

Date: March 27, 2019

Subject: MEDICARE AND MEDICAID CMS Should Assess Documentation Necessary to Identify Improper Payments

On March 27, 2019, the Government Accountability Office (GAO) published a report titled, [MEDICARE AND MEDICAID CMS Should Assess Documentation Necessary to Identify Improper Payments](#). The GAO examined the portion of the improper payment rates for Medicare and Medicaid programs that are attributed to insufficient documentation. In fiscal year (FY) 2017, Medicare fee-for-service (FFS) was estimated to have improperly paid \$23.2 billion and for Medicaid \$4.3 billion due to insufficient documentation. The improper payment rates for Medicare is reported by the Comprehensive Error Rate Testing (CERT) program and Medicaid's is reported by the Payment Error Rate Measurement (PERM) program.

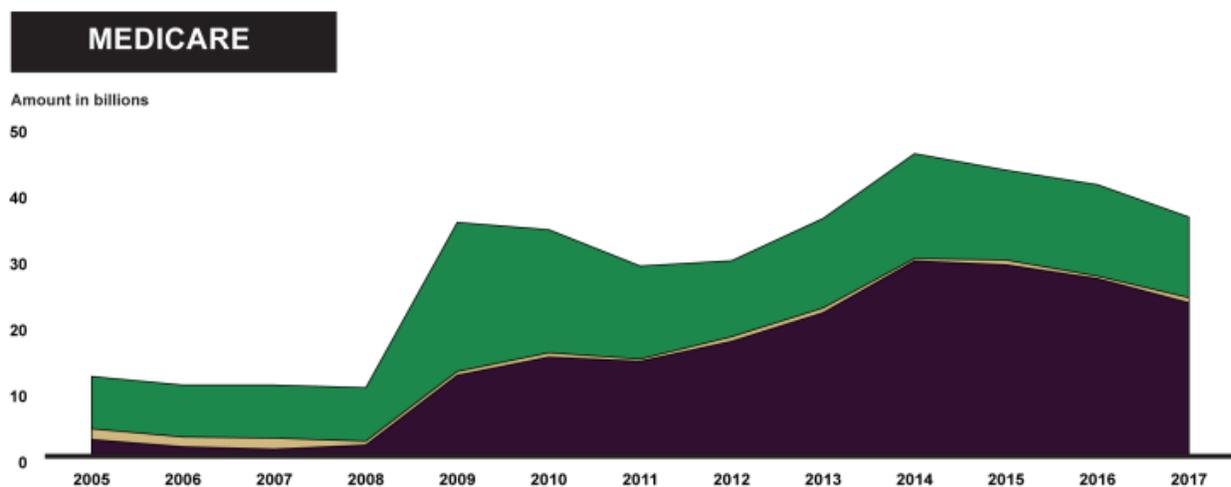
### METHODOLOGY

The GAO examined documentation requirements for the Medicare and Medicaid programs and improper payments data between FY2005-FY2017 and the factors that the documentation requirements contributes to insufficient documentation portion of the improper payment rates. The GAO interviewed CMS, CMS contractors, six Medicaid programs, and health care provider associations to conduct this report.

### FINDINGS

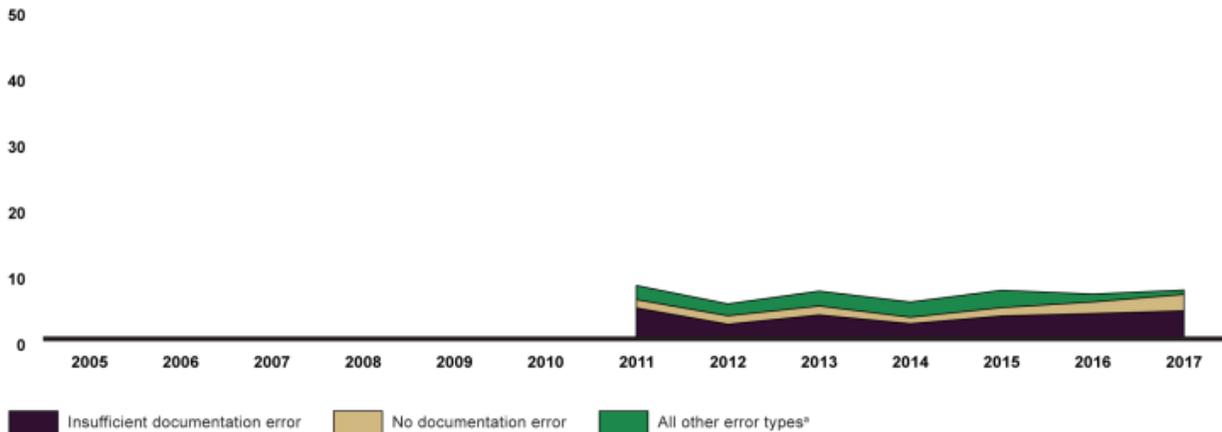
In FY2017, 64% of Medicare fee for service improper payments were due to insufficient documentation. Since 2009, improper payments due to insufficient documentation increased significantly for Medicare but has stayed steady for Medicaid.

