



March 2017

MEDICARE PROVIDER EDUCATION

Oversight of Efforts to Reduce Improper Billing Needs Improvement

Accessible Version

GAO Highlights

Highlights of [GAO-17-290](#), a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

For fiscal year 2016, HHS reported an estimated 11 percent improper payment rate and \$41.1 billion in improper payments in the Medicare fee-for-service program. To help ensure payments are made properly, CMS contracts with MACs to conduct provider education efforts. CMS cites the MACs' provider education department efforts as an important way to reduce improper payments.

GAO was asked to examine MACs' provider education department efforts and the results of MACs' probe and educate reviews. This report examines (1) the focus of MACs' provider education department efforts to help reduce improper billing and CMS oversight of these efforts and (2) the extent to which CMS measured the effectiveness of the MAC probe and educate reviews. GAO reviewed and analyzed CMS and MAC documents and MAC probe and educate review data for 2013-2016; interviewed CMS and MAC officials; and assessed CMS's oversight activities against federal internal control standards.

What GAO Recommends

GAO recommends that CMS should (1) require sufficient detail in MAC reporting to determine the extent to which MACs' provider education department efforts focus on vulnerable areas, (2) explicitly require MACs to work together to educate referring providers on proper documentation for DME and home health services, and (3) establish performance metrics for future probe and educate reviews. HHS concurred with GAO's recommendations.

View [GAO-17-290](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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What GAO Found

Medicare administrative contractors (MAC) process Medicare claims, identify areas vulnerable to improper billing, and develop general education efforts focused on these areas. MAC officials state that their provider education departments focus their educational efforts on areas vulnerable to improper billing; however, the Centers for Medicare & Medicaid Services' (CMS)—the agency within the Department of Health and Human Services (HHS) that administers Medicare—oversight and requirements for these efforts are limited.

- CMS collects limited information about how these efforts focus on the areas MACs identify as vulnerable to improper billing. According to CMS officials, the agency has not required the MACs to provide specifics on their provider education department efforts in these reports because it does not want to be overly prescriptive regarding MAC provider education department efforts. Federal internal control standards state that management should use quality reporting information to achieve the entity's objectives. Unless CMS requires sufficient MAC provider education department reporting, it cannot ensure that the departments' efforts are focused on areas vulnerable to improper billing.
- CMS does not require MACs to educate providers who refer patients for durable medical equipment (DME), including prosthetics, orthotics, and supplies, and home health services on proper billing documentation, nor does it explicitly require MACs to work together to provide this education. HHS has reported that a large portion of the high improper payment rates in these services is related to insufficient documentation. The absence of a requirement for MACs to educate referring providers about proper documentation for DME and home health claims is inconsistent with federal internal control standards, which state that in order to achieve an entity's objectives, management should assign responsibility and delegate authority. Without an explicit requirement from CMS to educate these referring providers, billing errors due to insufficient documentation may persist.

Short-stay hospital and home health claims have been the focus of the MACs' probe and educate reviews—a CMS strategy to help providers improve billing in certain areas vulnerable to improper billing. Under the probe and educate reviews, MACs review a sample of claims from every provider and then offer individualized education to reduce billing errors. CMS officials consider the completed short-stay hospital reviews to be a success based on anecdotal feedback from providers. However, the effectiveness of these reviews cannot be confirmed because CMS did not establish performance metrics to determine whether the reviews were effective in reducing improper billing. Furthermore, GAO found the percentage of claims remained high throughout the three rounds of the review process, despite the offer of education after each round. Federal internal control standards state that management should define objectives in specific and measurable terms and evaluate results against those objectives. Without performance metrics, CMS cannot determine whether future probe and educate reviews would be effective in reducing improper billing.

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Abbreviations

CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
CPAP	continuous positive airway pressure
DME	durable medical equipment
GPRA	Government Performance and Results Act of 1993
HH+H	home health and hospice
HHS	Department of Health and Human Services
IPIA	Improper Payments Information Act of 2002
IPRS	Improper Payment Reduction Strategy
MAC	Medicare administrative contractor

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March 10, 2017

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

In fiscal year 2016, the Department of Health and Human Services (HHS) reported that an estimated 11 percent of the payments made to health care providers under the Medicare fee-for-service program were made improperly, representing \$41.1 billion in improper payments.¹ Improper payments include payments made in error, such as payments that should not have been made; payments made in incorrect amounts, including overpayments and underpayments; and payments for claims that were not properly documented. Certain services in the Medicare fee-for-service program had higher improper payment rates, such as home health services, which had an estimated improper payment rate of 42 percent and represented an estimated \$7.7 billion in improper payments, also as reported in fiscal year 2016.² Insufficient documentation—one type of improper billing—was the most common source of improper payments in Medicare fee-for service, causing 65.2 percent of all improper payments in the same year.

To help ensure that payments are made properly, the Centers for Medicare & Medicaid Services (CMS), the agency within HHS that administers the Medicare program, contracts with Medicare administrative contractors (MAC). MACs—in addition to processing and paying

¹These figures are calculated from claims processed from July 2014 to June 2015. Department of Health and Human Services, *FY2016 Agency Financial Report* (Washington, D.C.: Nov. 14, 2016). Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare fee-for-service, or original Medicare, consists of Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance and covers physician, outpatient hospital, home health care, certain other services, and the rental or purchase of durable medical equipment, prosthetics, orthotics, and supplies.

²Department of Health and Human Services, *The Supplementary Appendices for the Medicare Fee-for-Service 2016 Improper Payments Report* (Washington, D.C.: Dec. 16, 2016).

Medicare claims—conduct education efforts intended to improve billing practices for the Medicare program. These efforts are in addition to CMS’s own education for providers on proper billing. MACs’ provider outreach and education (which we hereafter refer to as provider education) departments play a significant role in these efforts. There were 8 MACs that operated in 1 or more of the 20 total jurisdictions across the United States at the time of our review. Although the costs associated with a MAC’s provider education department account for a small portion of a MAC’s total costs, CMS cites provider education department efforts as an important way to help lower the improper payment rate. According to CMS, the fundamental goal of the provider education departments is to reduce the rate of improper payments by giving Medicare providers the information they need to understand the Medicare program, such as coverage and payment rules, and bill properly. For example, MACs’ provider education departments may distribute written guidance via email to educate providers on billing Medicare for physical therapy services or host a webinar to improve billing for Medicare radiology services.³ Providers can also be referred to the provider education department for education by MACs’ medical review departments.⁴ The medical review department may deny certain claims and refer certain providers to the provider education department for education if it finds errors in the providers’ billing documentation.

MACs also conduct probe and educate reviews as part of a CMS strategy to determine the extent to which providers understand recent policy changes for certain areas vulnerable to improper billing as identified by CMS and to help providers improve billing in these areas.⁵ CMS first began probe and educate reviews in 2013. Through these reviews, MACs analyze a small sample of claims from all providers who bill for inpatient hospital and home health services in order to identify and correct billing

³Webinars are seminars that are broadcast via the internet and allow a large audience to participate from various locations. Participants may take part in the seminar in real-time or sometimes afterwards if recorded.

⁴One role of the MAC’s medical review department is having staff with medical training review medical records associated with specific Medicare claims to determine if the service provided was medically necessary and documented properly.

⁵Improper billing includes inaccurate or insufficient billing documentation. For purposes of this report, areas vulnerable to improper billing includes services, items, and providers or suppliers that either have a high improper payment rate or have been identified by the MACs as vulnerable to improper billing.

issues through provider education, thereby reducing improper billing in those areas.

Given longstanding concerns about Medicare improper payments, you asked us to provide information about MACs' provider education department efforts and the results of the MACs' probe and educate reviews. This report examines

- the focus of MACs' provider education department efforts to help reduce improper billing and the extent to which CMS oversees these efforts, and
- the extent to which CMS measured the effectiveness of the MAC probe and educate reviews in reducing improper billing.

