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# Physician Advisor Services

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## OIG Continues Efforts to Reduce Medicare Improper Payments

On July 28, 2011, Daniel Levinson, Inspector General of the U. S. Department of Health & Human Services (HHS) testified to the House of Representatives Committee on Oversight & Government Reform's Subcommittee on Government Organization, Efficiency and Financial Management on Improper Medicare Payments. The testimony was an opportunity to update the Committee on the efforts of the Office of Inspector General (OIG) to "monitor and make recommendations to reduce Medicare improper payments." He stated that the mission of the OIG is to "protect the integrity of HHS programs, as well as the health and welfare of program beneficiaries." He told the committee that in 2010, CMS reported improper payments totaling $47.9 billion. That total is comprised of $34.3 paid to Medicare Fee-for-Service providers which equates to an estimated 10.5% error rate. Another $13.6 billion is attributed to Medicare Part C which equates to an estimated 14% error rate.

Inspector General Levinson stated that "some but not all improper payments are the result of fraud. Improper payments can also result from medically unnecessary claims, miscoded claims, eligibility errors, or insufficient documentation. Examples of improper payments include payments made to an ineligible recipient, duplicate payments, or payment for services not received."

Levinson explained that the OIG performs "targeted reviews to determine the scope of improper payments for specific service types and recommends actions to improve the program safeguards." Through the reviews he reports that they "uncover systemic payment vulnerabilities and make recommendations to address them."

He stated that medically unnecessary services are a real concern because of the potential negative impact they could have to the beneficiaries, such as, tests or procedures that have no benefit and may even cause harm to the beneficiary. In addition, the beneficiary is generally responsible for a 20% copayment for items and services provided under Medical Part B and therefor, suffers a financial harm.

As many hospitals are aware, the OIG is currently conducting a series of audits of "hospital compliance with Medicare requirements." There have been 27 "high risk" hospital billing practices that have been identified. Levinson stated, "Using data mining, we further focus on potential problem areas in selected hospitals, and then we select claims for testing. We conduct hospital site visits to perform comprehensive reviews of billing and medical record documentation. In addition to identifying and recovering improper Medicare payments, we are recommending improvements to internal controls to prevent future improper billings."

The testimony confirmed that investigative audits will continue as the OIG continues its efforts to "prevent fraud and promote compliance."

Click here for a link to the transcript of Inspector General Levinson's testimony.

If you have questions regarding this article or how physician advisor services can help you strengthen your compliance program, please contact Ann Purdy at 205-314-8859 or by clicking here.

***CMS Reports RAC 3rd Quarter Results, Click [here] for link.***

**Region A-DCS**
http://www.dcsrac.com/IssuesUnderReview.aspx
1-866-201-0580

**Region B-CGI**
http://racb.cgi.com/Issues.aspx?st=1
1-877-316-7222

**Region C-Connolly Healthcare**
http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx
1-866-360-2507

**Region D-HDI**
https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx
866-590-5598 (Part A)
866-376-2319 (Part B)

Medicare Fee for Service
National Recovery Audit Program, 3rd Quarter, FY 2011
**Quarterly Newsletter**

*Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections. Figures provided in millions. All correction data current through June 30, 2011. Retrieved July 2nd, 2011.

| | OVERPAYMENTS COLLECTED (3rd Qtr) | UNDERPAYMENTS RETURNED (3rd Qtr) | TOTAL 3rd QUARTER CORRECTIONS | FY TO DATE CORRECTIONS |
|---|---|---|---|---|
| Region A: DCS (Diversified Collection Services) | $40.4 | $5.0 | $45.4 | $98.2 |
| Region B: CGI (CGI Federal) | $33.9 | $9.8 | $43.7 | $118.5 |
| Region C: Connolly, Inc. | $46.9 | $7.4 | $54.3 | $133.3 |
| Region D: HDI (HealthData Insights) | $112.2 | $33.7 | $145.9 | $242.5 |
| **Nationwide Totals** | **$233.4** | **$55.9** | **$289.3** | **$592.5** |

| TOP ISSUE PER REGION *Based on collected amounts through June 17th, 2011 | |
|---|---|
| Region A: | **Renal and Urinary Tract Disorders**: (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with renal and urinary tract disorders needs to be complete and support all services provided. |
| Region B: | **Extensive operating room procedure unrelated to principal diagnosis**: (DRG validation) Principal diagnosis & principal procedure codes for an inpatient claim should be related. Errors occur when providers bill an incorrect principal and/or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis– Related Group assignment. |
| Region C: | **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided during an Inpatient stay**: (DMEPOS Automated Review) Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. |
| Region D: | **Minor Surgery and other treatment billed as Inpatient**: (Medical Necessity) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight. |

## RAC FAQs - Excerpts From CMS Website

***What is a semi-automated review?***

It is a two-part review that is now being used in the Recovery Audit Program. The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has a high index of suspicion to be an improper payment. The second part includes a Notification Letter that is sent to the provider explaining the potential billing error that was identified. The letter also indicates that the provider has 45 days to submit documentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issues. However, if the submitted documentation does support the billing of the claim, the claim will not be sent for adjustment and the provider will be notified that the review has been closed.

To view all of the CMS RAC FAQs, click here.