DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

NOV 29 2007

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Claim Payment Adjustments Identified by Quality Improvement Organizations (A-03-06-00005)

The attached final report provides the results of our review of claim payment adjustments identified by quality improvement organizations (QIO) during the fiscal year (FY) 2005 Hospital Payment Monitoring Program (HPMP).

The objective of our review was to determine whether fiscal intermediaries properly processed payment adjustments for claims referred by the QIOs.

Fiscal intermediaries properly processed the majority of payment adjustments for claims referred by the QIOs. Specifically, fiscal intermediaries properly adjusted 3,440 (96.4 percent) of the 3,568 claims referred based on the QIOs' case reviews and final determinations during the FY 2005 HPMP. The 3,440 adjusted claims had net overpayments totaling $9,247,343, or 95.5 percent of the $9,684,299 in net overpayments requiring adjustment. However, fiscal intermediaries did not properly adjust 128 claims with net overpayments totaling $415,677.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- instruct fiscal intermediaries to recover $415,677 for 128 claims with errors identified during the FY 2005 HPMP that were either not adjusted or only partially adjusted and

- follow up with the QIOs and fiscal intermediaries when adjustments identified by the QIOs are not processed properly.

In comments on our draft report, CMS agreed with our first recommendation. With respect to our second recommendation, CMS stated that it currently matches the HPMP database to the National Claims History file to determine the extent to which adjustments identified by the QIOs are processed. CMS also said that the Medicare administrative contractors (MAC), which are

replacing the fiscal intermediaries, will provide CMS with monthly listings of adjustments requested by the QIOs and their disposition.

CMS's current data match and its MAC reporting process are acceptable alternatives to the procedure recommended in our draft report. Accordingly, we revised our second recommendation to focus on the follow-up action needed when CMS determines that adjustments identified by the QIOs were not made or were made improperly.

Pursuant to 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 generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after this report is issued, it will be posted on the Internet at http://oig.hhs.gov.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. 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, Regional Operations, and Information Technology Audits, at (202) 619-1157 or through e-mail at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-03-06-00005 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CLAIM PAYMENT ADJUSTMENTS IDENTIFIED BY QUALITY IMPROVEMENT ORGANIZATIONS

Daniel R. Levinson
Inspector General

November 2007
A-03-06-00005

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

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, Office of Audit Services 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.)

OAS 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/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to process and pay Medicare inpatient hospital claims using a prospective payment system that includes a preestablished amount for each discharge based on a diagnosis-related group code. (CMS has begun replacing fiscal intermediaries with Medicare administrative contractors (MAC).) CMS also contracts with quality improvement organizations (QIO) to, among other things, ensure that inpatient hospital claims are paid appropriately for the care provided. QIOs review some claims for the Hospital Payment Monitoring Program (HPMP), which is part of the process used to determine the annual 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.

When a QIO identifies an error during a case review, it notifies the provider of its proposed claim adjustment and gives the provider 20 days to respond. If the provider agrees with the determination, the QIO notifies the fiscal intermediary to make a claim adjustment. If the provider disagrees with the determination, the provider may submit its rationale and additional documentation to support the claim. If this information is sufficient, the QIO reverses its decision and closes its review. However, if the QIO maintains that its decision is appropriate, it notifies the fiscal intermediary to make a claim adjustment, informs the provider that an adjustment was submitted, and notifies the provider of its appeal rights.

OBJECTIVE

The objective of our review was to determine whether fiscal intermediaries properly processed payment adjustments for claims referred by the QIOs.

SUMMARY OF FINDING

Fiscal intermediaries properly processed the majority of payment adjustments for claims referred by the QIOs. Specifically, fiscal intermediaries properly adjusted 3,440 (96.4 percent) of the 3,568 claims referred based on the QIOs' case reviews and final determinations during the fiscal year (FY) 2005 HPMP. The 3,440 adjusted claims had net overpayments totaling $9,247,343, or 95.5 percent of the $9,684,299 in net overpayments requiring adjustment. However, fiscal intermediaries did not properly adjust 128 claims with net overpayments totaling $415,677.