To examine MACs' provider education department efforts to reduce improper billing and the extent to which CMS oversees these efforts, we reviewed the first annual MAC Improper Payment Reduction Strategy (IPRS) report for the 8 MACs that had contracts as of July 1, 2016. These reports are intended to identify risks to Medicare and describe the planned interventions meant to ensure proper payments and address these risks. We reviewed 14 IPRS reports that covered 18 of 20 jurisdictions.⁶ The submission dates for the IPRS reports we reviewed ranged from November 2015 to July 2016, based on variations in MACs' contract years. We analyzed these reports to identify areas vulnerable to improper billing—often referred to as prioritized problem areas—that were common among the majority of MAC jurisdictions. We also analyzed these reports to determine the extent to which MACs listed specific provider education department efforts focusing on each of these areas vulnerable to improper billing. We reviewed CMS's statements of work for the MACs, which outline the functions CMS expects the MACs to perform, including a brief description of what is expected from MACs' provider education departments. We also reviewed the chapter of CMS's Medicare Contractor Beneficiary and Provider Communications Manual related to the provider education department, which further outlines CMS's

⁶MACs' contracts were not being renewed for two jurisdictions in 2016 and therefore those MACs did not have to submit IPRS reports for those jurisdictions. Contractors previously submitted an Error Rate Reduction Plan and a Medical Review Strategy separately. These two documents were combined and are now part of the IPRS. Elements of the previous Error Rate Reduction Plan document were incorporated into the IPRS, such as a comprehensive plan of medical review activities and other improper payment interventions.

expectations for MACs' provider education department efforts.⁷ Additionally, we interviewed CMS officials, MAC officials from each of the 8 MACs that collectively serve all 20 jurisdictions nationally, and 9 selected provider associations representing medical billers or specialties with both high and low improper payment rates, regarding MACs' provider education department efforts and CMS's oversight of these efforts. We also reviewed relevant federal standards for internal control in the federal government related to information and communications and the control environment.⁸

To examine the extent to which CMS measured the effectiveness of the MAC probe and educate reviews in reducing improper billing, we interviewed CMS officials about efforts they have undertaken to do so. We also reviewed relevant federal standards for internal control related to risk assessment and monitoring.⁹ To determine whether the results of the probe and educate reviews identified a resulting decrease in improper billing, we analyzed data CMS collected from the MACs about their reviews to better understand the extent of improper billing that existed before, during, and after the first completed probe and educate review. To date, CMS has required MACs to conduct two probe and educate reviews: a review of short-stay hospital claims, which has been completed, and a review of home health claims, which is ongoing.¹⁰ For both types of reviews, we analyzed the number of providers requiring review due to improper billing—including the change in the number of providers requiring review over the course of the reviews for the short-stay hospital reviews, the number of claims reviewed, and the denial rates for claims reviewed. The short-stay hospital review data was for fiscal years 2014 and 2015 and the preliminary home health review data was for fiscal year 2016. To assess the reliability of the data, we reviewed it to identify missing information and discrepancies, and interviewed CMS officials regarding the processes for collecting and verifying it. Based on

⁷Centers for Medicare & Medicaid Services. *Medicare Contractor Beneficiary and Provider Communications Manual, Internet-Only Manual: 100-09* (Baltimore, Md.: February 2015).

⁸GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

⁹[GAO-14-704G](#).

¹⁰A hospital stay is considered "short" if it spans less than two midnights.

these efforts, we determined that these data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from February 2016 to March 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare Administrative Contractors

MACs process and pay claims, conduct prepayment and postpayment claim reviews, and provide Medicare fee-for-service billing education to providers in their jurisdictions. For each type of Medicare claim, the number of jurisdictions and the number of MACs that handle that type of claim vary. For Medicare Part A and B claims—handled by A/B MACs—there are 12 jurisdictions in which 8 MACs operated at the time of our review. Three of these MACs also processed home health and hospice claims in addition to Medicare A/B claims and therefore served as MACs for the four home health and hospice (HH+H) jurisdictions. For durable medical equipment (DME), including orthotics, prosthetics, and supplies—handled by DME MACs—there are four jurisdictions in which two MACs operated at the time of our review.¹¹ A MAC can operate in more than one jurisdiction and handle more than one type of Medicare claim. For example, a MAC can operate as an A/B MAC in one jurisdiction and a DME MAC in another. (For maps of the 20 jurisdictions, see app. I.)

The provider education department is part of a MAC's provider customer service program, which is intended to provide timely information, education, and training to providers on Medicare fee-for-service billing, as outlined in CMS's provider customer service program manual. The costs

¹¹Claims for durable medical equipment, prosthetics, orthotics, and supplies are covered by Part B and are processed by the DME MACs. For the purposes of our report, we call these items 'DME'.

for MACs' provider education departments average 2.1 to 3.3 percent of their total annual costs.¹²

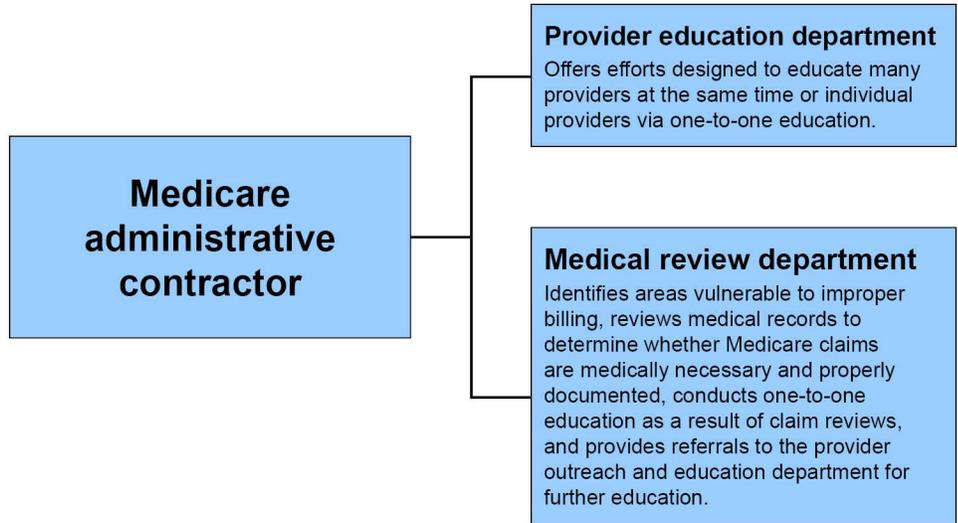
MACs' provider education department efforts are aimed at educating providers and their staff on Medicare program fundamentals, national and local policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through data analyses. Provider education departments provide education through a variety of methods, such as webinars, online tutorials available on-demand, 'ask-the-contractor' teleconferences, seminars at national conferences and association meetings, and website articles.¹³ These efforts are designed to educate many providers at the same time or individual providers via one-to-one education. Attendance at provider education department events is voluntary on the part of the providers. MACs are required to report their provider education department efforts monthly into the Provider Customer Service Program Contractor Information Database that CMS oversees and maintains. CMS also requires the MACs to submit a semi-annual Provider Customer Service Program Activities Report that summarizes and recounts Provider Customer Service Program activities, process improvements, and best practices during the reporting period.

MACs' medical review departments identify areas vulnerable to improper billing, review medical records to determine whether Medicare claims are medically necessary and properly documented, conduct one-to-one education as a result of claim reviews, and provide referrals to the provider education department for further education. This department frequently works with the provider education department to conduct educational efforts focusing on correcting provider billing (see fig. 1).

¹²These cost percentages come from total costs paid by CMS to the MACs that were reported between September 2011 and February 2014 for A/B MACs and December 2010 and February 2014 for DME MACs. These percentages come from cost reports for the most recent full contract year for which data were available for 9 of the 12 A/B MACs and all four of the DME MACs that were in operation as of April 2014. Average A/B MAC percentages also include costs for the HH+H workload in those cases where the A/B MAC was also responsible for home health and hospice claims. The percentages represent an average \$1.7 million and \$1.0 million for an A/B MAC's and DME MAC's provider education department costs, respectively. The total annual average cost per MAC is \$81.3 million and \$31.8 million for A/B and DME MACs, respectively.

¹³CMS also conducts national educational efforts for providers on billing through weekly newsletters, phone calls, and the Medicare Learning Network national education materials.

