



SEP 29 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Acting Inspector General

SUBJECT: Review of Providers' Responsiveness to Requests for Medical Records
Under the Comprehensive Error Rate Testing Program (A-01-04-00517)

Attached is a copy of our final report on health care providers' responsiveness to requests for medical records under the fiscal year (FY) 2004 Comprehensive Error Rate Testing (CERT) program. As required by law, the Centers for Medicare & Medicaid Services (CMS) develops an annual estimate of improper payments for Medicare fee-for-service paid claims. The CERT program produces an error rate for all provider claims other than acute care inpatient hospital claims. In administering the program, the CERT contractor obtains provider contact information from the affiliated contractors (fiscal intermediaries, carriers, and durable medical equipment regional carriers).

During FY 2003, CMS experienced a significant problem with providers that did not respond to requests for medical records for use in developing the CERT error rate. In response to concerns of the Chairman, Senate Committee on Finance, we previously reviewed CMS's actions to improve provider responsiveness during FY 2004. In June 2004, we reported that CMS had implemented a number of corrective actions that appeared to have increased provider responsiveness.¹ As of April 8, 2004, provider nonresponses represented about 2 percent of the number and 3 percent of the dollar value of claims selected for the FY 2004 CERT sample, compared with about 8 percent of the number and 7 percent of the dollar value for FY 2003.

The objectives of this review were to continue to monitor the rate of response by Medicare providers to requests for medical records during the FY 2004 CERT process and to determine the reasons cited by providers for nonresponses.

After we completed our previous review, providers continued to submit documentation. By June 11, 2004, provider nonresponses accounted for less than 1 percent of the total number and dollar value of claims selected for the FY 2004 CERT sample, according to CMS. We do not believe that the remaining nonresponses will have a significant impact on the reliability of CMS's estimate of the FY 2004 Medicare fee-for-service error rate.

¹"Review of Corrective Actions To Improve the Comprehensive Error Rate Testing Process for Obtaining Medical Records" (A-03-04-00005).

We attempted to locate the medical records for 505 claims, submitted by 392 providers, that the CERT contractor considered to be nonresponses as of June 11, 2004. For 355 of the 505 claims, providers told us that they did not receive the request letters (230 claims), had already provided the requested documentation (79 claims), or did not have direct access to medical records that were maintained at another location (46 claims). Regarding the remaining 150 claims reviewed, providers indicated numerous reasons for the nonresponses. (See the Appendix.)

Although some request letters were sent to incorrect addresses or did not reach the appropriate provider personnel, we believe that subsequent telephone contacts by the CERT contractor should have elicited responses from the providers. Our contacts with most of the 392 providers or their representatives resulted in the submission of 89 percent of the requested medical records. Because CERT officials did not thoroughly document the results of phone calls, however, we were unable to determine whether they made the required calls.

In addition, the CERT contractor initially maintained only one facsimile machine to receive medical records. Recognizing that facsimile utilization quickly grew beyond the capacity of one machine, CERT officials eventually added three more machines. We believe that the lack of sufficient facsimile machines contributed to the initial provider nonresponse problem. Further, the CERT contractor did not have controls to ensure that all faxed medical records were logged in the control system.

While CMS's diligence in obtaining medical records has reduced the nonresponse rate to less than 1 percent, we have identified improvements that would allow CMS to further enhance its process for ensuring the timely receipt of records. We recommend that CMS:

- require the affiliated contractors to perform outreach and education with medical records directors and compliance officers of large facilities to explain the CERT process, identify and resolve any issues that would prevent the providers from responding, and obtain current address and contact information
- require the CERT contractor to refer cases of incorrect or incomplete provider contact information to the affiliated contractors as soon as the initial request letter is returned as undeliverable or the CERT contractor is unable to complete the first phone call because of a nonworking telephone number
- define provider and affiliated contractor responsibilities for retrieving and submitting medical records maintained at an address other than that to which the original request was submitted
- direct the CERT contractor to thoroughly document telephone contacts with providers and to maintain phone logs in a computerized database

- consider devoting additional resources to followup telephone contacts with providers and increasing the number of facsimile machines at the CERT contractor to facilitate the receipt of medical records
- require the CERT contractor to include in request letters instructions to providers to obtain a facsimile confirmation that the CERT contractor received the medical records
- direct the CERT contractor to implement controls to ensure that all medical records received by facsimile are identified, logged in a control system, and filed for medical review

In commenting on a draft of this report, CMS officials orally agreed with the findings and recommendations.

