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 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

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

* 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](http://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 selected 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.
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](http://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.