Figure 1: Relationship between Provider Education and Medical Review Departments within a Medicare Administrative Contractor and Their Respective Functions



Source: GAO. | GAO-17-290

CMS requires each MAC to identify areas vulnerable to improper billing in its jurisdiction(s) to guide MAC efforts in medical review and provider education. Areas identified by the MACs are listed in their IPRS reports. MACs' medical review departments identify these areas by analyzing various internal and external data, such as data from CMS's Comprehensive Error Rate Testing (CERT) program, issues identified by recovery auditors, Office of Inspector General reports, comparative billing reports, and internal MAC data.¹⁴ The objective of the CERT program is to estimate the payment accuracy of the Medicare fee-for-service program, which results in a Medicare fee-for-service improper payment rate.¹⁵ Improper payment rates are computed at multiple levels: nationally, by

¹⁴Recovery auditors are a type of contractor tasked by CMS to identify improper payments after they have been made. A comparative billing report contains data-driven tables and graphs with an explanation of findings that compare an individual provider's billing and payment patterns to those of their peers on both a national and state level.

¹⁵CMS's CERT program was developed as part of its Improper Payments Information Act of 2002 (IPIA) compliance efforts. IPIA, as amended, requires executive branch agencies to annually identify programs susceptible to significant improper payments, estimate the amounts improperly paid, and report their estimates and actions taken to reduce them. Pub. L. No. 107-300, 116 Stat. 2350 (2002), as amended by the Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, 124 Stat. 2224 (2010), and the Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, 126 Stat. 2390 (2013) (codified at 31 U.S.C. § 3321 note).

MAC, by service, and by provider type. According to CMS's provider customer service program manual, MACs with improper payment rates a certain percentage above HHS's target for determining progress toward one of its Government Performance and Results Act of 1993 (GPRA) goals may be required by CMS to submit quarterly or monthly provider education department status updates.¹⁶ However, CMS officials told us that they have never required any MAC to submit these quarterly or monthly status updates and they are considering removing this requirement from the manual.

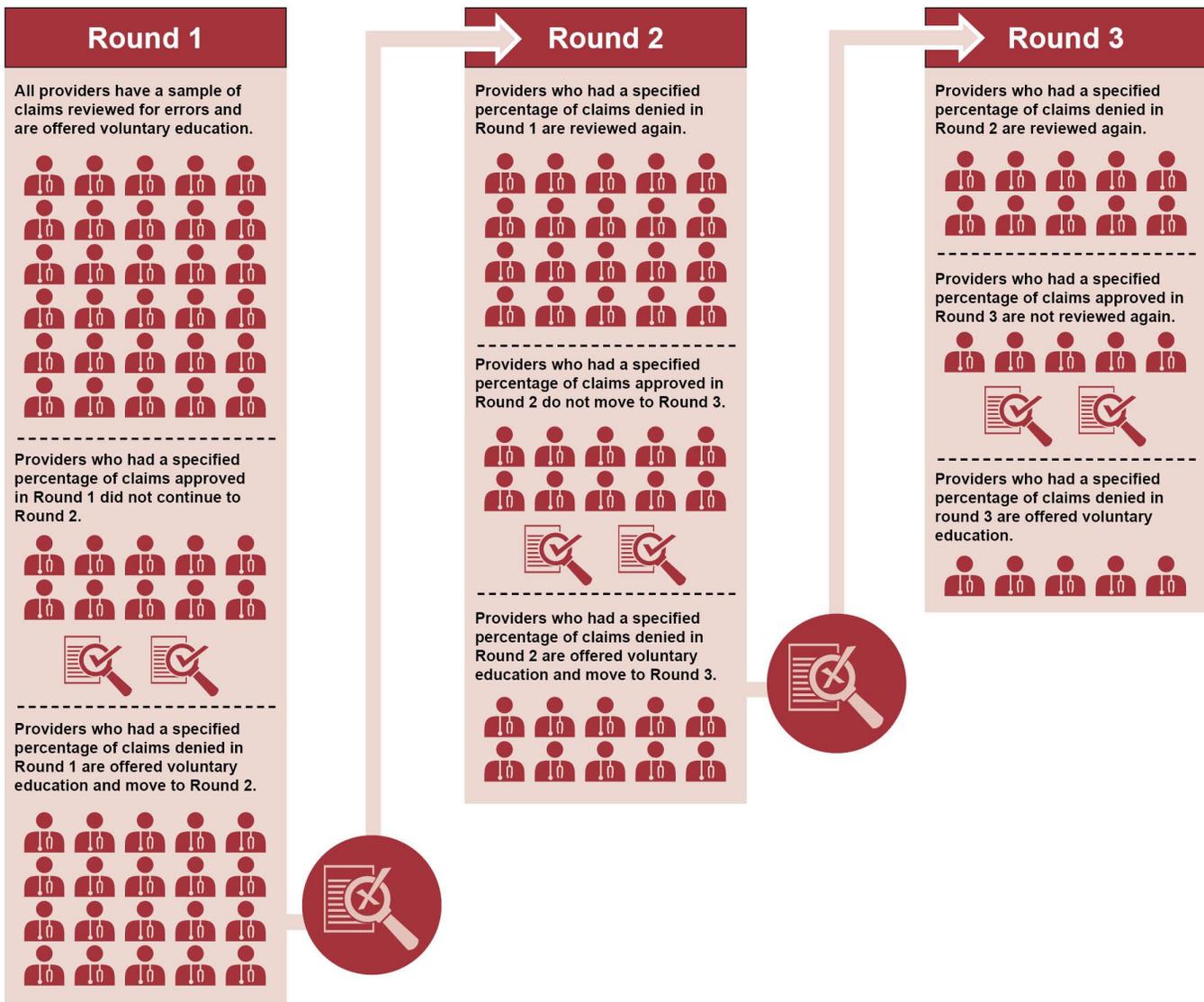
Probe and Educate Reviews

The probe and educate reviews are a CMS strategy to determine the extent to which providers understand recent policy changes for certain areas vulnerable to improper billing and help providers improve billing in these areas through a review of a sample of claims from every provider. Under the reviews, MAC medical review departments, with varying levels of coordination with the provider education departments, sample and review a certain number of claims from each provider to determine whether the claims were billed and documented properly. These reviews are resource intensive, because they involve manual review of associated medical records by trained medical review staff. Because of the resources involved, manual reviews are done infrequently in the Medicare program, with less than 1 percent of all Medicare claims receiving manual review. Following the first round of review, providers are informed of their results and those who billed and documented a specified percentage of claims improperly are offered voluntary one-to-one education to learn why each claim was approved or denied. Providers that billed and documented a specified percentage of claims properly are excluded from subsequent

¹⁶Each year under the Government Performance and Results Act of 1993, as amended by the GPRA Modernization Act of 2010, agencies are required to establish performance goals and measure their performance, among other things. Pub. L. No. 103-62, 107 Stat. 285 (1993), as amended by Pub. L. No. 111-352, 124 Stat. 3866 (2011). One of HHS's GPRA goals is to strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management. One performance measure HHS uses for this goal is the reduction of the Medicare fee-for-services improper payment rate. Department of Health and Human Services, *Fiscal Year 2017 Annual Performance Plan and Report* (Washington, D.C.: February 2016).

rounds of review, if any. MACs may repeat this process for subsequent rounds of review using a new sample of claims.¹⁷ (See fig. 2.)

Figure 2: Example of a Probe and Educate Review Process



Source: GAO. | GAO-17-290

¹⁷According to CMS officials, the number of probe and educate review rounds depends on several factors, which can include findings from previous rounds, other medical review initiatives that are taking place, and provider/supplier performance.

