Overview of Improper Payment Reviews Conducted by Medicare & Medicaid Review Contractors

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What is an Improper Payment Review?

- Improper Payment:
  - Any payment to the wrong provider for the wrong services or in the wrong amount
  - Overpayments and underpayments
  - Most often
    - Didn't meet the statutory coverage requests
    - Didn't meet the Medical necessity requirements
    - Incorrectly coded
    - Didn't submit sufficient documentation
- Improper payment Review: The evaluation of claims to determine whether the items/services are covered, correctly coded, and medically necessary
  - When: Prepay or Postpay
  - How: Automated (without Medical Records) or and Complex (with Medical Records)

What is the Error Rate Today?

Medicare FFS Error Rate:

- In 2009 it was 12.4%
- In 2010 it was 10.5% ($34.3 Billion)
- 2011 – available Nov 2011

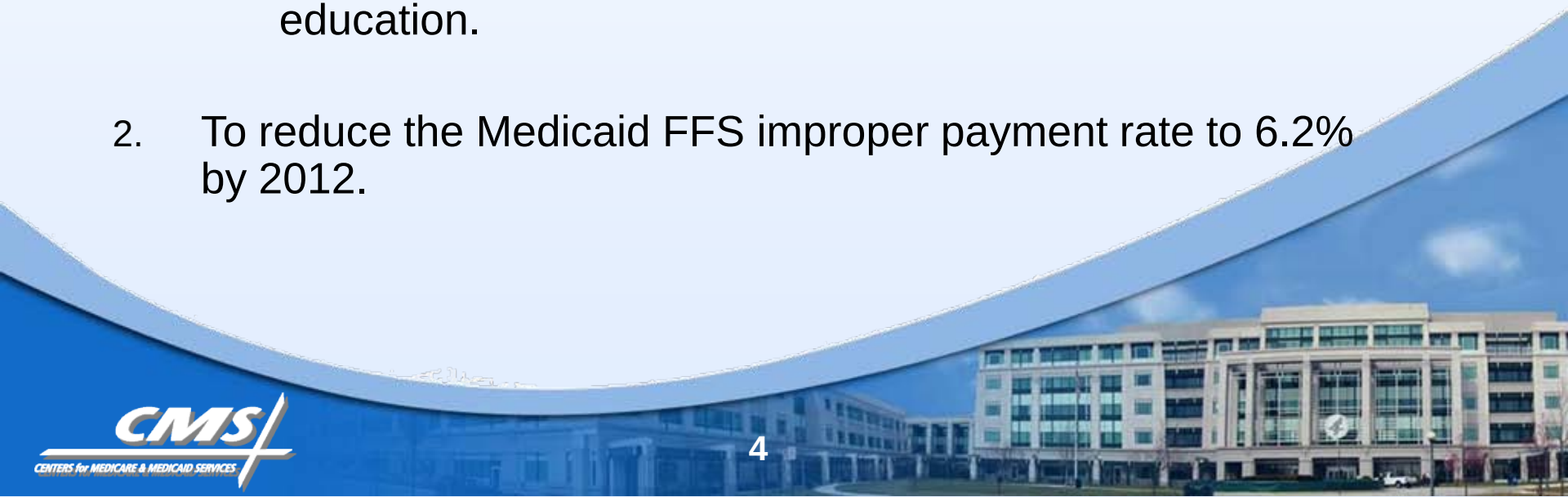
Medicaid FFS Error Rate: (3 year weighted average)

- In 2010 it was 9.4% ($22.5 Billion)
- In 2011 – available Nov 2011

Goals of the CMS Provider Compliance Group

1. To reduce the Medicare FFS improper payment rate to: 8.5% by Nov 2011 and 6.2% by Nov 2012.
   a. By **Identifying** past improper payments through data analysis
   b. **Correcting** past and improper payments through postpay review.
   c. **Preventing** future improper payments through provider education.