RECOMMENDATIONS

We recommend that CMS:

- instruct fiscal intermediaries to recover $415,677 for 128 claims with errors identified during the FY 2005 HPMP that were either not adjusted or only partially adjusted and

- follow up with the QIOs and fiscal intermediaries when adjustments identified by the QIOs are not processed properly.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS agreed with our first recommendation. With respect to our second recommendation, CMS stated that it currently matches the HPMP database to the National Claims History file to determine the extent to which adjustments identified by the QIOs are processed. CMS also said that the new MACs will provide CMS with monthly listings of adjustments requested by the QIOs and their disposition. CMS's comments are included as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS's current data match and its MAC reporting process are acceptable alternatives to the procedure recommended in our draft report. Accordingly, we revised our second recommendation to focus on the follow-up action needed when CMS determines that adjustments identified by the QIOs were not made or were made improperly.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act (the Act) established Medicare as a broad health insurance program for people 65 years of age and older and those under 65 who are disabled or who have end-stage renal disease. Medicare Part A covers inpatient hospital care. The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to process and pay inpatient hospital claims using a prospective payment system that includes a preestablished amount for each discharge based on a diagnosis-related group (DRG) code.[1]

Quality Improvement Organizations

Title XI of the Act established quality improvement organizations (QIO) to review inpatient hospital care provided to Medicare beneficiaries. Reviews by the 52 QIOs ensure that the care is medically necessary, reasonable, and provided in the appropriate setting and that it meets recognized health care standards.[2] QIOs also review inpatient records to ensure that claims are paid appropriately for the care provided. A difference between the amount that Medicare paid to a hospital and the amount that it should have paid is considered an error.

Hospital Payment Monitoring Program Claim Reviews

QIOs review some inpatient acute-care hospital claims for the Hospital Payment Monitoring Program (HPMP), which is part of the process used to determine the annual Medicare fee-for-service paid claims error rate.[3] Under contract with CMS, clinical data abstraction centers (CDAC) screen a statistical sample of inpatient acute-care Medicare discharges. CDACs obtain medical records from health care providers and perform two screenings: one to confirm admission necessity and one to validate the DRG used for billing the claim. If a claim fails one or both of the CDAC screenings, the CDAC refers the claim to a QIO for a case review and final determination. In addition, the CDAC refers to a QIO all sampled claims for which it does not receive medical records within the time allowed, as well as a quality control sample of 10 percent of the claims that do not fail the CDAC screenings. The QIO performs a case review to determine whether claims were paid appropriately for the services provided.[4]

---

[1]Pursuant to the contracting reform provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS is replacing fiscal intermediaries with Medicare administrative contractors (MAC). CMS contracted with the first MAC in July 2006 and with an additional four MACs from August through October 2007.

[2]Section 1154 of the Act establishes requirements for QIOs' utilization and quality control functions.

[3]CMS originally established the HPMP as the Payment Error Prevention Program.

[4]CMS's "Quality Improvement Organization Manual" (CMS Publication 100-10), Chapter 11, identifies the CDAC review and referral process as part of the HPMP.

When a QIO identifies an error during a case review, it notifies the provider of its proposed claim adjustment and gives the provider 20 days to research the claim and respond to the QIO's determination.[5] If the provider agrees with the determination, the QIO notifies the fiscal intermediary to make a claim adjustment. If the provider disagrees with the determination, the provider may submit its rationale and additional documentation to support the claim. If this information is sufficient, the QIO reverses its decision and closes its review. However, if the QIO maintains that its decision is appropriate, it notifies the fiscal intermediary to make a claim adjustment, informs the provider that an adjustment was submitted, and notifies the provider of its appeal rights.

For the fiscal year (FY) 2005 HPMP, the CDACs screened a statistical sample of 38,448 claims and referred 21,534 claims to the QIOs for a case review and final determination. This number included the quality control sample and 2,191 claims that the CDACs forwarded without review because the providers had not submitted medical records within the time allowed. The QIOs pursued these records and received them from the providers. After making final determinations, the QIOs referred 3,622 claims to fiscal intermediaries for financial adjustments. The QIOs also identified 24 claims with errors that did not require financial adjustments.

Other Reviews of Claim Adjustments

Reviews by CMS and its HPMP contractors showed that during FYs 2000 through 2003, fiscal intermediaries did not adjust 1,369 (6.7 percent) of 20,492 claims with errors and only partly adjusted an additional 189 claims (1 percent).[6]

In November 2005, we reported (report number A-03-05-00007) that fiscal intermediaries did not always adjust claims with identified errors and that we planned to perform additional work in this area.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether fiscal intermediaries properly processed payment adjustments for claims referred by the QIOs.

Scope

As part of the HPMP for FY 2005, the QIOs identified 3,646 claims with errors: 3,568 claims with net overpayments totaling $9,684,299 and 78 claims that did not need payment

[5]The "Quality Improvement Organization Manual," Chapter 4, describes the case review process. Section 4530 provides the specific procedures used to give providers the opportunity to discuss the results of the case reviews.

