error rate sample, compared with about 8 percent of the claims and about 7 percent of the dollar value for FY 2003. However, as of the same date, providers had failed to submit medical records for 2,239 of the 126,618 claims in the FY 2004 sample, even though CMS sent 4 request letters and made 3 telephone contacts to each provider.

CONCLUSION

We are not making any recommendations at this time because the effects of the corrective actions are still relatively new. However, we are concerned that providers failed to provide medical records supporting 2,239 claims, despite the CERT contractor's repeated efforts. Therefore, we have initiated an indepth review to determine why these providers failed to respond. Additionally, as part of our broader FY 2004 evaluation of the CERT program, we will further assess the impact of CMS's corrective actions.

CMS COMMENTS

To expedite the processing of our report, we obtained informal comments from CMS officials responsible for the Medicare error rate process. These officials concurred with our audit results and conclusion.

TABLE OF CONTENTS

Page

INTRODUCTION..1

BACKGROUND..1

Medicare Fee-for-Service Error Rate..1

FY 2003 Results and Congressional Concerns..1

OBJECTIVE, SCOPE, AND METHODOLOGY..2

Objective..2

Scope and Methodology..2

RESULTS OF REVIEW..2

CMS ACTIONS TO IMPROVE PROCESS FOR OBTAINING MEDICAL RECORDS......3

IMPROVEMENT IN FY 2004 PROVIDER RESPONSIVENESS..4

CONCLUSION..5

CMS COMMENTS..5

INTRODUCTION

BACKGROUND

CMS administers the Medicare program, which was established by Title XVIII of the Social Security Act, as amended. Medicare is a health insurance program that covers persons 65 years of age and older, along with those under 65 who are disabled or who have end stage renal disease.

Medicare Fee-for-Service Error Rate

From FY 1996 through FY 2002, OIG estimated the rate of error in Medicare fee-for-service paid claims. In response to an OIG recommendation to develop its own Medicare error rate process, CMS initiated two programs in FY 2000. The CERT program was established to produce an error rate for all provider claims other than inpatient acute care hospital claims. The Hospital Payment Monitoring Program was established to produce an error rate for inpatient acute care hospitals. When aggregated, those error rates produce an overall Medicare fee-for-service error rate similar to the one that OIG developed. Beginning in FY 2003, CMS assumed responsibility for developing the error rate.

For the FY 2004 error rate, the CERT contractor selected for review 126,618 calendar year 2003 claims processed by Medicare fiscal intermediaries, carriers, and durable medical equipment regional carriers—collectively referred to as affiliated contractors. Monthly, the CERT contractor randomly selects about 200 claims from each affiliated contractor. For the sampled items, the CERT contractor requests medical records from providers or, if previously reviewed, from the affiliated contractors.

FY 2003 Results and Congressional Concerns

For FY 2003, CMS experienced a significant, unexpected problem with providers that did not respond to requests for medical records under the CERT program. CMS reported[1] an initial error rate of 9.8 percent, of which over half was attributable to nonresponders. To report a more representative estimate, CMS adjusted the nonresponse rate to reflect OIG's 7 years of experience with nonresponders. CMS reported an adjusted rate of 5.8 percent, of which an estimated 82 percent was due to errors other than lack of documentation and an estimated 18 percent was due to provider nonresponses.

The Chairman of the Senate Committee on Finance and several House members expressed concerns with CMS's reporting of two error rates and the large number of providers that did not supply requested medical records. The Chairman asked us to assist CMS to "get a solid number that is reliable and credible; not two numbers," monitor the implementation of corrective action by CMS, and examine the information obtained through the CERT review process to further target resources to rid Medicare of waste and abuse.

---

[1] "CMS Financial Report: Fiscal Year 2003," November 2003.

This review, the first of several ongoing reviews of the FY 2004 Medicare error rate process, focuses on CMS's corrective actions to improve the CERT process for obtaining medical records.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to evaluate the adequacy of CMS's corrective actions to improve the CERT process for obtaining medical records.

Scope and Methodology

Our review was limited in scope, and we did not conduct an indepth review of CERT internal controls. We evaluated CMS's corrective actions taken and planned during the period January 1 through April 8, 2004. We also obtained an understanding of internal controls over areas reviewed and performed limited testing of internal controls necessary to satisfy our audit objective.

To accomplish our objective, we reviewed CMS's revised policies and procedures regarding the CERT process for obtaining medical records from providers and interviewed CERT personnel. We also evaluated implemented corrective actions to determine their impact on improving providers' responsiveness to requests for medical records. We performed fieldwork at CMS's CERT contractor, AdvanceMed, located in Richmond, VA, from January 21 through April 8, 2004. We conducted our review in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

CMS implemented a number of corrective actions to improve the FY 2004 CERT process for obtaining medical records. Those actions appear to have improved providers' responsiveness to requests for medical records. As shown in Table 1, nonresponses as of April 8, 2004 represented about 2 percent of the total number and 3 percent of the total dollar value of claims selected for the FY 2004 error rate.