In addition to the areas vulnerable to improper billing identified by the MACs, CMS identified two areas vulnerable to improper billing—short-stay hospital visits and home health services—and required MACs to conduct probe and educate reviews for each of these areas. The first probe and educate review examined short-stay hospital claims to determine the extent to which certain hospitals were properly applying the “two-midnight rule” that CMS implemented effective October 1, 2013. Under the rule, hospital stays for Medicare beneficiaries spanning two or more midnights should generally be billed as inpatient hospital claims. Conversely, hospital stays not expected to span at least two midnights should generally be billed as outpatient hospital claims. From October 1, 2013, through September 30, 2015, 64,776 short-stay inpatient hospital claims were reviewed by the MACs over three rounds.¹⁸ Beginning on October 15, 2015, quality improvement organizations began conducting these reviews at the direction of CMS.¹⁹

At the direction of CMS, MACs began conducting probe and educate reviews of home health agency claims on October 1, 2015, for episodes of care that occurred on or after August 1, 2015.²⁰ Round 1 was completed as of September 30, 2016, and the second round began on December 15, 2016. The purpose of these reviews is to ensure that home health agencies understand the new patient certification requirements that became effective January 1, 2015. These requirements stipulate that the referring physician, also referred to as the ordering or referring provider, must certify a patient’s eligibility for home health services as a condition of payment. As part of the certification, the referring provider

¹⁸As part of the probe and educate reviews for short-stay inpatient hospital visits, MACs drew a sample of 10 claims from small hospitals and 25 claims from large hospitals per round. CMS officials reported that large hospitals were those with \$100 million or greater in Medicare payments annually. A small hospital was considered to be billing properly if no more than 1 of the 10 claims sampled was denied and a large hospital was considered to be billing properly if no more than 2 out of the 25 claims sampled were denied.

¹⁹Quality improvement organizations are a type of CMS contractor composed of health quality experts, clinicians, and consumers who work to improve the quality of care for Medicare beneficiaries. According to CMS officials, quality improvement organizations have previous experience conducting hospital reviews, and they believe quality improvement organizations’ positive working relationships with hospitals will be beneficial in helping to educate providers.

²⁰An episode of home health care is 60 days. For the probe and educate review of home health services, MACs sampled five claims from each home health agency per round. A home health provider was considered to be billing properly if no more than one of five claims sampled was denied.

must document that a face-to-face patient encounter occurred within a certain time frame. In addition, the patient's medical record must support the certification of eligibility.

MAC Officials State Their Provider Education Efforts Focus on Areas Vulnerable to Improper Billing; CMS Oversight and Requirements for These Efforts Are Limited

MAC officials state that their provider education department efforts focus on areas vulnerable to improper billing. We found that these efforts are subject to limited oversight by CMS. Additionally, CMS does not require MACs to educate referring providers on documentation requirements for DME and home health services.

MAC Officials State Their Provider Education Department Efforts Focus on Areas Vulnerable to Improper Billing

MAC officials told us that their provider education departments focus education on areas vulnerable to improper billing, including those they've identified and listed in their annual IPRS reports. There were 278 areas listed in the IPRS reports we reviewed, and based on our analysis, some of these areas, such as skilled nursing facilities, ambulance services, and blood glucose monitors, were identified by a majority of MACs. A detailed description of the problem areas may also be identified in these IPRS reports, as illustrated by the examples below.

- **Part A.** A majority of Part A MACs reported claims from skilled nursing facilities and inpatient rehabilitation facilities as vulnerable to improper billing. Examples of reported problem areas within skilled nursing facilities included claims for individuals using an "ultra-high" level of therapy and episodes of care greater than 90 days.
- **Part B.** A majority of Part B MACs reported claims for evaluation and management and ambulance services as areas vulnerable to improper billing.²¹ Examples of reported problem areas within the evaluation and management category included the incorrect level of

²¹Evaluation and management services are a type of physician visit.

coding for office visits, hospital visits, emergency room visits, and home visits for assisted living and nursing homes.²²

- **DME.** A majority of DME MACs reported claims for glucose monitors, urological supplies, continuous positive airway pressure (CPAP) devices, oxygen, wheelchair options and accessories, lower limb prosthetics, and immunosuppressive drugs as areas vulnerable to improper billing.²³ An example of a reported problem area with oxygen billing was that the beneficiary medical record documentation did not provide support for symptoms that might be expected to improve with oxygen therapy.
- **HH+H.** Half of the HH+H MACs reported claims for home health therapy services and home health or hospice stays that were longer than average as areas vulnerable to improper billing. An example of a reported problem area with home health therapy services included claims from home health providers reporting a high average number of therapy visits for their patients as compared to their peers within the state and the MAC's jurisdiction.

CMS Collects Limited Information on MACs' Provider Education Efforts Focused on Areas Vulnerable to Improper Billing

CMS collects limited information on MACs' provider education department efforts that focus on areas vulnerable to improper billing. CMS officials told us that they oversee the extent to which MACs' provider education department efforts focus on areas vulnerable to improper billing by reviewing MACs' IPRS reports. Although the IPRS reports focus mainly on how the medical review departments will address the areas identified as vulnerable to improper billing, CMS's instructions to the MACs state

²²Most evaluation and management services are billed using codes that define the complexity level of the visit, with higher level codes representing more complex visits. The complexity level of these visits corresponds to the amount of skill, effort, time, responsibility, and medical knowledge required of the physician. Medicare payment is based in part on the complexity of the visit, with higher complexity visits receiving a larger payment.

²³A CPAP device uses mild air pressure to keep the airways open. CPAP devices are typically used by people who have breathing problems, such as sleep apnea.

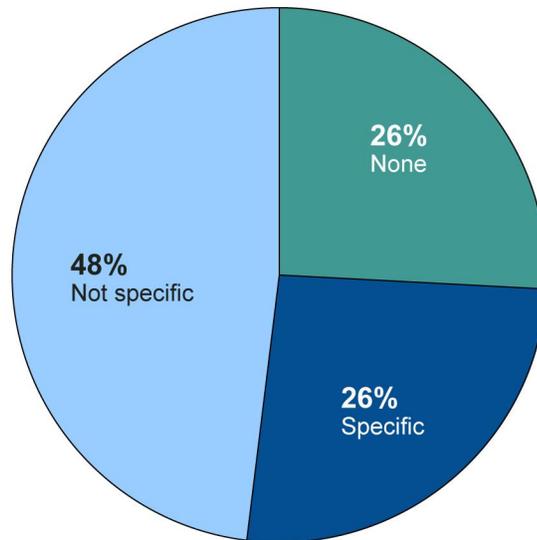
that they should also include information on related provider education department activities or provider education department referrals.²⁴

However, the IPRS reports we reviewed lacked specifics indicating how provider education department efforts focused on 74 percent of the 278 MAC-identified areas vulnerable to improper billing. We considered a provider education department effort to be specific if it included one or more of the following: the month, day, and year the event occurred or would occur; the type or number of providers attending; or a description of the event. As an example of a provider education department description that met our definition of 'specific,' one MAC reported its provider education department would conduct webinars focused on the top 5 to 10 denial reasons for oxygen equipment in the upcoming year. This MAC's IPRS report in our analysis listed specific provider education department efforts for all areas vulnerable to improper billing. However, 74 percent of the areas vulnerable to improper billing listed in the 14 IPRS reports we reviewed lacked specifics—48 percent of the time the provider education department efforts listed were not specific and 26 percent of the time no provider education department efforts were included.²⁵ As an example of a provider education department description that was not specific, one MAC reported that the medical review department would make provider referrals to its provider education department "as needed" for inpatient hospital and rehabilitation facilities admissions, but gave no additional detail (see fig. 3).

²⁴Although MACs report their provider education department efforts through several other reports, they do not demonstrate in these reports how their provider education department efforts are focused on the areas vulnerable to improper billing identified in the IPRS reports.

²⁵CMS does not require that a provider education department effort be included for each area vulnerable to improper billing listed in the IPRS report.

Figure 3: Specificity of Provider Education Department Efforts in Improper Payment Reduction Strategy Reports



Source: GAO review of Medicare administrative contractors' data. | GAO-17-290

Note: We examined 14 Medicare administrative contractors' (MAC) Improper Payment Reduction Strategy reports submitted to the Centers for Medicare & Medicaid Services from November 2015 through July 2016 to determine the extent to which MACs' reported provider education department efforts focused on the 278 areas they identified as vulnerable to improper billing. We considered provider education department efforts to be specific if they included one or more of the following: the month, day, and year the event occurred or would occur, the type or number of providers attending; or a description of the provider education department event. We considered provider education department efforts not specific if they mentioned provider education department efforts without these details.