[6]CMS conducts an annual Payment Error Cause Analysis to discern reasons for payment errors, including noncollection of error amounts. We obtained these data from the National Payment Error Management Information System data warehouse as of December 2005.

adjustments.[7] The 3,646 claims included 3,483 claims for which the CDACs had identified potential errors and 163 claims from the quality control sample that required claim payment adjustments.[8]

We limited our review of internal controls to QIO procedures for requesting claim payment adjustments from fiscal intermediaries and to fiscal intermediary procedures for making the adjustments. Our review included the providers' original claims and all related adjustments made by the fiscal intermediaries.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- reviewed QIO controls established to ensure that QIOs referred claims with identified errors to fiscal intermediaries for payment adjustments;
- reviewed fiscal intermediary controls established to ensure that fiscal intermediaries adjusted claims referred by the QIOs;
- compared the Common Working File claim payment data with the claims in the HPMP database to determine whether fiscal intermediaries adjusted the 3,646 claims with errors identified by the QIOs during the FY 2005 HPMP review;[9]
- interviewed representatives from six QIOs regarding the process followed to request that fiscal intermediaries adjust claims when the QIOs identify errors; and
- interviewed a CMS representative to determine why fiscal intermediaries did not make the appropriate adjustments for all claims with errors identified by the QIOs.

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

[7]The 78 claims consisted of 54 claims for which the QIO or the fiscal intermediary reversed the original error determination and 24 billing errors that did not result in monetary adjustments.

[8]The FY 2005 HPMP error rate estimate did not include error amounts for quality control claims submitted to the QIOs for review. However, we included in the scope of our review overpayment and underpayment amounts determined by the fiscal intermediaries when they processed the QIOs' adjustments for the 163 quality control claims. In response to recommendations in report number A-03-05-00007, CMS began including the quality control adjustment amounts in its error rate estimates.

[9]The Common Working File is a Medicare Part A and Part B benefit coordination and claim validation system that maintains a record of all claim payments and adjustments.

FINDING AND RECOMMENDATIONS

Fiscal intermediaries properly processed the majority of payment adjustments for claims referred by the QIOs. Specifically, fiscal intermediaries properly adjusted 3,440 (96.4 percent) of the 3,568 claims referred based on the QIOs' case reviews and final determinations during the FY 2005 HPMP. The 3,440 adjusted claims had net overpayments totaling $9,247,343, or 95.5 percent of the $9,684,299 in net overpayments requiring adjustment. However, fiscal intermediaries did not properly adjust 128 claims with net overpayments totaling $415,677.[10]

FINANCIAL ADJUSTMENTS NOT MADE TO ALL CLAIM PAYMENTS

Section 11005 of the "Quality Improvement Organization Manual" requires the QIOs to review cases forwarded by the CDACs for potential errors found in admission-necessity and DRG validation screenings. When a QIO identifies an error, it is required to notify the appropriate fiscal intermediary to make a financial adjustment to the claim payment. Section 130.1 of the "Medicare Claims Processing Manual" (CMS Publication 100-04) requires fiscal intermediaries to make financial adjustments to claim payments when requested by the QIOs.

For 128 claims, fiscal intermediaries did not make adjustments or improperly made adjustments. For 111 claims with net overpayments of $332,895, fiscal intermediaries made no adjustments. For the remaining 17 claims with overpayments totaling $133,865, the QIO reviews identified two types of errors: incorrect DRGs and denied admissions for lack of medical necessity. Fiscal intermediaries made partial net overpayment adjustments totaling $51,083 based on changes to the DRGs. However, the fiscal intermediaries should have processed adjustments for the full amounts of the claims because of the admission denials. As a result, fiscal intermediaries did not collect net overpayments totaling $82,782 for the 17 claims.

RECOMMENDATIONS

We recommend that CMS:

- instruct fiscal intermediaries to recover $415,677 for 128 claims with errors identified during the FY 2005 HPMP that were either not adjusted or only partially adjusted and

- follow up with the QIOs and fiscal intermediaries when adjustments identified by the QIOs are not processed properly.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS agreed with our first recommendation. CMS said that it would coordinate with us to obtain the needed claim information and that it would instruct the intermediaries and the new MACs to initiate appropriate recovery action.