If you have any questions, please do not hesitate to call me, or your staff may contact David M. Long, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at david.long@oig.hhs.gov. Please refer to report number A-01-04-00517 in all correspondence.

Attachment

cc:

Mr. Timothy Hill

Ms. Kimberly Brandt

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF PROVIDERS'
RESPONSIVENESS TO REQUESTS
FOR MEDICAL RECORDS UNDER
THE COMPREHENSIVE ERROR
RATE TESTING PROGRAM**



SEPTEMBER 2004

A-01-04-00517

Office of Inspector General

<http://oig.hhs.gov>

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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

In accordance with the Improper Payments Information Act of 2002, the Centers for Medicare & Medicaid Services (CMS) submits to Congress an annual estimate of improper payments for Medicare fee-for-service claims. The overall error rate for these claims consists of an error rate for acute care inpatient hospitals and an error rate for all other provider claims.

The subject of this report is the error rate for all other provider claims, which CMS develops through the Comprehensive Error Rate Testing (CERT) program. CMS contracts with AdvanceMed (the CERT contractor) to administer the CERT program. The CERT contractor obtains provider contact information from the affiliated contractors (fiscal intermediaries, carriers, and durable medical equipment regional carriers).

During the fiscal year (FY) 2003 error rate review process, CMS experienced a significant problem with providers that did not respond to requests for medical records under the CERT program. These nonresponses accounted for more than half of the 9.8-percent initial error rate reported by CMS. To report a more representative estimate, CMS adjusted the nonresponse rate to reflect the Office of Inspector General's (OIG) 7 years of experience with nonresponders. CMS reported an adjusted error rate of 5.8 percent.

In response to concerns of the Chairman, Senate Committee on Finance, about CMS's reporting of two error rates and the high nonresponse rate, we reviewed CMS's actions to improve provider responsiveness. On June 2, 2004, we reported that CMS had implemented a number of corrective actions that appeared to have increased provider responsiveness.¹ As of April 8, 2004, provider nonresponses represented about 2 percent of the total number and 3 percent of the total dollar value of claims selected for the FY 2004 error rate sample, compared with about 8 percent of the number and about 7 percent of the dollar value for FY 2003.

OBJECTIVES

Our objectives were to continue to monitor the rate of response by Medicare providers to requests for medical records during the FY 2004 CERT process and to determine the reasons cited by providers for nonresponses.

SUMMARY OF RESULTS

Receipt of 99 Percent of Requested Medical Records

Between April 8, 2004, when we completed fieldwork on our previous review, and June 11, 2004, providers continued to submit documentation to the CERT contractor. According to CMS, by June 11, provider nonresponses accounted for less than 1 percent of the total number and 0.7 percent of the total dollar value of claims selected for the FY 2004 CERT sample.

¹"Review of Corrective Actions To Improve the Comprehensive Error Rate Testing Process for Obtaining Medical Records" (A-03-04-00005).

Reasons Cited by Providers for Nonresponses

We attempted to locate the medical records for 505 claims, submitted by 392 providers, that the CERT contractor considered to be nonresponses. For 355 of the 505 claims, providers told us that they:

- did not receive the request letters (230 claims)
- had already provided the requested documentation (79 claims)
- did not have direct access to medical records that were maintained at another location (46 claims)

Regarding the remaining 150 claims reviewed, providers indicated numerous reasons for the nonresponses. (See the Appendix.)

We asked providers to confirm the addresses to which the request letters were mailed. Providers responsible for 111 of the 505 nonresponses stated that the letters were sent to incorrect addresses, and providers responsible for 84 nonresponses said that the letters were not forwarded to the appropriate people or departments. Despite this problem, we believe that subsequent telephone contacts by the CERT contractor should have elicited responses from these providers. Our contacts with most of the 392 providers or their representatives resulted in the submission of 89 percent of the requested medical records. Because the CERT contractor did not thoroughly document the results of phone calls, we were unable to determine whether the CERT contractor made the required calls.

