



March 2019

# MEDICARE AND MEDICAID

## CMS Should Assess Documentation Necessary to Identify Improper Payments

Accessible Version

# GAO Highlights

Highlights of [GAO-19-277](#), a report to congressional addressees

## Why GAO Did This Study

In fiscal year 2017, Medicare FFS had an estimated \$23.2 billion in improper payments due to insufficient documentation, while Medicaid FFS had \$4.3 billion—accounting for most of the programs' estimated FFS medical review improper payments. Medicare FFS coverage policies are generally national, and the program directly pays providers, while Medicaid provides states flexibility to design coverage policies, and the federal government and states share in program financing.

Among other things, GAO examined: (1) Medicare and Medicaid documentation requirements and factors that contribute to improper payments due to insufficient documentation; and (2) the extent to which Medicaid reviews provide states with actionable information. GAO reviewed Medicare and Medicaid documentation requirements and improper payment data for fiscal years 2005 through 2017, and interviewed officials from CMS, CMS contractors, and six state Medicaid programs. GAO selected the states based on, among other criteria, variation in estimated state improper payment rates, and FFS spending and enrollment.

## What GAO Recommends

GAO is making four recommendations to CMS, including that CMS assess and ensure the effectiveness of Medicare and Medicaid documentation requirements, and that CMS take steps to ensure Medicaid's medical reviews effectively address causes of improper payments and result in appropriate corrective actions. CMS concurred with three recommendations, but did not concur with the recommendation on Medicaid medical reviews. GAO maintains that this recommendation is valid as discussed in this report.

View [GAO-19-277](#). For more information, contact James Cosgrove at (202) 512-7144, or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov), or Carolyn L. Yocom at [yocomc@gao.gov](mailto:yocomc@gao.gov)

March 2019

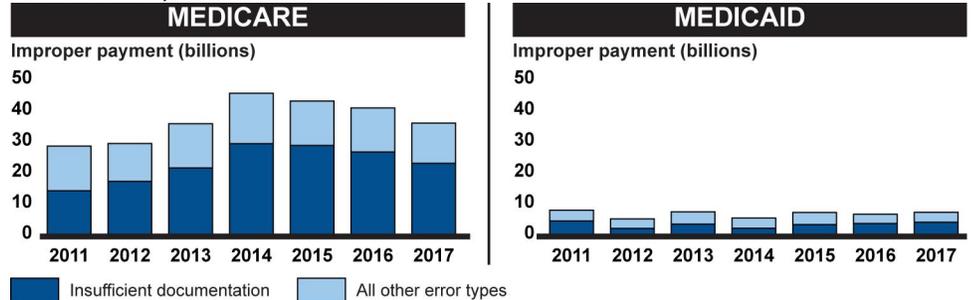
# MEDICARE AND MEDICAID

## CMS Should Assess Documentation Necessary to Identify Improper Payments

### What GAO Found

The Centers for Medicare & Medicaid Services (CMS) uses estimates of improper payments to help identify the causes and extent of Medicare and Medicaid program risks and develop strategies to protect the integrity of the programs. CMS estimates Medicare and Medicaid fee-for-service (FFS) improper payments, in part, by conducting medical reviews—reviews of provider-submitted medical record documentation to determine whether the services were medically necessary and complied with coverage policies. Payments for services not sufficiently documented are considered improper payments. In recent years, CMS estimated substantially more improper payments in Medicare, relative to Medicaid, primarily due to insufficient documentation (see figure).

**Estimated Improper Payments Identified through Medical Review in Medicare and Medicaid Fee-for-service, Fiscal Years 2011-2017**



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

For certain services, Medicare generally has more extensive documentation requirements than Medicaid. For example, Medicare requires additional documentation for services that involve physician referrals, while Medicaid requirements vary by state and may rely on other mechanisms—such as requiring approval before services are provided—to ensure compliance with coverage policies. Although Medicare and Medicaid pay for similar services, the same documentation for the same service can be sufficient in one program but not the other. The substantial variation in the programs' improper payments raises questions about how well the programs' documentation requirements help identify causes of program risks. As a result, CMS may not have the information it needs to effectively address program risks and direct program integrity efforts.