According to CMS officials, they do not require IPRS reports to have a certain level of specificity regarding how provider education department efforts focus on areas vulnerable to improper billing because they do not want to be overly prescriptive regarding MACs' provider education department efforts. As a result, CMS receives limited and varying degrees of information on the extent to which provider education department efforts are focused on the MAC-identified areas vulnerable to improper billing. CMS's collection of limited information is inconsistent with federal internal control standards related to information and communications, which state that management should use quality information to achieve the entity's objectives—CMS's objective in this instance being the education of providers about proper billing.²⁶ Unless CMS requires sufficient MAC provider education department reporting, it cannot ensure

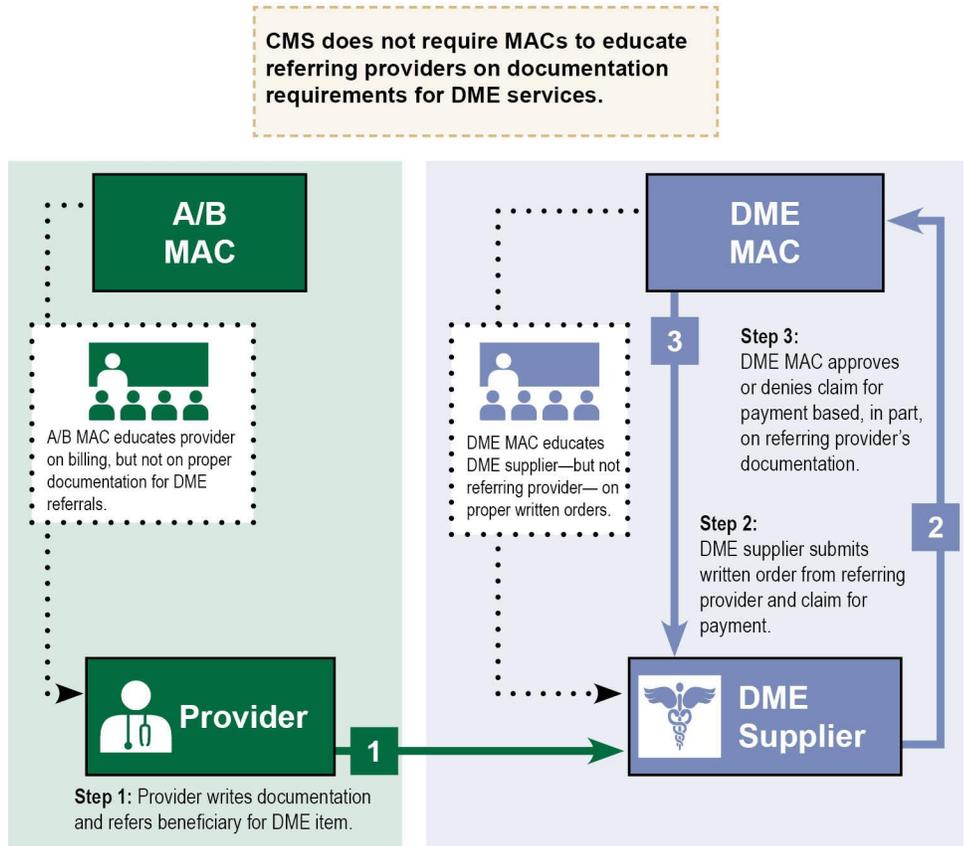
²⁶GAO-14-704G.

that MACs' provider education department efforts are focused on areas vulnerable to improper billing.

CMS Does Not Require MACs to Educate Referring Providers for Durable Medical Equipment and Home Health Services

CMS does not require A/B MACs to educate referring providers on documentation requirements for ordering DME and home health services because referring providers do not bill for any DME or home health services on these orders. DME suppliers and home health agencies are responsible for submitting a proper written order from the referring provider to receive payment, and DME and HH+H MACs are required to educate DME suppliers and home health agencies—but not the referring provider—on a proper written order. However, when a DME supplier or home health agency accepts a written order, its payment may be denied if the claim is reviewed and the referring provider's medical record documentation does not support the supply or service provided. See figure 4 for an example in the case of DME.

Figure 4: Education Provided by Medicare A/B and DME MACs and Claim Payment Process



Legend: A/B MAC=Medicare Parts A and B administrative contractor; Beneficiary=Medicare fee-for-service beneficiary; CMS=Centers for Medicare & Medicaid Services; DME=Durable medical equipment prosthetics, orthotics, and supplies; DME MAC=Durable medical equipment prosthetics, orthotics, and supplies Medicare administrative contractor.

Source: GAO. | GAO-17-290

Some MAC officials told us they have started working with other MACs voluntarily to provide education to referring providers regarding DME and home health services documentation requirements in some jurisdictions, although CMS has not specifically required this collaboration. As an example, officials from one DME MAC told us that they and three A/B MACs that operate within its jurisdiction co-hosted two webinars on documentation requirements when ordering durable medical equipment and prosthetics and orthotics in September 2015; these webinars focused on the medical records and orders that are part of the supplier

requirement for documentation. However, this voluntary collaboration does not ensure that referring providers are always being educated.²⁷ For example, two A/B MACs reported that they have done little collaboration with the HH+H MAC that serves their jurisdiction for referring providers on proper billing documentation for home health services. CMS officials stated that they have not explicitly required the MACs to work together on this activity because it has not risen to a level of significant concern.

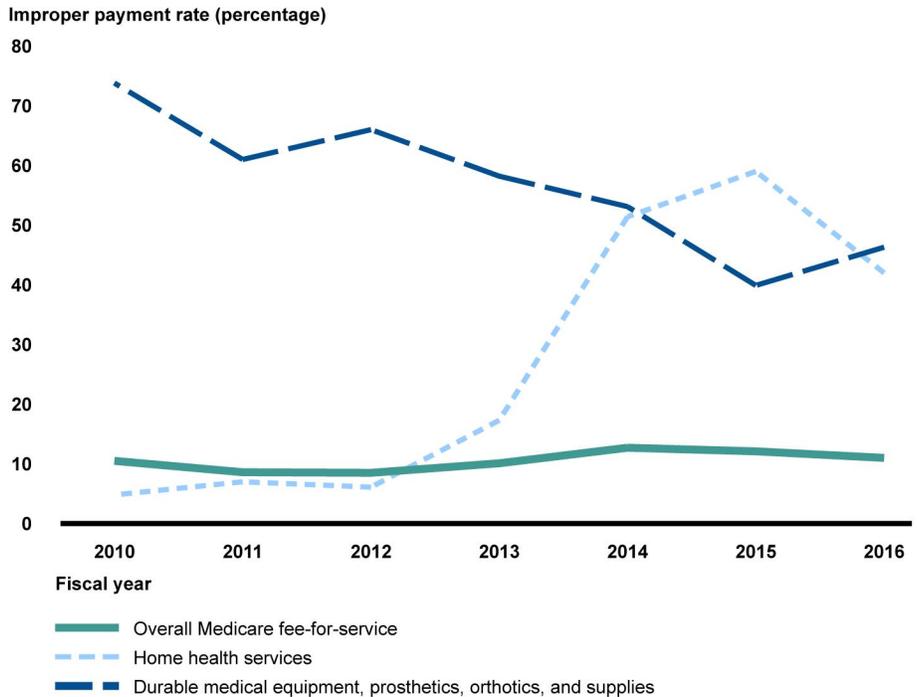
If education were provided, officials from two DME MACs told us there would still be a lack of incentive for referring providers to bill properly for DME and home health services because they do not experience any repercussions for insufficient documentation—one type of improper billing. Instead, when DME or home health claims are denied due to insufficient documentation, from either the supplier or the referring provider, the DME or home health provider loses the payment, while the referring provider does not.

This education gap is problematic because insufficient documentation is the most common reason for improper payments for home health services and DME, which have high improper payment rates. As reported for fiscal year 2016, DME had a 46.3 percent improper payment rate with the Medicare program paying an estimated \$3.7 billion improperly; home health services had a 42.0 percent improper payment rate with the program paying an estimated \$7.7 billion improperly (see fig. 5.). Of these improper payment amounts, 81 percent and 96 percent were the result of insufficient documentation for DME and home health services, respectively. Although the DME improper payment rate has decreased somewhat in recent years, both the home health and DME programs' improper payment rates remain higher than the overall Medicare fee-for-service improper payment rate of 11.0 percent.²⁸

²⁷ Some MAC officials reported that similar issues exist with referring providers' documentation for third party services such as radiology and labs. However, education in these cases is provided by the A/B MAC for both the service provider and the referring physician.

