OCT 18 2006

TO: Timothy B. Hill
Chief Financial Officer
Centers for Medicare & Medicaid Services

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

SUBJECT: Oversight and Evaluation of the Fiscal Year 2006 Hospital Payment Monitoring Program (A-03-06-00010)

The attached final report provides the results of our oversight and evaluation of the fiscal year (FY) 2006 Hospital Payment Monitoring Program (HPMP). The Centers for Medicare & Medicaid Services (CMS) developed the HPMP primarily to establish the Medicare fee-for-service paid claims error rate for inpatient acute-care and long-term care hospital claims. CMS includes the HPMP results in its annual report on erroneous Medicare payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

The objectives of our FY 2006 audit were to determine (1) whether CMS ensured that the Clinical Data Abstraction Center (CDAC) and the Quality Improvement Organizations (QIO) had appropriate controls to ensure that sampling procedures, admission-necessity and diagnosis-related group (DRG) validation screenings, and quality control reviews followed established procedures and operated effectively; (2) the status of initiatives to reduce the HPMP error rate that CMS proposed in its November 2005 "Improper Fee-for-Service Payments Long Report"; and (3) whether CMS took appropriate action on the recommendations in our FY 2005 audit report.

CMS ensured that the CDAC and the QIOs had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively. In addition, CMS advised us that it had performed several tasks to accomplish its initiatives to reduce the HPMP error rate. Finally, CMS took appropriate action on the recommendations in our FY 2005 audit report.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Lori S. Pilcher, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-03-06-00010.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2006 HOSPITAL PAYMENT MONITORING PROGRAM

Daniel R. Levinson
Inspector General

October 2006
A-03-06-00010

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the Hospital Payment Monitoring Program (HPMP) primarily to establish the Medicare fee-for-service paid claims error rate for inpatient acute-care hospital services.

Under contracts with CMS, several companies were responsible for operating the HPMP during fiscal year (FY) 2006. The Clinical Data Abstraction Center (CDAC) conducted admission-necessity screenings and diagnosis-related group (DRG) validation screenings for a sample of short-term acute-care inpatient claims. The CDAC forwarded claims that failed one or both of its screenings to a Quality Improvement Organization (QIO) for a complete claim review and final determination. In addition, the CDAC reviewed a sample of short- and long-term care inpatient claims for which a fiscal intermediary had denied payment to determine whether the denial was appropriate. The QIOs also performed a complete claim review and final determination for a sample of long-term care inpatient claims.

CMS includes the HPMP results in its annual report on erroneous Medicare payments required by the Improper Payments Information Act of 2002 (Public Law 107-300).

OBJECTIVES

The objectives of our FY 2006 HPMP audit were to determine:

- whether CMS ensured that the CDAC and the QIOs had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively;

- the status of initiatives to reduce the HPMP error rate that CMS proposed in its November 2005 "Improper Fee-for-Service Payments Long Report"; and

- whether CMS took appropriate action on the recommendations in our FY 2005 audit report.

SUMMARY OF RESULTS

CMS ensured that the CDAC and the QIOs had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively. In addition, CMS advised us that it had performed several tasks to accomplish its initiatives to reduce the HPMP error rate. Finally, CMS took appropriate action on the recommendations in our FY 2005 audit report.

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INTRODUCTION

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established Medicare as a broad health insurance program that covers people 65 years of age and older, along with those under 65 who are disabled or who have end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program through a number of contractors.

Medicare Error Rate

In fiscal year (FY) 2000, CMS initiated two programs to develop a fee-for-service Medicare error rate. The Hospital Payment Monitoring Program (HPMP), which is the subject of this report, was established to produce an error rate for inpatient acute-care hospital claims.[1] The Comprehensive Error Rate Testing program, the subject of another Office of Inspector General report (A-03-06-00011), was established to produce an error rate for all other provider claims. When aggregated, those error rates produce an overall Medicare fee-for-service paid claims error rate. An error is the difference between the amount that Medicare paid to a hospital and the amount that it should have paid.

Using the results of the Medicare error rate programs, CMS annually submits to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims pursuant to the Improper Payments Information Act of 2002 (Public Law 107-300). Implementing guidance from the Office of Management and Budget requires that the Department of Health and Human Services include the estimate in the "Performance and Accountability Report" for each FY.