CMS's Medicaid medical reviews may not provide the robust state-specific information needed to identify causes of improper payments and address program risks. In fiscal year 2017, CMS medical reviews identified fewer than 10 improper payments in more than half of all states. CMS directs states to develop corrective actions specific to each identified improper payment. However, because individual improper payments may not be representative of the causes of improper payments in a state, the resulting corrective actions may not effectively address program risks and may misdirect state program integrity efforts. Augmenting medical reviews with other sources of information, such as state auditor findings, is one option to better ensure that corrective actions address program risks.

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### **Abbreviations**

CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
FFS	fee-for-service
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services' Office of the Inspector General
IPIA	Improper Payments Information Act of 2002
IRR	interrater reliability
OMB	Office of Management and Budget
PERM	Payment Error Rate Measurement

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March 27, 2019

Congressional Addressees

Medicare and Medicaid provide health insurance coverage to nearly 120 million Americans, with combined annual expenditures that exceeded \$1 trillion in fiscal year 2017.<sup>1</sup> We have designated Medicare and Medicaid high-risk programs in part because their size and complexity make them vulnerable to improper payments—payments that should not have been made or were made in incorrect amounts based on program requirements.<sup>2</sup>

Medicare and Medicaid provide health coverage through different mechanisms, including fee-for-service (FFS), in which individual health care providers are paid for each service delivered.<sup>3</sup> In fiscal year 2017, Medicare FFS spending was an estimated \$381 billion, and combined federal and state spending for Medicaid FFS was an estimated \$320 billion. In the same year, estimated Medicare FFS improper payments

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<sup>1</sup>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. Medicaid is a joint federal-state program that finances health care for low-income and medically needy individuals.

<sup>2</sup>See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, [GAO-17-317](#) (Washington, D.C.: February 2017). An improper payment is statutorily defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. 31 U.S.C. § 3321 note. Office of Management and Budget guidance provides that when an agency's review is unable to discern whether a payment was proper as a result of no or insufficient documentation, this payment must be considered an improper payment.

<sup>3</sup>Medicare and Medicaid also provide coverage through managed care, in which private managed care plans receive a periodic payment per beneficiary to provide a specific set of covered services to beneficiaries. In this report, we will focus solely on Medicare and Medicaid FFS improper payments.

were \$36.2 billion and estimated Medicaid FFS improper payments were \$41.2 billion.<sup>4</sup>

The Centers for Medicare & Medicaid Services (CMS)—the Department of Health and Human Services (HHS) agency responsible for administering the Medicare program and, in conjunction with the states, the Medicaid program—estimates Medicare and Medicaid FFS improper payments in part by reviewing provider medical record documentation to determine whether claims that providers submit for payment comply with program coverage policies. Among other types of improper payment errors, payments are improper when providers do not submit required documentation to support their claims, or the documentation submitted is insufficient to demonstrate compliance with coverage policies.<sup>5</sup> In fiscal year 2017, Medicare had an estimated \$23.8 billion in improper payments due to providers submitting no or insufficient documentation, while Medicaid had an estimated \$6.8 billion. CMS uses estimates of improper payments, including those due to no and insufficient documentation, to better understand the causes and extent of program risks, develop strategies to protect program integrity, and measure progress toward reducing improper payments.

We prepared this report under the authority of the Comptroller General to conduct evaluations to support congressional oversight of issues of national importance.<sup>6</sup> This report:

1. describes CMS's processes for obtaining and reviewing medical record documentation needed to estimate improper payments in Medicare and Medicaid FFS;
2. examines Medicare and Medicaid documentation requirements and factors that contribute to improper payments due to insufficient documentation; and

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<sup>4</sup>All Medicaid improper payment estimates in this report include federal and state spending.

<sup>5</sup>Medicaid tracks two types of improper payments due to insufficient documentation—one for payments when specific documentation is not provided, and another for payments for when the submitted documentation is insufficient. In this report we use the term insufficient documentation to refer to both types of improper payments.

<sup>6</sup>31 U.S.C. § 717(b).

3. examines the extent to which reviews of medical record documentation provide state Medicaid agencies with actionable information on the underlying causes of improper payments.

To describe CMS's processes for obtaining and reviewing medical record documentation to estimate improper payments in Medicare and Medicaid FFS, we reviewed CMS documents for Medicare's Comprehensive Error Rate Testing (CERT) and Medicaid's Payment Error Rate Measurement (PERM) programs, respectively. CMS uses the CERT and PERM programs to identify improper payments and estimate Medicare and Medicaid improper payment amounts and rates. We interviewed CMS officials and CMS's CERT and PERM contractors regarding processes for obtaining and reviewing documentation, including steps taken by the contractors before determining that a claim is improper due to no or insufficient documentation.<sup>7</sup> We obtained data on the outreach to providers conducted by the CERT and PERM contractors to obtain documentation, and information on referrals of claims with evidence of potential fraud to other Medicare and Medicaid program integrity entities.