As part of CMS's corrective actions to improve the FY 2004 response rate, providers were given the option to submit medical records by facsimile. However, the CERT contractor initially maintained only one facsimile machine. Recognizing that facsimile utilization quickly grew beyond the capacity of one machine, CERT officials eventually added three additional facsimile machines. We believe that the lack of sufficient facsimile machines contributed to the initial provider nonresponse problem. Further, the CERT contractor did not have controls to ensure that all received facsimile medical records were logged in the control system.

CONCLUSION

CMS's diligence in obtaining medical records has reduced the nonresponse rate to less than 1 percent of the number and dollar value of claims included in the sample. We do not believe that the remaining nonresponses will have a significant impact on the reliability of CMS's estimate of the FY 2004 Medicare fee-for-service paid claims error rate. However, we have identified areas where improvements would allow CMS to further enhance its process for ensuring that records are received timely.

RECOMMENDATIONS

We recommend that CMS:

- require the affiliated contractors to perform outreach and education with medical records directors and compliance officers of large facilities to explain the CERT process, identify and resolve any issues that would prevent the providers from responding, and obtain current address and contact information
- require the CERT contractor to refer cases of incorrect or incomplete provider contact information to the affiliated contractors as soon as the initial request letter is returned as undeliverable or the CERT contractor is unable to complete the first phone call because of a nonworking telephone number
- define provider and affiliated contractor responsibilities for retrieving and submitting medical records maintained at an address other than that to which the original request was submitted
- direct the CERT contractor to thoroughly document telephone contacts with providers and to maintain phone logs in a computerized database
- consider devoting additional resources to followup telephone contacts with providers and increasing the number of facsimile machines at the CERT contractor to facilitate the receipt of medical records
- require the CERT contractor to include in request letters instructions to providers to obtain a facsimile confirmation that the CERT contractor received the medical records
- direct the CERT contractor to implement controls to ensure that all medical records received by facsimile are identified, logged in a control system, and filed for medical review

CMS COMMENTS

To expedite the processing of our report, we obtained informal comments from CMS officials responsible for the Medicare error rate process. These officials concurred with our findings and recommendations.

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INTRODUCTION

BACKGROUND

Medicare Fee-for-Service Error Rate

The Improper Payments Information Act of 2002 requires Federal agencies to annually estimate improper payments for programs and activities that the agencies have determined may be susceptible to significant improper payments and submit those estimates to Congress. Because Medicare fee-for-service claims are susceptible to significant improper payments, CMS must annually estimate the amount of improper payments associated with those claims.

CMS established the CERT program to produce an error rate for all provider claims other than inpatient acute care hospital claims. When aggregated with the error rate for inpatient acute care hospitals produced by the Hospital Payment Monitoring Program, CMS produces an estimate of the overall error rate for Medicare fee-for-service paid claims. CMS contracts with AdvanceMed to administer the CERT program.

CERT Contractor Responsibilities

Each month, the CERT contractor randomly selects about 200 claims from each Medicare fiscal intermediary, carrier, and durable medical equipment regional carrier—collectively referred to as the affiliated contractors. For the sampled claims, the CERT contractor requests medical records from providers or, if previously reviewed, from the affiliated contractors.

To obtain medical records from providers, the CERT contractor's procedures include sending up to four request letters and making followup telephone calls to providers at specified intervals. The affiliated contractors supply provider contact information, including addresses and telephone numbers, to the CERT contractor.

FY 2003 Results and Congressional Concerns

During the FY 2003 error rate review process, CMS experienced a significant problem with providers that did not respond to requests for medical records under the CERT program. These nonresponses accounted for more than half of the 9.8-percent initial error rate reported by CMS. To report a more representative estimate, CMS adjusted the nonresponse rate to reflect OIG's 7 years of experience with nonresponders. CMS reported an adjusted error rate of 5.8 percent, of which 82 percent was due to errors other than lack of documentation and 18 percent was due to provider nonresponses to requests for medical records.

The Chairman of the Senate Committee on Finance and other members of Congress expressed concerns about CMS's reporting of two error rates in FY 2003 and the large number of providers that did not supply requested medical records.