²⁸ Hospice services are reported separately from the home health services improper payment rate. In fiscal year 2016, hospice services had a 14.6 percent improper payment rate with the Medicare program paying an estimated \$2.1 million improperly. See Department of Health and Human Services, *The Supplementary Appendices*.

Figure 5: Improper Payment Rates for Overall Medicare Fee-for-Service, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and Home Health Services for Fiscal Years 2010-2016



Source: GAO analysis of the Centers for Medicare & Medicaid Services' Comprehensive Error Rate Testing program improper payment rates. | GAO-17-290

Because referring physicians do not receive education from MACs for the required documentation to support referrals for DME and home health services, the risk is increased that DME suppliers or home health agencies will improperly submit claims with insufficient documentation from referring providers. Although both the A/B and DME MAC contracts contain a requirement for the MACs to share ideas and coordinate their efforts as necessary, they do not explicitly require collaboration between these MACs to address this education gap for referring providers. The absence of a requirement for MACs to educate referring providers about proper documentation for DME and home health claims is inconsistent with federal internal control standards, which state that in order to achieve an entity's objectives, management should assign responsibility, and delegate authority.²⁹ Without explicitly requiring that MACs educate

²⁹GAO-14-704G.

referring providers, the billing errors that result from referring providers' insufficient documentation may persist.

CMS Officials Consider Hospital Probe and Educate Reviews a Success, but Did Not Measure Effectiveness

Although CMS officials consider the MACs' short-stay hospital probe and educate reviews to be a success, they did not measure the effectiveness of this new strategy in reducing improper billing. CMS officials consider the reviews to be a success based on feedback from providers who were happy with the education they received and based on the reduction in the number of providers from the first to third rounds who were billing and documenting claims improperly.

We found that the effectiveness of the MACs' short-stay hospital probe and educate reviews cannot be confirmed because CMS did not establish performance metrics to determine whether the probe and educate reviews were effective in reducing improper billing. Although CMS stated the objective of the reviews was to determine the extent to which providers understood recent policy changes for certain services and were billing properly for those services, CMS officials told us they did not establish performance metrics that defined their objectives in measurable terms and would allow them to evaluate whether they met those objectives—for instance, specifying the percentage decrease they'd want to see in the number of providers reviewed from the first round to third rounds. This is inconsistent with federal internal control standards that specify management should define objectives in specific and measurable terms, establish appropriate performance measures for the defined objectives, and conduct ongoing monitoring to evaluate whether they are meeting those objectives.³⁰

We reviewed the data provided by the MACs to CMS about the inpatient short-stay probe and educate reviews and found that the reviews may not have been a clear success. For instance, the percentage of providers who continued to require review remained high throughout the three

³⁰[GAO-14-704G](#).

rounds—over 90 percent.³¹ Additionally, the percentage of claims denied in each round also remained high throughout the three rounds (see table 1). CMS officials told us that because providers billing properly were removed after each round, they could not determine how much the overall denial rate effectively decreased from the first to third rounds, noting that the decrease in the claims denial rate could be greater than results indicate. However, the number of providers removed after each round was small. It is too early to say whether the home health probe and educate reviews are successful because only one round of reviews had been completed at the time of our review.³² CMS officials told us they have not established specific performance metrics for the home health reviews either.

Table 1: Short-Stay Inpatient Hospital Probe and Educate Reviews: Number of Providers, Claims Reviewed, and Percent of Claims Denied, Fiscal Years 2014 and 2015

Round	Number of providers requiring review	Percent of providers remaining from Round 1	Number of claims reviewed	Percent of total claims denied
1	4,846	—	27,506	53%
2	4,745	98%	23,315	44
3 ^a	4,527	93%	13,955	42

Source: GAO analysis of Medicare administrative contractor data collected by the Centers for Medicare & Medicaid Services | GAO-17-290

^aAccording to Centers for Medicare & Medicaid Services officials, Medicare administrative contractors were permitted to start a third round of short-stay inpatient hospital probe and educate reviews, but had to stop all reviews by the end of fiscal year 2015. Therefore, although the Centers for Medicare & Medicaid Services estimates that 4,527 providers advanced to the third round of review, only 2,866 providers had claims reviewed during this round, which resulted in a lower number of claims reviewed compared to the first two rounds.

The probe and educate reviews are resource-intensive. Though their costs have not been quantified by CMS, the reviews require manual assessments of thousands of claims, as well as the offer of one-to-one education from the MACs to certain providers. The importance of

³¹Providers that continued to a subsequent round were considered to be providers that continued to require review, although they may not have had claims reviewed in the third round. This is because according to CMS officials, MACs were permitted to start a third round of short-stay inpatient hospital probe and educate reviews, but had to stop all reviews by the end of fiscal year 2015. Therefore, although CMS estimates that a certain number of providers advanced to the third round of review, only some of those providers had claims reviewed during this round.

³²In fiscal year 2016, the denial rate for the home health probe and educate review averaged 65 percent across the four HH+H MAC jurisdictions. During the first round, MACs reviewed 49,760 claims from 11,201 home health providers.

measuring the effectiveness of these probe and educate reviews is highlighted by their resource-intensive nature, as well as by the fact that the percentage of providers requiring review and claims denied remained high throughout the three rounds of the probe and educate reviews of short inpatient hospital stays. Therefore, without performance metrics, CMS cannot determine whether future probe and educate reviews would be effective in reducing improper billing.

Conclusions

The MACs' provider education departments play an important role in reducing the rate of improper payments by educating Medicare providers on coverage and payment policies so that they can bill properly. However, CMS has missed opportunities to improve the effectiveness and its oversight of those efforts. CMS needs sufficient reporting from the MACs to determine if their provider education department efforts are focusing on areas vulnerable to improper billing. Lack of detail in the MACs' IPRS reporting provides CMS with insufficient information for oversight. Without sufficient reporting, CMS cannot assure that the MACs are focusing their provider education department efforts on reducing areas vulnerable to improper billing.

In order to reduce the high improper payment rates for home health and DME, education on proper documentation for providers who refer their patients for DME and home health services is necessary; however, MACs are not required to provide this education to the referring providers. To provide this education, collaboration is needed between the A/B MACs, which are the primary contacts for the referring providers, and the DME and HH+H MACs, which have expertise in the DME and home health billing areas. Without requiring MACs to work together to educate referring providers, CMS has little assurance that referring providers are being educated in order to help reduce improper billing in DME and home health services.

Finally, CMS has not determined the effectiveness of the probe and educate reviews. CMS does not have sufficient information to indicate whether the reviews help to reduce improper billing; establishing performance metrics would help CMS determine if the reviews are effective in doing so. Without performance metrics, little assurance exists that the probe and educate reviews are effective in reducing improper billing and whether they should be used for additional areas vulnerable to improper billing in the future.

Recommendations for Executive Action

To ensure MACs' provider education efforts are focused on areas vulnerable to improper billing and to strengthen CMS's oversight of those efforts, we recommend that CMS take the following three actions:

1. CMS should require sufficient detail in MAC reporting to allow CMS to determine the extent to which MACs' provider education department efforts focus on areas identified as vulnerable to improper billing.
2. CMS should explicitly require that A/B, DME, and HH+H MACs work together to educate referring providers on documentation requirements for DME and home health services.
3. For any future probe and educate reviews, CMS should establish performance metrics that will help the agency determine the reviews' effectiveness in reducing improper billing.

Agency Comments

We provided a draft of this product to HHS for comment. In its written comments, which are reprinted in appendix II, HHS concurred with our recommendations. HHS also provided technical comments, which we incorporated as appropriate. HHS acknowledged the role of referring providers in ensuring proper billing for Medicare services, stating it will ensure the MACs work together to educate referring providers on documentation requirements for DME and home health services. Further, HHS noted that it will work with the MACs on providing additional information related to their provider education department efforts. HHS also noted it is currently developing performance metrics to help measure the effectiveness of future probe and educate reviews.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, this report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff has any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page

of this report. GAO staff who made key contributions to this report are listed in appendix III.

