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Medicare Raises Standards for Contractor Claim Reviews

It Would Be Wise for Providers and Suppliers to Develop Strategies for Complying

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The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, recently issued new instructions for Medicare contractors to follow when reviewing claims for payment. This new guidance has been added to the Medicare Program Integrity Manual (PIM), CMS Publication 100-8. The revision to the Medicare PIM is responsive to recommendations by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and illustrates the continuing efforts by CMS to ensure that comprehensive and meaningful review of documentation underlying claims for payment is conducted by Medicare contractors. With this additional guidance, and the requirement that contractors adhere to these standards in conducting "complex medical reviews," it is likely that Medicare contractors will be increasingly vigilant in their review of claims.

By way of background, Medicare contractors conduct three types of claim reviews:

- automated prepayment reviews (performed by computers);
- routine prepayment and postpayment medical reviews; and
- complex prepayment and postpayment medical reviews.[1]

Only a complex medical review entails review by a medical professional of the underlying medical records to determine whether a claimed item or service is covered by Medicare and medically necessary. As specified in the Medicare PIM, a medical reviewer conducting a complex medical review must apply national coverage determinations (NCDs) and local coverage determinations (LCDs) and consider the beneficiary's clinical condition as reflected in the medical records.[2]

Under the new CMS instructions, all Medicare contractors will be obligated to use "clinical review judgment" when undertaking a "complex review determination" of a claim for payment. In a transmittal issued on May 14, 2010, to be implemented by June 15, 2010, CMS added a new section to the PIM explaining what constitutes clinical review judgment in the context of claims reviews and mandating that Medicare contractors apply these standards when making a complex review determination. The CMS transmittal specifically notes that clinical medical judgment "is not to be used to assume facts not in evidence in the medical record, nor can [it] supersede any policy or regulation."[3]

The new section added to the Medicare PIM states:

> Clinical Review Judgment involves two steps:
>
> 1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient, and
>
> 2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been made.

CMS also notes:

> Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, CMS rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).[4]

In addition to inclusion of these new instructions for Medicare claims review contractors in the Medicare PIM, the information regarding the use of clinical review judgment is set forth in an MLN Matters article issued by CMS for health care professionals.[5]

The new standards for Medicare contractors regarding clinical review judgment to be used when conducting complex medical reviews supplements other instructions issued on March 16, 2010 (to be implemented on April 16, 2010) regarding signature requirements for documentation underlying claims for payment.[6] The Medicare PIM was revised to state:

> For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable.[7]

Also added to the PIM were "Signature Guidelines" for Medicare contractors to use in reviewing claims and standards regarding "E-prescribing." This information was also set forth in an MLN Matters article issued by CMS for health care professionals on April 26, 2010.[8]

The new PIM provisions are indicative of the increased scrutiny that CMS is requiring its contractors to undertake when reviewing claims for Medicare payment. To illustrate its intention to only pay proper and appropriate claims, the following language was added to the PIM:

> At any time, evidence of fraud shall result in referral to the PSC/ZPIC for further development. If [a contractor] reviewer identifies a pattern of missing/illegible signatures it shall be referred to the appropriate PSC/ZPIC for further development.[9]

In light of these instructions, it may be anticipated that greater numbers of claims

without the necessary supporting documentation will be referred to the CMS program safeguard contractors (PSCs) and successor zone program integrity contractors (ZPICs) for further review. Accordingly, providers and suppliers are well advised to ensure that complete and adequate medical documentation exists to support claims for Medicare payment. As is specified in the Medicare statute, payment will only be made where adequate documentation exists to support the claim.[10]

The heightened attention and requirements imposed on Medicare claims review contractors are the result of a series of audits conducted by the OIG regarding the CMS comprehensive error rate testing (CERT) program for establishing an annual Medicare error rate for provider/supplier payments. The CERT program was established by CMS in order to submit "to Congress an estimate of the amount of improper payments for Medicare fee-for-service claims pursuant to the Improper Payments Information Act of 2002 (Public Law. 107-300)."[11] With respect to claims for durable medical equipment (DME) paid by Medicare Part B in fiscal year 2006, based on a CERT contractor's medical review, CMS reported to Congress that the error rate was 7.5 percent, or about $700 million in improper payments.