To examine Medicare and Medicaid documentation requirements and factors that contribute to improper payments due to insufficient documentation, we reviewed Medicare and Medicaid documentation requirements based on statutes, regulations, and other national and state coverage policies. We reviewed data on Medicare improper payment amounts for fiscal years 2005 through 2017; Medicaid improper payment amounts for fiscal years 2011 through 2017; and fiscal year 2017 estimated improper payment amounts and rates for four selected services types—home health, durable medical equipment (DME), laboratory, and hospice.<sup>8</sup> We selected these services based on their relatively high estimated amounts and rates of improper payments due to insufficient

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<sup>7</sup>The CERT and PERM programs each have two contractors—a statistical contractor that designs the programs' statistical sampling strategy and estimates improper payments, and a review contractor that reviews medical record documentation to determine whether claims were paid or denied properly. We interviewed the CERT and PERM statistical and review contractors.

<sup>8</sup>During the period of our review, fiscal year 2017 data represented the most recent, complete data for both Medicare and Medicaid FFS estimated improper payment amounts and rates. As of March 2019, CMS published the fiscal year 2018 Medicare FFS Supplemental Improper Payment Data report, but had not published the 2018 Medicaid FFS Supplemental Improper Payment Data report. See appendix II for fiscal year 2018 Medicare improper payment data.

documentation, particularly in Medicare.<sup>9</sup> Specifically, these services accounted for \$10.7 billion of \$23.2 billion in Medicare improper payments due to insufficient documentation in fiscal year 2017.<sup>10</sup> We interviewed CMS officials; CERT and PERM contractor staff; officials from six state Medicaid agencies—California, Delaware, Indiana, Massachusetts, Michigan, and New York; officials from provider associations representing the four selected services; and an association representing physicians regarding the causes of improper payments due to insufficient documentation.<sup>11</sup> We selected the six states to review based on a range of estimated FFS improper payment rates, a range of FFS enrollment and expenditures, regional geographic diversity, and states representing each PERM cycle year.<sup>12</sup> The information we obtained from the six states and the provider associations cannot be generalized. We obtained illustrative examples from CMS of Medicare and Medicaid improper payments due to insufficient documentation for our selected services; these examples cannot be generalized. We also reviewed documentation about CMS initiatives to examine and revise provider documentation requirements. We assessed Medicare and Medicaid documentation requirements and processes for identifying improper payments due to insufficient

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<sup>9</sup>We examined documentation requirements and improper payments due to insufficient documentation for comparable services in both programs. Several Medicaid services with relatively high amounts and rates of insufficient documentation, such as personal support and outpatient prescription drug services, do not have comparable Medicare FFS services.

<sup>10</sup>The Medicare FFS category for estimated improper payments for laboratory services used in our analysis is specific to laboratories that are clinically independent and bill Medicare Part B, while the Medicaid estimated improper payments for laboratory services also includes X-ray and imaging services. While the categories are not directly comparable, we used the estimated improper payments to examine factors that contribute to improper payments for laboratory services due to insufficient documentation.

<sup>11</sup>We interviewed officials from the following provider associations: American Association for Homecare, American Clinical Laboratory Association, American Medical Association, and National Association for Home Care & Hospice.

<sup>12</sup>The PERM computes an annual rolling average of improper payment rates across all states based on a 17-state, 3-year rotation cycle. For example, the fiscal year 2017 improper payment rate included states sampled as part of the 2015, 2016, and 2017 review years.

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documentation against *Standards for Internal Control in the Federal Government*.<sup>13</sup>

To examine the extent to which reviews of medical record documentation provide actionable information on the underlying causes of improper payments, we reviewed CMS's PERM and corrective action plan guidance, the PERM program's processes for estimating improper payments, national and state-level error rate data, and relevant statutes, regulations, and state coverage policies. We interviewed officials from the Office of Management and Budget (OMB) regarding agency requirements to estimate and address improper payments. We also interviewed officials from the six selected state Medicaid agencies regarding the PERM process, and reviewed the states' improper payments rates, causes of improper payments, and corrective action plans to address identified improper payments. The information we obtained from the six states cannot be generalized. Additionally, we reviewed guidance from the Association of Certified Fraud Examiners and interviewed officials from the HHS Office of the Inspector General (HHS-OIG) and the National Association of Medicaid Fraud Control Units to learn about best practices for investigative and review entities.<sup>14</sup> We assessed PERM processes and corrective actions plans against federal internal control standards and best practices for investigative and review entities.