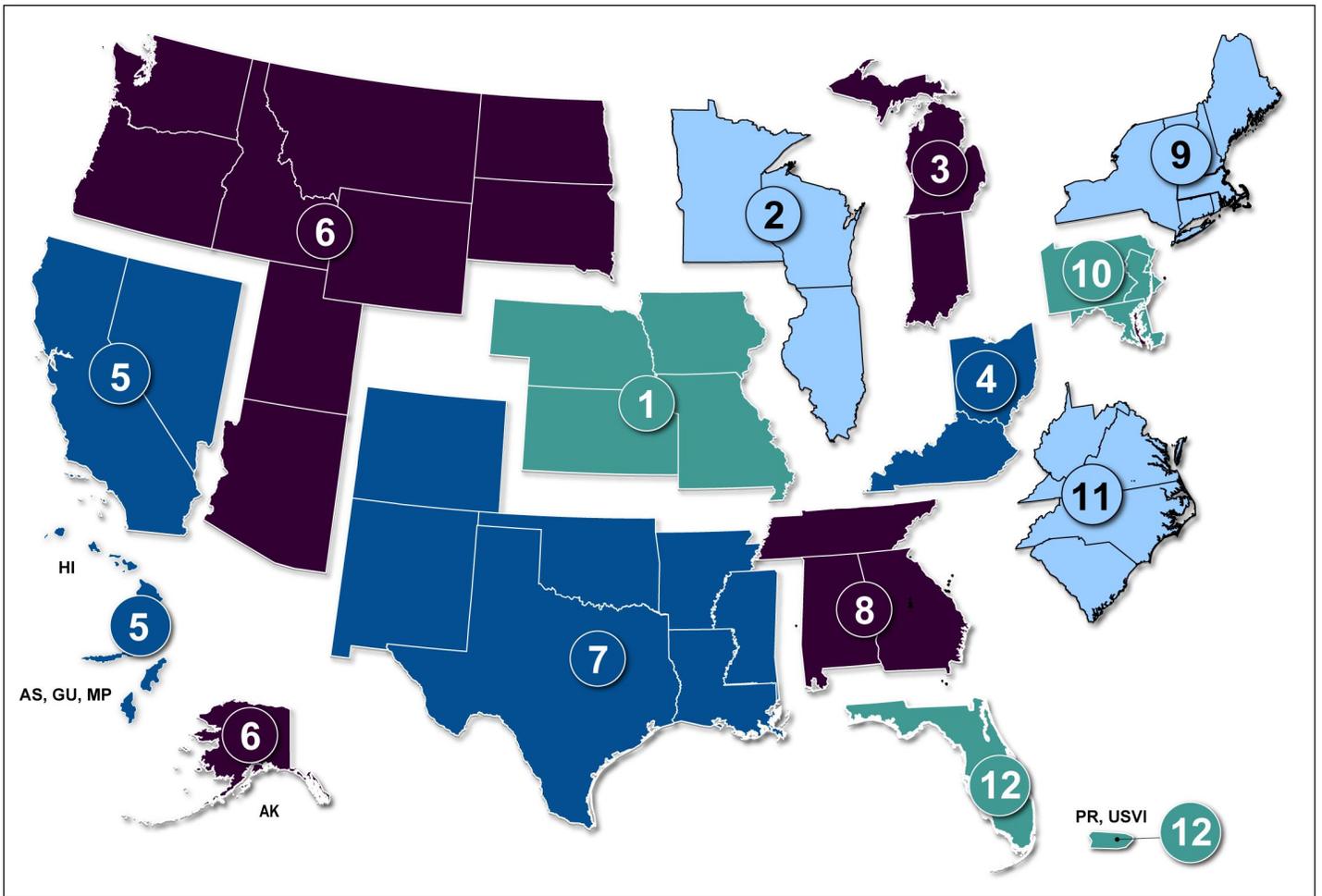
Sincerely yours,

A handwritten signature in black ink that reads "Kathleen M. King". The signature is written in a cursive style with a large, looped initial 'K'.

Kathleen M. King
Director, Health Care

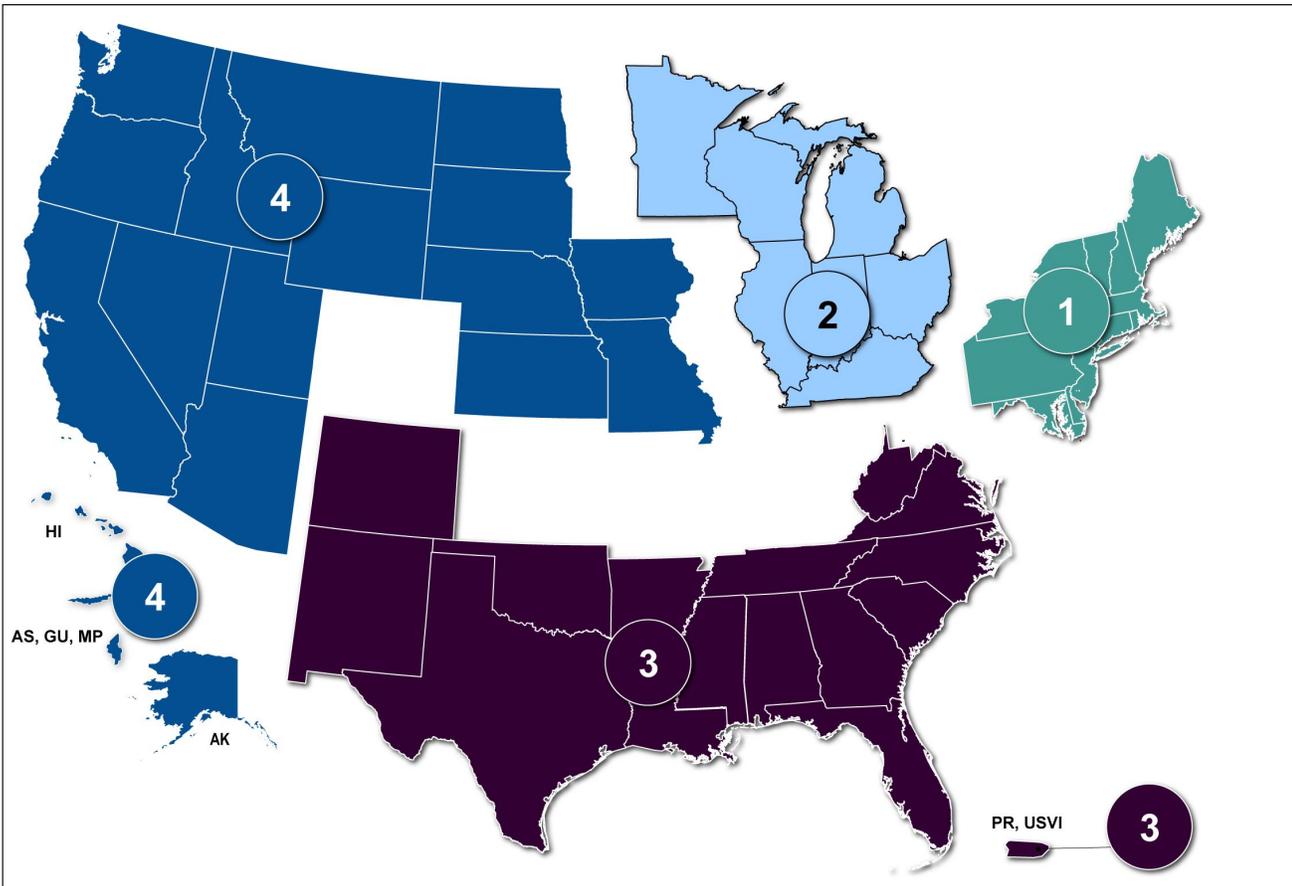
Appendix I: Medicare Administrative Contractor Jurisdictions