Table 1: Status of FY 2004 CERT Medical Record Requests (as of April 8, 2004)
(Categories Explained Following Table)

Status of Medical Records	Number of Claims		Dollar Value	
Requested	11,207	8.85%	$ 3,530,129	10.95%
Under Review	40,005	31.59%	10,215,732	31.69%
Review Completed	73,167	57.79%	17,469,263	54.19%
Subtotal	**124,379**	**98.23%**	**31,215,027**	**96.83%**
Nonresponse	2,239	1.77%	1,021,808	3.17%
Total	**126,618**	**100.0%**	**$32,236,935**	**100.0%**

The categories listed in Table 1 are explained below:

- *Requested* includes claims for which additional request letters and phone contacts are likely to be made.
- *Under Review* includes claims for which the medical records have been received and the claims are being reviewed.
- *Review Completed* includes claims for which reviews of the medical records have been completed.
- *Nonresponse* includes claims for which the CERT contractor sent four request letters and made three followup phone contacts, but providers failed to submit the requested medical records.

At the completion of our fieldwork, CMS directed the affiliated contractors to request medical records from nonresponsive providers. We anticipate that this key corrective action, which was to be fully implemented by April 30, 2004, will significantly reduce the number of remaining nonresponses because the affiliated contractors process providers' claims and thus have an established relationship with providers. However, we are still concerned that providers failed to submit requested medical records for 2,239 of the 126,618 claims in the FY 2004 sample, despite repeated requests.

CMS ACTIONS TO IMPROVE PROCESS FOR OBTAINING MEDICAL RECORDS

As part of the FY 2004 Medicare error rate process, CMS implemented a number of corrective actions to improve the CERT process for obtaining medical records. A description of the more substantive corrective actions follows:

- **Affiliated Contractor Education and Participation.** 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. Also, as stated above, CMS recently directed the affiliated contractors to contact providers that did not submit beneficiary medical records when requested.

- **Revised Medical Record Request Letters.** CMS took the following steps to enhance its process for obtaining medical records from providers:

    - Dating and Mailing. For the FY 2004 review, CMS began to automatically print and predate request letters for mailing within 24 hours of their production. During FY 2003, request letters were frequently delayed because of a more manual process and lack of staff availability.
    - Health Insurance Portability and Accountability Act (HIPAA) Conformance. CMS revised its request letters to highlight the CERT contractor's authorization, acting on CMS's behalf, to obtain medical records from providers. This authorization allows the CERT contractor to request medical records for Medicare claims without obtaining prior beneficiary authorization. According to CMS,

providers may not have realized that sending medical records to the CERT contractor was permissible under the HIPAA regulations.

- o Option To Submit Medical Records by Facsimile. Medical record request letters now give providers the option of submitting the records by facsimile. This option should reduce the providers' costs and processing time and encourage a greater response rate.

- **Improved Procedures for Contacting Providers.** CMS added two followup telephone contacts to its procedures for obtaining medical records from providers. The CERT contractor makes these phone calls before sending a second request letter to the provider. Table 2 compares the request procedures used in FYs 2003 and 2004.

Table 2: CERT Provider Contacts

Calendar Day	FY 2003	FY 2004
0	Letter 1	Letter 1
10		Phone Contact 1
20	Letter 2	Phone Contact 2
25	Phone Contact 1	
30		Letter 2
35	Letter 3	Phone Contact 3
40		Letter 3
45	Letter 4	Letter 4

- **Internet-Based Claims Tracking System.** CMS developed a new Internet-based claims tracking system to provide CMS, the CERT contractor, and the affiliated contractors with the weekly status of the review process. This tracking system will be useful to affiliated contractors in identifying providers that have not submitted beneficiary medical records.

IMPROVEMENT IN FY 2004 PROVIDER RESPONSIVENESS

The provider nonresponse rate for FY 2004 claims appears to have decreased significantly when compared with the FY 2003 rate, as shown in Table 3. 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 FY 2004 and about 3 percent based on the total dollar value of claims for the same period. In contrast, the final FY 2003 nonresponse rate, unadjusted for claims weighting, was about 8 percent of the total number and 7 percent of the total dollar value of claims.[2]

[2] The FY 2003 unadjusted 9.8-percent Medicare paid claims error rate was dollar-weighted to compensate for differences in Medicare claim activity. Because the weighting process takes place at the end of the review, the FY 2004 error rate has not been dollar-weighted. Consequently, to compare FY 2003 with FY 2004, we used actual, unweighted dollar totals for both years.

Table 3: Comparison of FY 2003 and FY 2004 CERT Nonresponses

Status of Medical Records	FY 2003		FY 2004	
	Claims	Dollar Value	Claims	Dollar Value
Requested, Under Review, or Review Completed	65,015	$ 11,101,828	124,379	$ 31,215,027
Nonresponse	5,553	876,000	2,239	1,021,808
Total	**70,568**	**$11,977, 828**	**126,618**	**$32,236,935**
Nonresponse Rate	**7.87%**	**7.31%**	**1.77%**	**3.17%**

CONCLUSION

After completion of the FY 2003 error rate process, CMS developed and implemented several corrective actions to improve providers' responsiveness to requests for medical records. Our review of data for the first three quarters of the FY 2004 error rate sample indicates that the nonresponse rate has decreased significantly from FY 2003.

We are not making any recommendations at this time because the effects of the corrective actions are still relatively new. However, we are concerned that providers failed to submit medical records supporting 2,239 claims after the CERT contractor sent 4 letters and made 3 telephone contacts. Therefore, we have initiated an indepth review to determine why providers failed to respond to repeated requests for medical records. Additionally, as part of our broader FY 2004 evaluation of the CERT program, which is underway, we will further assess the impact of CMS's corrective actions.

CMS COMMENTS

To expedite the processing of our report, we obtained informal comments from CMS officials responsible for the Medicare error rate process. These officials concurred with our audit results and conclusion.