2. To reduce the Medicaid FFS improper payment rate to 6.2% by 2012.



Roles of Various Medicare Improper Payment Review Entities

	Types of Claims	How selected	Volume of Claims	Type of Review	Purpose of Review	Other Functions
QIO	**Inpatient Hospital claims only**	All claims where hospital submits an adjusted claim for a higher-weighted DRG Expedited Coverage Reviews requested by beneficiaries	**Very small**	•Prepay & Concurrent (Patient still in hospital) •Complex Only	To prevent improper payments through DRG upcoding To resolve discharge disputes between beneficiary and hospital	Quality Reviews
CERT*	**All Medical Claims**	**Randomly**	**Small**	•Postpay only •Complex only	To **measure** improper payments	None
PERM*	**All Medical Claims Randomly**	**Randomly**	**Small**	•Postpay only •Automated & Complex	To **measure** improper payments	None
Medical Review Units* at MACs	**All Medicare FFS Claims**	**Targeted**	Depends on number of claims with possible improper payments for this provider	•Prepay & Postpay •Automated, & Complex	To **prevent future** improper payments	•Education •Appeals
Medicare Recovery Auditors*	**All Medicare FFS Claims**	**Targeted**	Depends on number of claims with possible improper payments for this provider	•Postpay •Automated and Complex	To **detect and correct past** improper payments	None
PSC/ZPICS	**All Medicare FFS Claims**	**Targeted**	Depends on number of potentially fraudulent claims submitted by provider	•Prepay and Postpay •Automated and Complex	To identify **potential fraud**	**----**
OIG	**All Claims**	**Targeted**	Depends on number of potentially fraudulent claims submitted by provider	•Postpay •Complex	To identify **fraud**	**----**

*** Overseen by OFM/PCG**

The CERT Review Process

- Claims are selected randomly from all claims submitted for payment each day.
- The CERT **Documentation** Contractor requests medical records via a paper letter.

  If a provider fails to submit a requested record, it counts as an improper payment is recouped from the providers.
- Reviews are conducted by at least one nurse at the CERT **Review** Contractor.

  Claims determined to be paid incorrectly are scored as errors and payments are adjusted.
- Error rates are calculated and reported.