Figure 6: Part A/B Medicare Administrative Contractor Jurisdictions



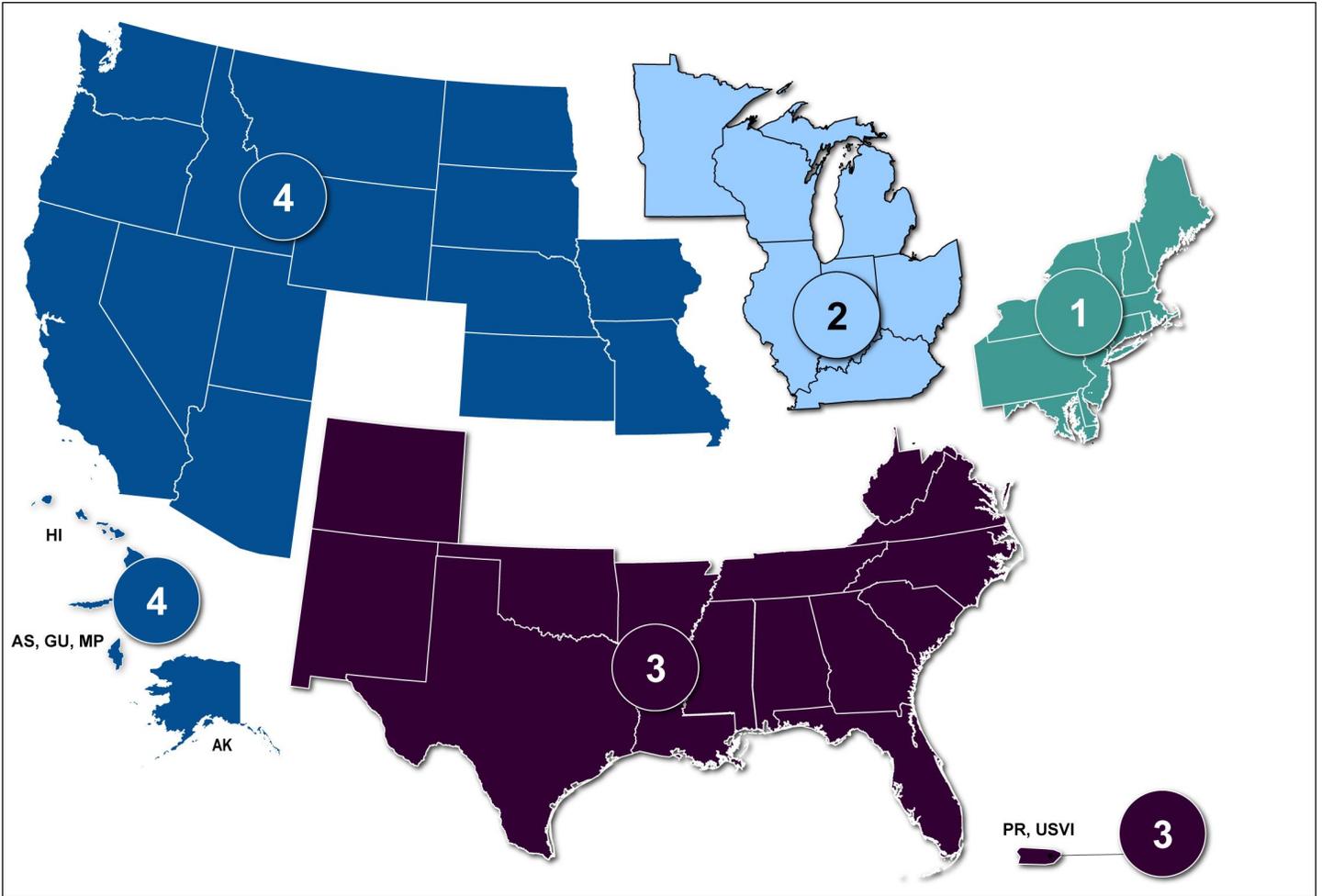
Sources: The Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-17-290

Figure 7: Home Health and Hospice Medicare Administrative Contractor Jurisdictions



Sources: The Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-17-290

Figure 8: Durable Medical Equipment Medicare Administrative Contractor Jurisdictions



Sources: The Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-17-290

Appendix II: Comments from the Department of Health and Human Services

	DEPARTMENT OF HEALTH & HUMAN SERVICES	OFFICE OF THE SECRETARY
		Assistant Secretary for Legislation Washington, DC 20201

FEB 17 2017

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare Provider Education: Oversight of Efforts to Reduce Improper Billing Needs Improvement*" (GAO-17-290).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,


Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE PROVIDER EDUCATION: OVERSIGHT OF EFFORTS TO REDUCE IMPROPER BILLING NEEDS IMPROVEMENT (GAO-17-290)

The Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS strives to provide Medicare beneficiaries with access to high quality health care while protecting taxpayer dollars.

In addition to processing and paying claims, Medicare Administrative Contractors (MACs) play an important role in the reduction of improper billing. MACs analyze claims to identify providers and suppliers with patterns of errors or unusually high volumes of particular claims, as well as conduct provider education, outreach, and technical assistance. One of the goals of provider education and outreach is to give providers the timely and accurate information they need to bill correctly the first time. MACs educate Medicare providers and their staff about Medicare policies and procedures, including local coverage policies, significant changes to the Medicare program, and issues identified through review of provider inquiries, claim submission errors, medical review data, and Comprehensive Error Rate Testing program data.

In addition, Probe and Educate reviews are one of many tools used by HHS to closely examine areas that are vulnerable to improper payments and ensure that providers understand recent policy changes or clarifications. These Probe and Educate reviews in particular help to determine if the requirements for certification/recertification, patient eligibility, coding, and medical necessity were met, and help MACs determine areas where potential additional provider education is needed. Probe and Educate reviews began in 2013, and the first two areas of review have focused on inpatient hospital claims and home health services. During these reviews, MACs analyze a small sample of claims from each provider, reviewing medical records to ensure that claims are properly documented and supported, and conducting provider education with the relevant billing providers as necessary.

HHS remains committed to supplying providers with the information they need to bill Medicare correctly, and appreciates the GAO's work in this area.

GAO's recommendations and HHS' responses are below.

GAO Recommendation

HHS should require sufficient detail in MAC reporting to allow HHS to determine the extent to which MACs' provider education department efforts focus on areas identified as vulnerable to improper billing.

HHS Response

HHS concurs with GAO's recommendation. HHS will work with the MACs on providing additional information related to their provider education department efforts within existing funding limitations.

GAO Recommendation

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE PROVIDER EDUCATION: OVERSIGHT OF EFFORTS TO REDUCE IMPROPER BILLING NEEDS IMPROVEMENT (GAO-17-290)

HHS should explicitly require that A/B, DME, and HH+H MACs work together to educate referring providers on documentation requirements for DME and home health services..

HHS Response

HHS concurs with GAO's recommendation and recognizes the role of referring providers in ensuring proper billing for Medicare services. HHS will work with the A/B, DME, and HH+H MACs to ensure they work together to educate referring providers on documentation requirements for DME and home health services as part of their regular training and education efforts within existing funding limitations.

GAO Recommendation

For any future Probe and Educate reviews, HHS should establish performance metrics that will help the agency determine the reviews' effectiveness in reducing improper billing.

HHS Response

HHS concurs with this recommendation. HHS has multiple methods in place to assist in reducing improper billing so any decreases in the error rate cannot be attributed to a single tool. However, HHS is currently developing performance metrics to help measure the effectiveness of future Probe and Educate reviews.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Teresa Tam, Analyst-in-Charge; Cathleen Hamann; Deborah Linares; Vikki Porter, and Jennifer Whitworth made key contributions to this report.

Appendix IV: Accessible Data

Data Tables

Data Table for Figure 3: Specificity of Provider Education Department Efforts in Improper Payment Reduction Strategy Reports

Category	Percentage
None	26%
Specific	26%
Not specific	48%

Data Table for Figure 5: Improper Payment Rates for Overall Medicare Fee-for-Service, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and Home Health Services for Fiscal Years 2010-2016

FY	Overall Medicare Fee-for-Service	Durable Medical Equipment	Home Health
2010	10.5	73.8	4.8
2011	8.6	61	7
2012	8.5	66	6.1
2013	10.1	58.2	17.3
2014	12.7	53.1	51.4
2015	12.1	39.9	59
2016	11	46.3	42

Agency Comment Letter

Text of Appendix II: Comments from the Department of Health and Human Services

Page 1

Kathleen King Director, Health Care

U.S. Government Accountability Office 441 G Street NW

Washington, DC 20548 Dear Ms. King:

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