In its November 2005 "Improper Fee-for-Service Payments Long Report," CMS reported that the aggregate Medicare fee-for-service error rate for FY 2005 was 5.2 percent. CMS also reported that the HPMP error rate was 5.2 percent and provided details by Quality Improvement Organization (QIO). In addition, CMS described its initiatives to reduce the paid claims error rate.

Hospital Payment Monitoring Program

The HPMP establishes the Medicare paid claims error rate for inpatient acute-care hospitals on a State and national level and provides statistical and administrative data for use in reducing improper admissions and payments. Policies and procedures for the HPMP are included in the "Payment Error Surveillance Tracking System Manual for the Hospital Payment Monitoring Program." The HPMP includes reviews of (1) short-term acute-care inpatient claims, (2) long-term care inpatient claims, and (3) short- and long-term inpatient claims denied by fiscal intermediaries.

[1]The FY 2006 HPMP error rate calculation included short-term acute-care inpatient and long-term hospital claims, excluding critical access, psychiatric, and rehabilitation hospital claims.

As described below, CMS assigned responsibilities for the FY 2006 HPMP to several contractors.

Clinical Data Abstraction Center

Serving as the Clinical Data Abstraction Center (CDAC), Computer Sciences Corporation obtained medical records from health care providers and performed admission-necessity screenings and diagnosis-related group (DRG) validation screenings for a sample of short-term acute-care inpatient claims. Because CMS does not pay Maryland claims based on DRGs, nonphysician reviewers performed admission-necessity and length-of-stay screenings for Maryland claims.

The CDAC also reviewed a sample of short- and long-term claims for which a fiscal intermediary had denied payment. The CDAC reviewed information in the Common Working File to determine whether the denial was appropriate. If the Common Working File did not support the denial, the CDAC requested the medical record from the provider, reviewed the medical record for admission necessity, and made a final determination; however, the CDAC did not send a payment adjustment to the fiscal intermediary.

The CDAC measured the accuracy of its screening and medical review process through several ongoing quality control reviews.

Quality Improvement Organizations

The CDAC forwarded to 1 of the 53 QIOs all short-term acute-care inpatient claims that had failed one or both of the CDAC screenings and a sample of short-term acute-care claims for which the CDAC screenings found no errors. CMS also provided the QIOs a sample of long-term care inpatient claims. For each claim, the QIO evaluated the medical necessity, quality, and appropriateness of services provided using professionally developed criteria on providing care, diagnosis, and treatment and made a final determination.

Other Hospital Payment Monitoring Program Contractors

CMS contracted with two additional organizations to operate the HPMP and to provide analytical support and management. TMF Health Quality Institute (the QIO Support Contractor) maintained the Payment Error Surveillance and Tracking System and provided support to CMS and the QIOs in operating the HPMP. The Iowa Foundation for Medical Care (the Standard Data Processing System Data Management Contractor) maintained, collated, and analyzed information provided by the CDAC and the QIOs.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our FY 2006 HPMP audit were to determine:

- whether CMS ensured that the CDAC and the QIOs had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively;

- the status of initiatives to reduce the HPMP error rate that CMS proposed in its November 2005 report; and

- whether CMS took appropriate action on the recommendations in our FY 2005 audit report.[2]

Scope

We reviewed claims from four groups:

- *Short-Term Acute-Care Inpatient Hospital Claims*. CMS selected 38,448 of the 11,725,589 short-term claims with discharge dates between January and December 2005. We judgmentally selected 30 of the 38,448 claims to test whether the CDAC followed established HPMP policies and procedures.

- *Long-Term Care Inpatient Hospital Claims*. CMS selected 1,392 of the 133,377 long-term care inpatient claims with discharge dates between January and December 2005. We judgmentally selected 30 of the 1,392 claims to test whether the QIOs had adequate documentation to support the results reported in the long-term care inpatient claims database.

- *Inpatient Claims Denied by Fiscal Intermediaries*. CMS selected 1,142 of the 311,276 short- and long-term inpatient claims that fiscal intermediaries had denied during calendar year 2005. We judgmentally selected 16 of the 1,142 claims to verify that the CDAC followed established HPMP policies and procedures and accurately reported the results in the denied claims database.

- *Quality Control Claims*. The CDAC performed quality control reviews of 570 short-term claims and 30 claims denied by fiscal intermediaries. We judgmentally selected 30 of the 570 short-term claims and 5 of the 30 claims denied by fiscal intermediaries to determine whether the CDAC claim review and quality control processes were reliable.