  www.cms.gov/cert

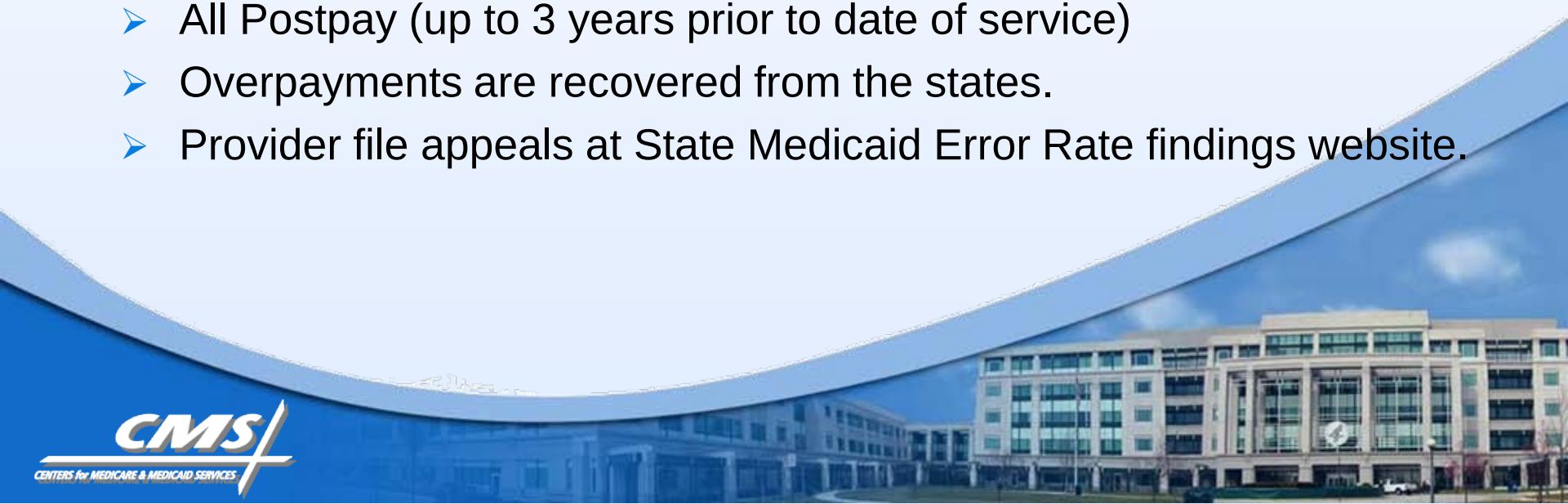
  - 10.5% error rate

  - 9 out of 10 errors are overpayments

  - 1 out of 10 errors are underpayments
- Provider file appeals at MAC.

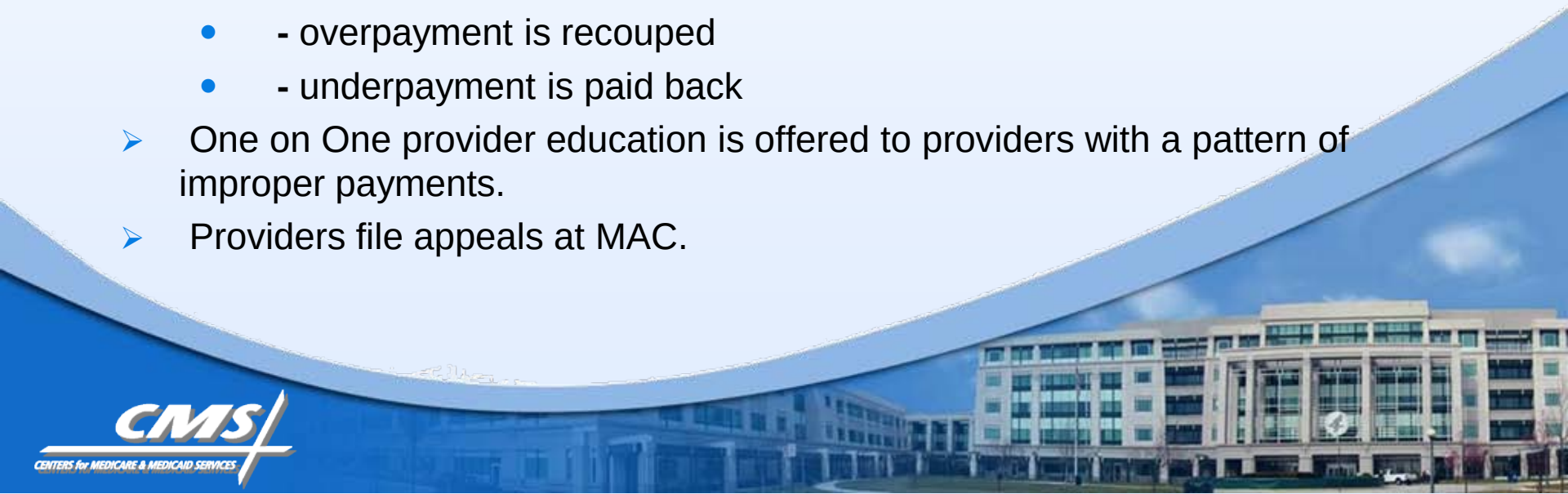
The PERM Review Process

- Claims are selection randomly.
- The PERM Contractors requests medical records via paper letter.
  - If a provider fails to submit a requested record, it counts as an improper payment and the payment recouped from the provider.
- Reviews are conducted by clinicians and certified coders.
- All Postpay (up to 3 years prior to date of service)
- Overpayments are recovered from the states.
- Provider file appeals at State Medicaid Error Rate findings website.