Previous OIG Report on Corrective Actions To Improve the CERT Process for Obtaining Medical Records

In response to the Chairman's concerns, we reviewed CMS's actions to improve provider responsiveness. On June 2, 2004, we reported that CMS had implemented a number of actions to improve procedures for obtaining medical records. The more substantive corrective actions, which were implemented at different points during the FY 2004 error rate process, included:

- **Affiliated Contractor Education and Participation.** CERT management gave presentations to the affiliated contractors to educate them on the CERT contractor's role and assisted them in responding to providers' questions. CMS also directed the affiliated contractors to contact providers that did not submit medical records when requested.
- **Revised Medical Record Request Letters.** CMS revised its procedures to improve the timeliness of mailing request letters. In addition, CMS revised the request letters to highlight the CERT contractor's authorization to request medical records on CMS's behalf and to give providers the option of submitting medical records by facsimile.
- **Improved Procedures for Contacting Providers.** CMS added two followup telephone contacts to its procedures for obtaining medical records from providers, bringing the total number of phone contacts to three. The CERT contractor makes the two additional phone calls before sending a second request letter to the provider.
- **Internet-Based Claims Tracking System.** CMS developed an Internet-based claims tracking system to provide CMS, the CERT contractor, and the affiliated contractors with the weekly status of the medical record receipt process.

Our report stated that CMS's corrective actions appeared to have increased provider responsiveness to requests for medical records. At the conclusion of our fieldwork on April 8, 2004, provider nonresponses represented about 2 percent of the total number and 3 percent of the total dollar value of claims selected for the FY 2004 error rate sample, compared with about 8 percent of the number and about 7 percent of the dollar value for FY 2003.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to continue to monitor the rate of response by Medicare providers to requests for medical records during the FY 2004 CERT process and to determine the reasons cited by providers for nonresponses.

Scope and Methodology

Except for our testing of controls over phone logs, our review was limited to contacting Medicare providers with claims that the CERT contractor considered to be nonresponses as of June 11, 2004, the last date that providers could submit requested medical records for the

FY 2004 CERT sample. Our review of internal controls at CMS and the CERT contractor was limited to obtaining an understanding of controls related to obtaining medical records. We did not review affiliated contractor or provider internal controls.

To accomplish our objectives:

- We reviewed CMS’s policies and procedures for obtaining medical records during the FY 2004 CERT process.
- We attempted to locate the medical records for 505 of the 1,162 claims that the CERT contractor considered to be nonresponses as of June 11, 2004. The 505 claims represented 91.8 percent of the dollar value of the 1,162 nonresponse claims and involved 392 providers.
- We attempted to contact providers through telephone calls, overnight mail, and site visits.
- We contacted the affiliated contractors to obtain and discuss supporting documentation regarding their contacts with nonresponding providers.

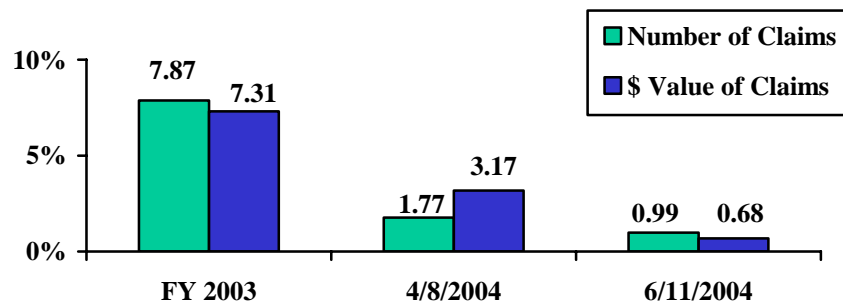
We performed the review from May to August 2004 at the CERT contractor’s office in Richmond, VA, CMS headquarters in Baltimore, MD, and various provider locations. We conducted our review in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

RECEIPT OF 99 PERCENT OF REQUESTED MEDICAL RECORDS

Between April 8, 2004, when we completed fieldwork on our previous review, and June 11, 2004, providers continued to submit documentation to the CERT contractor. According to CMS, by June 11, provider nonresponses to requests for medical records accounted for less than 1 percent of the total number and 0.7 percent of the total dollar value of claims selected for the FY 2004 error rate sample. The chart below illustrates the dramatic improvement in the provider nonresponse rate as a result of CMS’s corrective actions.

Nonresponse Rate by Number and Dollar Value of Claims



We commend CMS for its diligence in obtaining medical records. We do not believe that the remaining nonresponses will have a significant impact on the reliability of CMS’s estimate of the FY 2004 Medicare fee-for-service paid claims error rate.