We limited our review to assessing and testing critical HPMP internal controls at CMS, the CDAC, and the QIOs. We did not independently evaluate the CDAC claim screenings or the QIO medical review decisions.

We performed the review at CMS headquarters in Baltimore, Maryland, and at the CDAC in York, Pennsylvania, from April to August 2006.

[2]"Oversight and Evaluation of the Fiscal Year 2005 Hospital Payment Monitoring Program" (A-03-05-00007, issued November 10, 2005).

Methodology

To accomplish our objectives, we:

- performed limited testing and analysis of:

  - CDAC case screenings and quality control reviews,
  - QIO case reviews, and
  - short-term acute-care inpatient hospital, long-term care inpatient hospital, and denied inpatient hospital claim databases for accuracy and completeness;

- reviewed CMS's November 2005 "Improper Fee-for-Service Payments Long Report" to identify initiatives to reduce the HPMP error rate and discussed the status of those initiatives with CMS officials; and

- discussed with CMS officials the actions taken to address the recommendations in our FY 2005 audit report.

We performed the review in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

CMS ensured that the CDAC and the QIOs had appropriate controls to ensure that sampling procedures, admission-necessity and DRG validation screenings, and quality control reviews followed established procedures and operated effectively. In addition, CMS advised us that it had performed several tasks to accomplish its initiatives to reduce the HPMP error rate. Finally, CMS took appropriate action on the recommendations in our FY 2005 audit report.

APPROPRIATENESS OF CONTROLS

Based on our review of separate samples of short-term acute-care inpatient hospital claims, long-term care inpatient hospital claims, inpatient claims denied by fiscal intermediaries, and quality control claims, the CDAC and the QIOs followed established HPMP policies and procedures and accurately reported the results in the claims databases. Specifically:

- The CDAC followed established HPMP policies and procedures for reviewing short-term acute-care claims.

- The QIOs had adequate documentation to support the results reported in the long-term care inpatient claims database.

- The CDAC followed established HPMP policies and procedures for reviewing claims denied by the fiscal intermediaries and accurately reported the results in the denied claims database.

- The CDAC claim review and quality control processes were reliable.

INITIATIVES TO REDUCE THE ERROR RATE

In its November 2005 report, CMS stated that one of its performance goals was to reduce improper Medicare fee-for-service payments. The report stated that to achieve that goal, CMS was working with the QIOs and hospitals to implement several initiatives to reduce the HPMP paid claims error rate.

CMS described the following actions taken to implement its initiatives:

- CMS provided First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) reports to the QIOs each quarter. The QIOs used these State-specific hospital billing reports to analyze State data, develop proposals to target payment errors, and generate hospital-specific reports identifying areas prone to payment errors. The QIOs then forwarded the hospital-specific reports to hospitals to support and guide their compliance auditing efforts.

- The QIOs worked with individual providers when they identified payment error issues, medically unnecessary admissions, and other errors identified during case reviews.

CMS believed that these initiatives had increased the understanding and use of FATHOM data and had assisted the QIOs and providers in identifying problem areas that they need to monitor and address.

STATUS OF PRIOR-YEAR RECOMMENDATIONS

In our audit of the FY 2005 HPMP (A-03-05-00007), we recommended that CMS direct its contractors to (1) establish appropriate controls to select a long-term care hospital sample in accordance with established criteria, (2) use the CMS PRICER software to reprice error amounts for claims with DRGs revised by the QIOs, and (3) include in future error rate calculations the error amounts identified by the QIOs during their quality control reviews.

CMS took appropriate action on these recommendations.

CMS concurred with the first recommendation and stated that it had corrected a programming error in the selection of the long-term care hospital sample and had taken actions to prevent recurrence of the problems we noted.

For the second recommendation, CMS stated that it had investigated the costs and benefits of the various ways of incorporating PRICER into the HPMP process and had concluded that it was not advantageous to use PRICER. CMS planned to continue using its current method of calculating error amounts for DRGs revised by the QIOs.

CMS concurred with the third recommendation and included in the HPMP error rate calculations the error amounts identified during the QIOs' quality control reviews. Having determined that the current methodology was sufficient for the error rate estimate, CMS stated that it would not extrapolate quality control findings to the entire population of records.