**Figure 2: Estimated Improper Payments Identified through Medical Review in Medicare and Medicaid Fee-for-service, Fiscal Years 2005-2017**



## MEDICAID

Amount in billions



Source: GAO analysis of Centers for Medicare & Medicaid Services' data. | GAO-19-277

Note: Prior to 2011, CMS did not separately report Medicaid improper payments for medical review error categories. Medical review refers to the process through which trained reviewers manually examine medical record documentation associated with provider claims to identify improper payments.

CMS explained the increase in insufficient documentation may have been caused by CERT's suspension of using clinical inference beginning in FY2009 and the increase in Medicare documentation requirements.

In FY2017, Medicare's improper payment rate due to insufficient documentation was 6.1% and was greater than Medicaid's which was at 1.3%. But the gap is even more significant for services like DME and home health, which had a rate of 27 percentage points greater than Medicaid. GAO reports that this variation is due to the differences in the documentation requirements for the two programs, below are four that were highlighted in the report.

Face-to-Face Requirement: While Medicare has already implemented the Affordable Care Act's requirement for referring physicians to conduct a face-to-face examination for home health and DME, as of FY2017, Medicaid was still in the process of implementing this requirement across the country.

Prior Authorization: CMS has used prior authorization for certain services under Medicare and all six Medicaid states that were selected for this review required prior authorization for DME and five of these states had prior authorization for home health.

Signature Requirements: Although, both programs have physician signature requirements, Medicare has specific standards for a valid physician signature. For example, Medicare requires signatures and initials that are legible, otherwise, the signatures are generally considered invalid, unless it is signed over a printed name. In contrast, Medicaid's review contractors generally rely on the reviewer's judgment to determine the validity of the physician signatures.

Medical Necessity Requirements: Medicare requires documentation to support medical necessity, but Medicaid generally does not have this requirement. Documentation to support medical necessity is primarily established by states and the PERM contractor stated they do not usually review medical

necessity documentation when reviewing claims for referred services. CMS, CERT and provider associations shared challenges of meeting documentation requirements for referred services. Some CMS officials acknowledged the lack of incentive for referring physicians to meet the documentation requirements as they do not have any financial repercussions when the claim is determined improper. Physician groups interviewed for this report stated referring physicians may not document in medical records in a way that meets Medicare requirements to support referred services and usually physicians refer patients to an array of services and they are challenged by the different Medicare requirements for each service.

Due to the different documentation requirements for Medicare and Medicaid, the same service with the same documentations can meet criteria for Medicaid but not Medicare. The GAO states the variation in improper payment rates between the two programs raises concerns about the effectiveness of the documentation requirements and the ability to identify program risks. CMS responded the differences in the documentation requirements is due to the states' ability to establish documentation requirements under Medicaid.

CMS' Patients Over Paperwork initiative is an effort to simplify processes, including documentation requirements. Although current efforts are only focused on Medicare, CMS intends to help providers that service both Medicare and Medicaid. For FY2018, CMS found that 3% of improper payments were due to clerical errors, such as missing documentation elements that may be found elsewhere in the medical records. CMS officials expressed that more information on the clerical errors may inform efforts to simplify requirements.

The GAO found that the national estimate of the improper payment data for Medicare is more specific than the data for Medicaid. CMS shared that estimating improper payments for a specific service type within each state with the same precision as the national estimate would require a substantially larger reviewing budget. PERM contractor does not review a statistically significant sample size, and therefore the improper payments identified are likely not a prevalent issue. The GAO states that without a robust program to identify improper payments at the state-level, Medicaid programs are not able to develop appropriate corrective actions.

The GAO found that states do not have a process in place to determine whether providers that are being reviewed by PERM are also under fraud investigations by other agencies. Without such coordination of the different reviewing bodies, PERM reviews could potentially interfere with ongoing fraud investigations.

### CONCLUSIONS

GAO concludes that CMS and states need to identify the underlying causes of improper payments rates and develop corrective actions to improve the improper payment rates. The variation in the improper payment rates between the two programs raises concerns about the effectiveness of the documentation requirements. CMS and states are missing opportunities to identify and improve program risks by not providing robust information on PERM reviews to the Medicaid programs. Medicaid agencies' lack of communication with the PERM on fraud investigations also potentially compromises any fraud investigations.

### RECOMMENDATIONS & CMS RESPONSE

Below are GAO's recommendations to the CMS Administrator followed by CMS' responses:

1. The Administrator of CMS to set a routine process to review documentation requirements for Medicare and Medicaid to ensure they are effective at demonstrating compliance.
  - CMS concurred with this recommendation.
2. The Administrator of CMS should take steps to institute requirements to have Medicaid medical reviewers to provide robust information to help states with corrective actions that would address the underlying causes of the improper payments.
  - CMS did not concur with this recommendation.
3. The Administrator of CMS should address the concerns with PERM reviewers not being informed on fraud investigations.
  - CMS concurred with this recommendation.
4. The Administrator of CMS should address the disincentives the Medicaid agencies have with notifying PERM contractor of providers under fraud investigations.
  - CMS concurred with this recommendation.