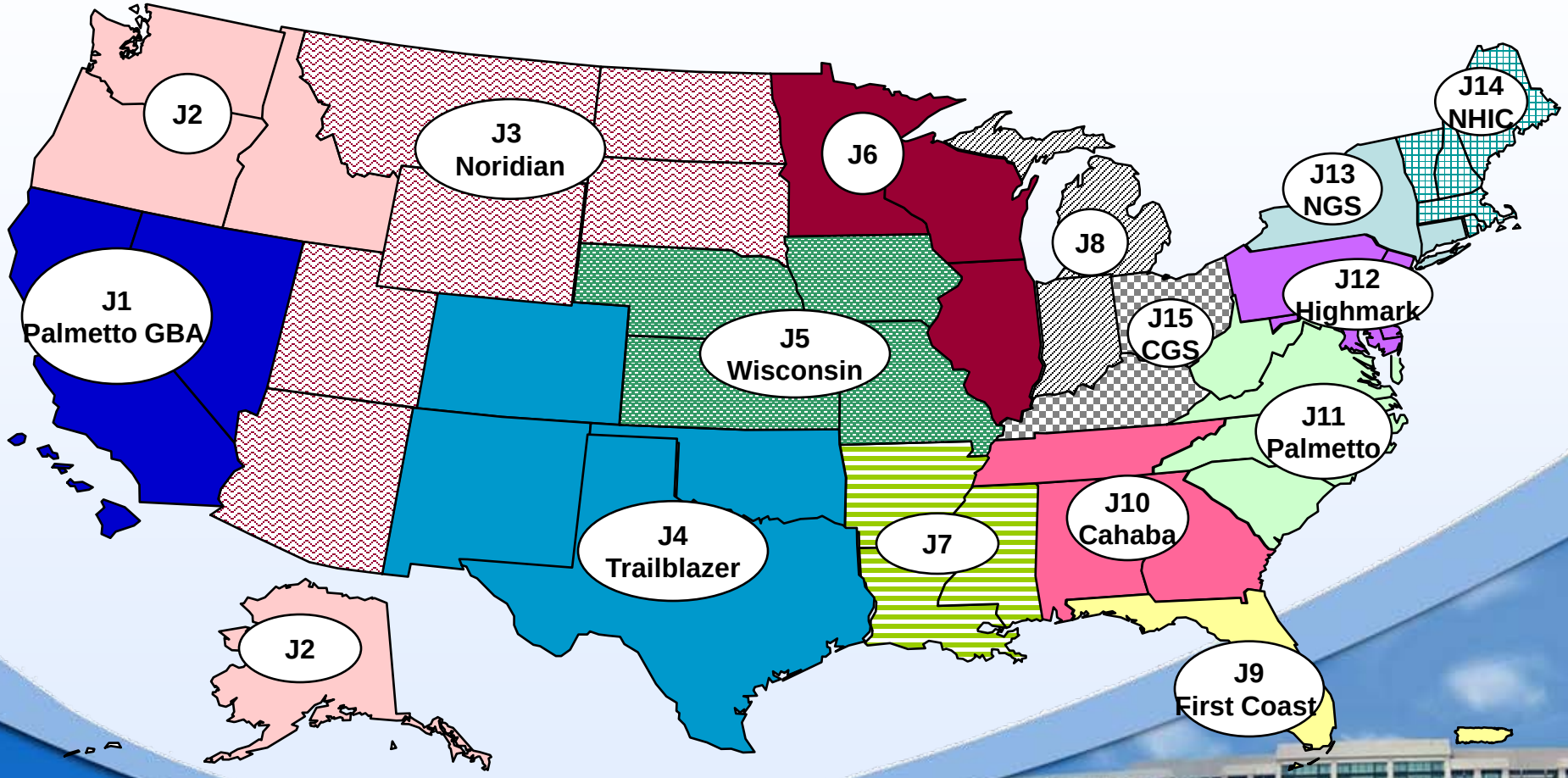


The MAC Review Process

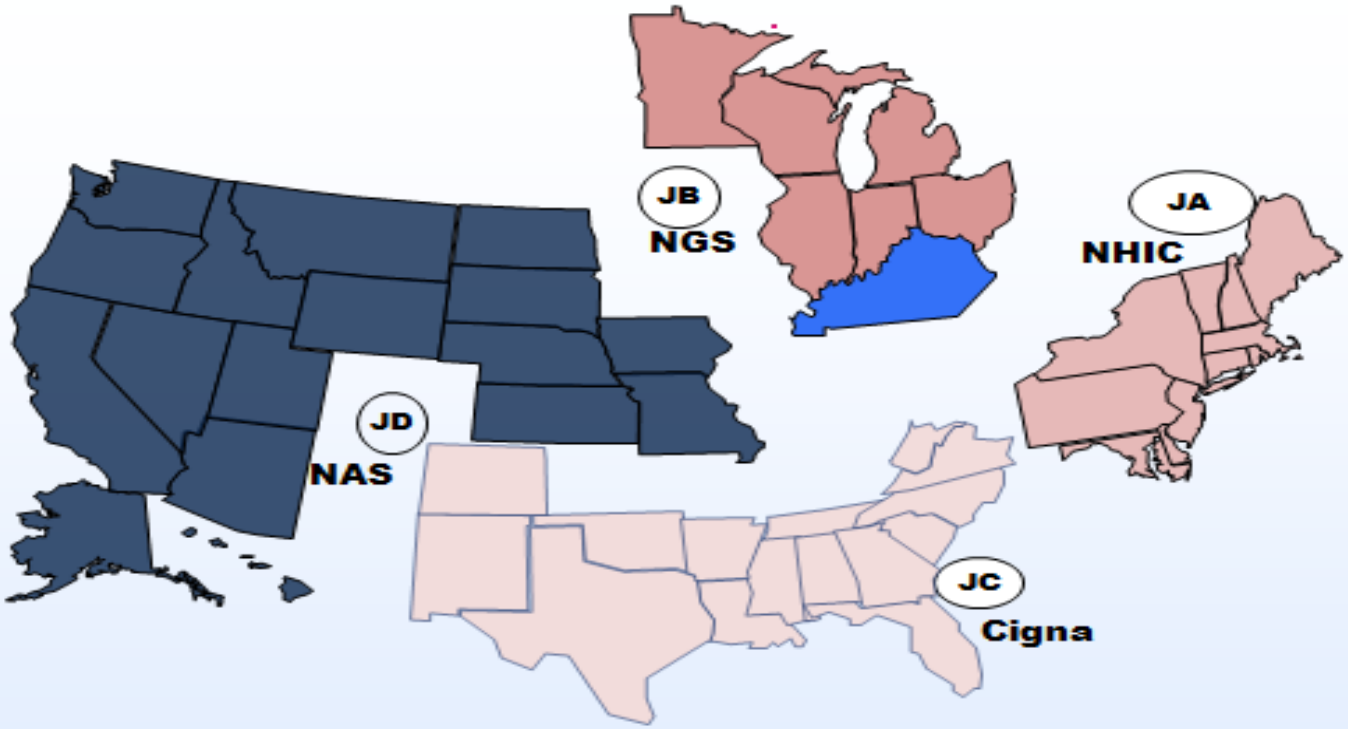
- Claims selection targeted to claims that are most likely to contain an improper payment.
- The MAC requests medical records via paper letter.
- Reviews are conducted by clinicians (nurses, physical therapists, etc) and certified coders:
  - Prepay claims that are found to be improper:
    - - claim is denied and no payment issued
  - Postpay claims that are found to be improper:
  - - overpayment is recouped
  - - underpayment is paid back
- One on One provider education is offered to providers with a pattern of improper payments.
- Providers file appeals at MAC.



