

Understanding the Medical Review Process as Performed by the CERT Contractor

The following is an edited version of the CERT Report. This report can be found at http://www.cms.hhs.gov/apps/er_report/index.asp

The CERT (Comprehensive Error Rate Testing Program) contractor has been producing annual and semi-annual reports indicating the National Error Rate for Medicare services. The last report to be published was in May 2008 when it estimated that the national error rate had been further reduced from the original estimate in 1996 of 14.2% all the way down to 3.6% in 2008.

CMS's goal was to get the error rate down to less than 3.8% which it appeared to have achieved. The method of performing Medical Reviews had been standardized by CMS and published in the IOM Program Integrity Manual and was to be followed by all contractors performing Medical Review activities.

The OIG performed an audit of CERT's methods of processing reviews and determined that it had not converted to the more in depth procedures of the new requirements. As a result of these changes, a more complete accounting of improper payments was achieved. The 2009 error rate increased to an overall level of 7.8 % compared with the previous year. This number did not indicate an increase in Medicare fraud but implementation of stricter regulations including enforcement of documentation requirements outlined in Medicare regulation, statute, and policy, including Local Coverage Determinations (LCDs). In previous years, the CERT contractor was using clinical review judgment based on billing history and other available information.

The primary modification required the medical reviewers under CERT to strictly follow the documentation requirements outlined in Medicare regulation, statute, and policy, *including Local Coverage Determinations (LCDs)*.

A significant portion of the new errors found in FY 2009 were due to a strict adherence to the documentation requirements, *signature legibility requirements*, and regulation along with the use of each contractor's *LCDs*.

CMS has indicated that it will analyze the improper payment data to determine if there are geographic trends that can assist in identifying errors that highlight programmatic weaknesses. CMS will review trends by types of service to locate potential vulnerabilities. CMS will use this knowledge to design new innovative approaches to reduce improper payments, particularly in *high risk areas* such as *durable medical equipment and home health*. The error rate is not a measure of fraud; however, it may be an indication of a program weakness that requires more oversight and diligence by CMS.

The CERT Process

CMS established the CERT program to monitor the accuracy of Medicare FFS payments made by the Medicare claims contractors. The main objective of the CERT program is to measure the degree to which CMS and contractors are meeting the goal of "Paying it Right".

Sampling and Medical Record Requests:

For this report, the CERT Contractor randomly sampled approximately 100,000 claims from Carriers, FIs, and MACs. CERT designed this process to pull a blind, electronic sample of claims each day from all of the claims providers submitted that day.

CERT requested the medical record associated with the sampled claim from the provider and sent the initial request for medical records via letter. If the provider failed to respond to the initial request after 30 days, the CERT Contractor sent up to three subsequent letters in addition to follow-up phone calls to the provider.

In cases where the CERT Contractor received no documentation from the provider once 75 days had passed since the initial request, the CERT Contractor considered the case to be a ***no documentation claim*** and counted it as an error. The CERT Contractor considered any documentation received after the 75th day "late documentation." If the CERT Contractor received late documentation prior to the documentation cut-off date for this report (day 31 to day 75 days), they reviewed the records and, if justified, revised the error in each rate throughout the report. If the CERT Contractor received late documentation after the cut-off date for this report, they attempted to complete the review process before the final production of the report. Claims that completed the review process were included in the report. Claims for which the CERT contractor received no documentation were counted as no documentation errors.

Review of Claims:

Upon receipt of medical records, the CERT's clinicians conducted a review of the claim and the submitted documentation to identify any improper payments. They checked the Common Working File to see if the person receiving the services was an eligible Medicare beneficiary, to see if the claim was a duplicate and to make sure that no other insurer was responsible for paying the claim. When performing these reviews, the CERT contractor followed Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective contractor's Local Coverage Determinations (LCDs), and articles.

Methodology Overview:

The CERT contractor randomly selects a sample of paid claims submitted to the claims contractors during the reporting period. This is then followed by the ADR (Additional Development Request) to the provider requesting supporting medical records for the claims submitted.

Once the medical record is received, the claim(s) and the associated medical records are reviewed to see if ***the claim(s)*** complied with Medicare coverage, coding, and billing rules. If not compliant, the claim is assigned to the appropriate error category. If medical records are ***not submitted*** by the provider, CERT classifies the case as a no documentation claim and counts it as an error.

The CERT then sends the providers overpayment letters/notices or makes adjustments for claim(s) where an overpaid or underpaid determination was made. Finally the projected improper payment rate is calculated based on the actual erroneous claims identified in the sample.

CERT reports a ***paid claims error rate*** which is based on dollars paid after the Medicare contractor made its payment decision on the claim. This rate includes fully denied claims. The paid claims error rate is the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied and is a good

indicator of how claim errors in the Medicare FFS Program impact the trust fund. CMS calculated the gross rate by adding underpayments to overpayments and dividing that sum by total dollars paid.

Sampling Methodology:

For the 2009 report, the CERT Contractor randomly sampled approximately 99,500 claims across all provider settings. CERT designed this process to pull a *blind, electronic sample of claims each day* from all of the claims providers submitted that day.

Error Categories:

Based on the review of the medical records, claim errors are categorized into 5 different error categories. The 5 categories of error under the CERT program are described below.

No documentation (0.1% error)—Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medial records in support of the claim. –

Insufficient documentation (1.9% error) —Claims are placed into the category when the medical documentation submitted does not include pertinent patient facts (e.g. the patient’s overall condition, diagnosis, and extent of services performed).

Medically unnecessary service (4.0% error) — Claims are placed into this category when claim review staff identify enough documentation in the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies.

Incorrect coding (1.6% error) — Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted.

Other (0.1% error) —Represents claims that do not fit into any of the other categories (e.g. service not rendered, duplicate payment error, not covered or unallowable service).

National Claims Error Rate:

Although the error rate percentages may appear small, it cost the Medicare program \$23 billion in overpayments. Underpayments (yes they did identify some) were \$1.1 billion. For FY 2009, the Medicare FFS providers were paid a total of \$308.4 billion from the Trust Fund.

Disclaimer:

Encompass Consulting & Education, LLC has produced this article as an informational reference for the readers of our E-Zine. The information contained in this article is current as of the time of publication.

Medicare regulations are constantly changing and it is the responsibility of the provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited are subject to change at any time. Current Medicare regulations can be found on the CMS website at www.cms.hhs.gov

As always, the provider should be aware of other regulations that might supersede the Medicare payment guidelines such as the State Practice Act and the State Administrative Code. In any scenario, the practitioner must go with the most stringent requirement in order to be compliant.