REASONS CITED BY PROVIDERS FOR NONRESPONSES

We reviewed 505 claims, submitted by 392 providers, that the CERT contractor considered to be nonresponses. For 355 of the 505 claims, providers told us that they:

- did not receive the request letters (230 claims)
- had already provided the requested documentation (79 claims)
- did not have direct access to medical records that were maintained at another location (46 claims)

Regarding the remaining 150 claims reviewed, providers indicated numerous reasons for the nonresponses. Information regarding these reasons can be found in the appendix.

Reasons for Nonresponses

Reason Cited	Number of Claims	Percentage of Total Claims Reviewed
1. The provider did not receive the CERT contractor’s request	230	45.5%
2. The provider received the request and submitted the documentation	79	15.6%
3. The medical records were at another location	46	9.1%
4. Other reasons	150	29.8%
Total	505	100.0%

Requirement To Submit Documentation

As a Program Safeguard Contractor, the CERT contractor has been authorized, pursuant to section 1893 of the Social Security Act, to conduct medical reviews for CMS. In accordance with section 1833 of the Social Security Act, Medicare providers and suppliers must provide, on request, medical records or other information as is necessary to determine whether Medicare payments are or were due. Failure to comply with this request authorizes CMS to deny the claims and recover payments for all services provided on the dates in question.

Reason 1: Did Not Receive CERT Contractor's Requests

For 230, or 45.5 percent, of the 505 claims reviewed, providers indicated that they did not receive the CERT contractor's request letters, as follows:

- For 111 nonresponses, providers indicated that they did not receive the request letters because the letters were mailed to the incorrect address. For example, a home health agency moved approximately 2 years ago, and the letters were mailed to the agency's former address.
- For 84 nonresponses, providers stated that they did not receive the request letters because the letters were not forwarded to the appropriate person or department. For example:
 - Requests were mailed to a physician's billing address, which was a lock box accessible only by the physician's billing agency. The billing agency did not have access to medical records and did not forward the requests to the physician's office where the records were maintained.
 - Requests were mailed to the main address of a hospital without specifying the name of a person or department. According to the hospital's Director of Health Information Management, who was responsible for responding to requests for medical records, the request letters were never forwarded to her department.
- For 35 nonresponses, providers acknowledged that the letters were sent to the correct address; however, they could not determine why they had not received the letters.

Although request letters were sent to incorrect addresses or did not reach the appropriate provider personnel, we believe that subsequent telephone contacts by the CERT contractor should have elicited a response from the providers. Our contacts with most of the 392 providers or their representatives resulted in the submission of 89 percent of the requested medical records.

When we asked the CERT contractor for supporting phone logs for the 392 providers, CERT officials responded that they did not fully document the results of phone calls made to nonresponsive providers. Phone call documentation was recorded in manual phone logs that did not always identify the CERT identification numbers for individual claims. Consequently, we were unable to determine if the CERT contractor made all required phone calls or the outcome of those calls.

Reason 2: Documentation Submitted but Not Recorded As Received

For 79, or 15.6 percent, of the 505 claims reviewed, providers indicated that they had complied with the request for medical records by submitting documentation to the CERT contractor by mail or facsimile. The majority of the providers were unable to confirm that they had submitted requested medical documentation. Only 11 providers had confirmations: 9 had facsimile confirmations, and 2 had mail receipts. Several additional providers, while not having facsimile

confirmations, indicated that they had sent medical records by facsimile. Further, several affiliated contractors told us that over the past year, providers had complained about problems with the CERT contractor's facsimile equipment.

As part of CMS's corrective actions to improve the response rate for the FY 2004 error rate process, providers were given the option to submit medical records by facsimile. However, the CERT contractor initially maintained only one analog facsimile machine. During the FY 2004 CERT process, CERT officials recognized that facsimile utilization quickly grew beyond the capacity of one machine, and they eventually added three additional facsimile machines with digital lines. The new machines had the capability, when in use, to automatically transfer calls to another facsimile machine. We believe that the lack of sufficient facsimile machines contributed to the initial provider nonresponse problem.

We also found that the CERT contractor did not have controls to ensure that all received facsimile medical records were identified, logged in the control system, and filed for medical review. Because of the increased use of the facsimile for submitting medical records and the installation of additional machines, the contractor recently began maintaining an automated record of all received documentation.