With respect to our second recommendation, CMS stated that it currently matches the HPMP database to the National Claims History file to determine the extent to which adjustments

[10]The 128 claims were associated with 25 fiscal intermediaries and 106 providers.

identified by the QIOs are processed. CMS also said that the MACs will provide CMS with monthly listings of adjustments requested by the QIOs and their disposition. CMS added that the first MAC already submits such listings.

CMS's comments, including a technical comment, are provided in the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

On September 6, 2007, we provided CMS with detailed information on the 128 claims that the intermediaries did not properly adjust. We agreed to provide additional information as needed.

CMS's current data match and its MAC reporting process are acceptable alternatives to the procedure recommended in our draft report. Accordingly, we revised our second recommendation to focus on the follow-up action needed when CMS determines that adjustments identified by the QIOs were not made or were made improperly. In addition, we addressed CMS's technical comment.

OTHER MATTER: NO STANDARD METHOD TO MONITOR FINANCIAL ADJUSTMENTS

The QIOs and fiscal intermediaries had no standard method to ensure that the QIOs submitted all claim adjustments to fiscal intermediaries or that the fiscal intermediaries received and correctly processed the adjustments.

All 52 QIOs manually referred claims to fiscal intermediaries. The QIO provided the fiscal intermediary with a copy of the denial letter sent to the provider or a separate letter identifying the type of adjustment requested. Although three of the six QIOs we contacted stated that they had "internal systems" to monitor whether the fiscal intermediary made an adjustment, the systems were unique to each QIO. There was no standard method to monitor all requested adjustments. As a result, the QIOs and fiscal intermediaries could not verify that fiscal intermediaries processed all claim adjustments identified by the QIOs. In addition, we could not verify whether the QIOs submitted all requests to fiscal intermediaries or whether fiscal intermediaries received the requests.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

RECEIVED
2007 OCT 10 AM 9:01
OFFICE OF INSPECTOR GENERAL

DATE: SEP 2 6 2007

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General's (OIG) Draft Report: "Claim Payment Adjustments Identified by Quality Improvement Organizations" (A-03-06-00005)

Thank you for the opportunity to review and comment on the OIG draft report "Claim Payment Adjustments Identified by Quality Improvement Organizations" (A-03-06-00005). We appreciate the OIG's efforts to ensure that adjustments identified by Quality Improvement Organizations (QIOs) are processed appropriately.

As mentioned in the report, reviews by the Centers for Medicare & Medicaid Services (CMS) and its Hospital Payment Monitoring Program (HPMP) contractors showed that, for discharges during fiscal year (FYs) 2000 through 2003 resulting in QIO-identified adjustments, fiscal intermediaries did not adjust 1,369 (6.7 percent) of 20,492 claims with errors, and only partly adjusted an additional 189 claims (1 percent). Subsequently, the OIG conducted a review of claim payment adjustments identified by QIOs through FY 2005 HPMP activities. For this later period, the OIG found that fiscal intermediaries did not properly adjust 128 (3.6 percent) of the 3,568 claims referred; these 128 claims comprised net overpayments of $415,677.

OIG Recommendation

CMS should instruct fiscal intermediaries to recover $415,677 for 128 claims with errors identified during the FY 2005 HPMP that were either not adjusted or only partially adjusted.

CMS Response

CMS agrees. CMS will coordinate with the OIG to obtain needed information on the claims involved and will instruct the affected fiscal intermediaries and Medicare administrative contractors (MACs) to initiate appropriate recovery action.

OIG Recommendation

CMS should match the error results in its HPMP database with the Common Working File to ensure that all adjustments identified by the QIOs are processed by the fiscal intermediaries and

should follow up with the QIOs and fiscal intermediaries when adjustments are not processed promptly.

CMS Response

CMS currently conducts two annual analyses to monitor the completion of QIO adjustments determined through HPMP activities: one which is publicly released in each year's error rate report in November for that year's sample used in generating the error rate, and one for each Fiscal Year. These analyses match the error results in the CMS HPMP database with data contained in the National Claims History file to determine the extent that adjustments identified by the QIOs are processed. Further, to monitor the timing of processing QIO adjustments, under the MAC contracts, listings of QIO adjustments and their disposition are to be generated monthly by the MAC for CMS review and approval. The first Part A/Part B MAC contractor has been submitting these reports since January 2007.

Additional CMS Comment

Footnote 7 states that, "The FY 2005 HPMP database did not record an error amount for quality control claims submitted to the QIOs for review". CMS would like to provide the following correction: Error amounts for payment errors found in quality control claims have always been included in the HPMP database; these error amounts were not previously included in calculating error rate estimates.