The OIG subsequently arranged for an independent audit of the CERT review of claims and calculation of the DME "error rate" for fiscal year 2006. Using the same procedures and medical records as the CERT contractor, the OIG determined that the "error rate in the FY 2006 CERT DME sample was 17.3 percent."[12] The OIG concluded that the discrepancy in findings, *i.e.*, between a 7.5 percent and 17.3 percent error rate, could be attributed "to the CERT contractor's inadequate review of available documentation and to CMS' lack of written policies and procedures on the appropriate use of clinical inference."[13]

The OIG also sponsored a second review using additional medical records of physicians and other health care providers and information obtained from beneficiary and provider interviews. Based on this second review, the OIG determined that "the error rate in the FY 2006 CERT DME sample was 28.9 percent."[14] In its final report, the OIG attributed the differential between the CMS calculation of the DME "error rate" of 7.5 percent and its estimate of 28.9 percent to:

> the CERT contractor's reliance on clinical inference rather than additional medical records available from health care providers, CMS' inconsistent policies regarding proof-of-delivery documentation, physicians' lack of understanding of documentation requirements, and CMS' lack of procedures for obtaining information on high-risk DME items from beneficiaries.[15]

Accordingly, the OIG recommended that CMS:

- require the CERT contractor to review all available supplier documentation;
- establish a written policy to address the appropriate use of clinical inference; and
- require the CERT contractor to review all medical records including, but not limited to, physician medical records necessary to determine compliance with applicable requirements on medical necessity.[16]

The OIG conducted a subsequent review of CMS' calculation of the fiscal year 2008 error rate and determined that the actual error rate continued to be significantly higher than that reported by CMS. Accordingly, it recommended that CMS require the CERT contractor to "perform a complex medical review by obtaining and reviewing all medical records from all relevant providers to support the medical necessity of DME claims."[17] In response, CMS noted that the Medicare PIM "is vague regarding how much clinical judgment contractors can use when reviewing [medical record] documentation." Thus, CMS advised that

it would "revise its manuals to clarify requirements for reviewing documentation to promote uniform interpretation of…policies across all medical reviews performed by Medicare contractors…"[18]

The recent additions to the Medicare PIM reflect CMS attempts to ensure consistent and comprehensive review of medical record documentation by contractors performing complex medical reviews. It is intended to clarify the process for making a "clinical review judgment" related to coverage and payment of Medicare claims. In light of this clarification of instructions to Medicare review contractors, it would be prudent for providers and suppliers to become familiar with and develop strategies for complying with these medical review standards. By ensuring that adequate and complete medical documentation is available to support claims for payment, providers and suppliers will be able to ensure timely and accurate coverage and payment of their Medicare claims.

Endnotes:

1. Medicare Program Integrity Manual (CMS Pub. 100-8), chapter 3, section 3.4.5.
2. OIG Report, "Independent Contractor's Review of Durable Medical Equipment Claims from the Fiscal Year 2008 Comprehensive Error Rate Testing Program," A-01-09-00500 (May 2009).
3. CMS Transmittal 338, May 14, 2010 at 1.
4. CMS Pub. 100-8, chapter 30, § 3.14.
5. www.cms.gov/MLNMattersArticles/downloads/MM6954.pdf.
6. CMS Transmittal #327 (March 16, 2010).
7. CMS Pub. 100-8, chapter 30, § 3.4.1.1(B).
8. www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf.
9. CMS Pub. 100-8, chapter 30, § 3.4.1.1(J).
10. Section 1833(e) of the Social Security Act.
11. OIG Report, "Medical Review of Claims for the Fiscal year 2006 Comprehensive Error Rate Testing Program," A-01-07-00508 (August 2008), at 1.
12. *Id.* at 4.
13. *Id.*
14. *Id.* at 5.
15. *Id.*
16. *Id.* at 11-12.
17. Supra fn. 2 at 8.
18. *Id. at appendix page 2.*

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