Reason 3: Medical Records Maintained at Another Location

For 46, or about 9.1 percent, of the 505 claims reviewed, providers stated that they failed to respond to requests for medical records because the records were maintained at another location. For example, a physician provided services to a hospital patient. The medical records supporting the services were maintained at the hospital, rather than the physician's office. The hospital did not reply to repeated requests from the physician's office for a copy of the medical records. As a result, the physician did not submit the requested documentation to the CERT contractor.

Other Reasons Cited

Regarding the remaining 150, or 29.8 percent, of the 505 claims reviewed, providers indicated numerous reasons for not responding to the CERT contractor's requests for medical records. Information regarding these reasons can be found in the Appendix.

IMPACT OF NONRESPONSES ON THE MEDICARE ERROR RATE AND THE MEDICARE PROGRAM

Failure to obtain medical record documentation affects the error rate. For example, nonresponses accounted for more than half of the 9.8-percent initial error rate reported by CMS for FY 2003. Furthermore, nonresponses prevent identification of the actual cause of payment errors and hamper CMS's efforts to fully use the results of the error rate process to safeguard the Medicare trust fund.

CONCLUSION

We commend CMS for its diligence in obtaining medical records associated with the FY 2004 CERT sample. Soliciting medical records is a difficult process to manage, and we recognize that a certain percentage of nonresponse is inevitable. We believe that CMS has made excellent progress in obtaining medical records because it has reduced the provider nonresponse rate to less than 1 percent of the number and dollar value of claims included in the sample. We do not believe that the remaining nonresponses will affect the reliability of CMS's estimate of the FY 2004 Medicare fee-for-service paid claims error rate. However, we have identified areas where improvements would allow CMS to further enhance its process for ensuring that records are received timely.

RECOMMENDATIONS

We recommend that CMS:

- require the affiliated contractors to perform outreach and education with medical records directors and compliance officers of large facilities to explain the CERT process, identify and resolve any issues that would prevent the providers from responding, and obtain current address and contact information
- require the CERT contractor to refer cases of incorrect or incomplete provider contact information to the affiliated contractors as soon as the initial request letter is returned as undeliverable or the CERT contractor is unable to complete the first phone call because of a nonworking telephone number
- define provider and affiliated contractor responsibilities for retrieving and submitting medical records maintained at an address other than that to which the original request was submitted
- direct the CERT contractor to thoroughly document telephone contacts with providers and to maintain phone logs in a computerized database
- consider devoting additional resources to followup telephone contacts with providers and increasing the number of facsimile machines at the CERT contractor to facilitate the receipt of medical records
- require the CERT contractor to include in request letters instructions to providers to obtain a facsimile confirmation that the CERT contractor received the medical records
- direct the CERT contractor to implement controls to ensure that all medical records received by facsimile are identified, logged in a control system, and filed for medical review.

CMS COMMENTS

To expedite the processing of our report, we obtained informal comments from CMS officials responsible for the Medicare error rate process. These officials concurred with our findings and recommendations.

APPENDIX

APPENDIX

OTHER REASONS FOR NONRESPONSES

Because the following reasons individually either are not significant or represent situations where medical records were unattainable, we did not list them in the body of our report. These reasons collectively account for 150, or 29.8 percent, of the 505 claims reviewed.

	<u>Number of Claims</u>	<u>Percentage</u>
OIG was unable to locate provider.	40	7.90%
Provider deceased/no longer employed/ no longer in business.	19	3.80%
Provider's headquarters/home office/compliance officer must review the request for medical records.	13	2.55%
Provider is in the process of responding to the request.	13	2.55%
Provider cannot locate the medical records.	12	2.40%
Provider concerned about the Health Insurance Portability and Accountability Act or unfamiliar with CERT requirements.	10	2.00%
The services were not performed and were billed in error.	10	2.00%
Claim cancelled subsequent to request.	7	1.40%
Provider forgot or misplaced request.	5	1.00%
Not cost beneficial/too busy to retrieve records.	4	0.80%
Request unclear or confusion due to multiple requests.	3	0.60%
Medical records confiscated by an investigatory agency.	3	0.60%
Other miscellaneous reasons.	<u>11</u>	<u>2.20%</u>
Total	150	29.80%