A/B MAC Jurisdictions



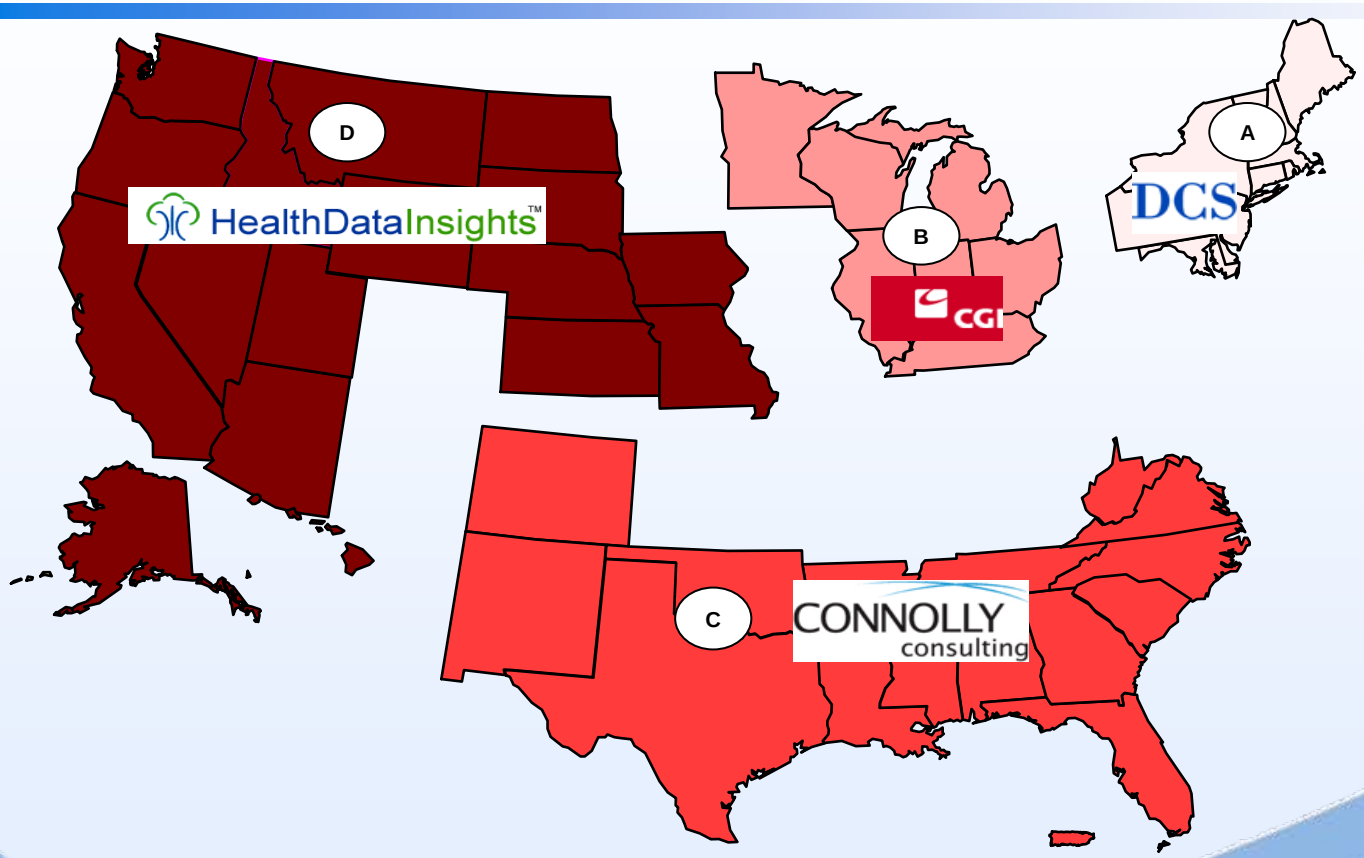
DME MAC Jurisdictions



The RAC Review Process

- Claims selection targeted to claims that are most likely to contain an improper payment.
- The RAC requests medical records via paper letter.
- Reviews conducted by clinicians and certified coders.
- All Postpay (up to 3 years prior to date of service)
  - Over payments are recouped
  - Under payments are paid back
- Top issues are posted on www.cms.gov/rac
- Providers file appeals at MAC

RAC Regions



Major Causes of Improper Payments

- Physician orders missing.
- Illegible/missing signatures.
- National policy or Local policy requirements not met.
- The medical record does not support medical necessity.

Note: Medical records from the ordering physicians are critical to support medical necessity when the billing entity is not the ordering physician, e.g., DME, clinical diagnostic tests.