The scope of our review is limited to the estimation of Medicare and Medicaid FFS improper payments and thus does not include other estimates of improper payments in these programs. In addition to the CERT's estimation of Medicare FFS improper payments, CMS has separate programs to estimate improper payments for Medicare's managed care and outpatient prescription drug programs, neither of which are included in the scope of our review. The PERM program estimates Medicaid improper payments for three key components of the

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<sup>13</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 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.

<sup>14</sup>See Association of Certified Fraud Examiners, *Fraud Examiners Manual: 2018 International Edition* (Austin, Tex.: Association of Certified Fraud Examiners, 2018), 3.143-3.144. The Association of Certified Fraud Examiners is an anti-fraud organization that provides anti-fraud training and education. The National Association of Medicaid Fraud Control Units is an organization that promotes interstate cooperation between Medicaid Fraud Control Units—state agencies that investigate Medicaid provider fraud, among other things.

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Medicaid program—FFS, managed care, and beneficiary eligibility determinations. Our review only examines the FFS component of the PERM program, and within the FFS component, those improper payments identified through reviews of documentation. Medicaid FFS claims are also subject to data processing reviews and these reviews are not within the scope of our review.<sup>15</sup>

We conducted this performance audit from August 2017 to March 2019 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.

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## Background

Medicare and Medicaid FFS are federal health care programs, though there are certain distinctions between the programs' coverage and financing. Medicare coverage policies are generally established at the national level, and the program directly pays providers for services rendered. Medicaid is a federal-state program, and states are provided flexibility to design their coverage policies. State Medicaid agencies pay providers for services rendered, and the federal government and states share in the financing of the program, with the federal government matching most state expenditures.

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## Estimating Improper Payments in Medicare and Medicaid

The Improper Payments Information Act of 2002 (IPIA), as amended, requires federal executive branch agencies to report a statistically valid estimate of the annual amount of improper payments for programs

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<sup>15</sup>Medicaid data processing reviews examine claims to validate that states processed the claims correctly. The reviews identify improper payments that should not have been processed, such as payments to providers that did not comply with Medicaid enrollment and screening requirements. In recent years, data processing errors have accounted for the majority of Medicaid FFS improper payments. For example, data processing errors accounted for an estimated \$35 billion in improper payments in fiscal year 2017.

identified as susceptible to significant improper payments.<sup>16</sup> To accomplish this, agencies follow guidance for estimating improper payments issued by OMB.<sup>17</sup> According to the HHS-OIG, which conducts annual compliance reviews and regularly reviews the estimation methodology for both the Medicare FFS and Medicaid improper payment measurement programs, the methodology for both programs' estimates comply with federal improper payment requirements.<sup>18</sup>

To estimate improper payments in Medicare and Medicaid FFS, respectively, CMS's CERT and PERM contractors randomly sample and manually review medical record documentation associated with FFS claims for payment from providers, also known as medical reviews.<sup>19</sup> The CERT and PERM programs project the improper payments identified in the sample to all FFS claims to estimate improper payment amounts and rates for the programs nationally for a given fiscal year. For Medicare, the CERT contractor conducted medical reviews on about 50,000 Medicare claims in fiscal year 2017. For Medicaid, the PERM contractor conducted medical reviews on nearly 31,000 Medicaid claims across fiscal years

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<sup>16</sup>IPIA, 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, and the Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, 126 Stat. 2390 (2013), codified as amended at 31 U.S.C. § 3321 note. In lieu of reporting a statistically valid estimate, agencies may report an estimate that is otherwise appropriate, using an OMB-approved methodology.

<sup>17</sup>See Office of Management and Budget, *Appendix C to Circular No. A-123, Requirements for Effective Estimation and Remediation of Improper Payments*, OMB Memorandum M-15-02 (Washington, D.C.: October 2014). OMB updated its guidance in June 2018, effective starting in fiscal year 2018 unless otherwise noted in the revised guidance. See Office of Management and Budget, *Appendix C to Circular No. A-123, Requirements for Payment Integrity Improvement*, OMB Memorandum M-18-20 (Washington, D.C.: June 2018).

<sup>18</sup>The Improper Payments Elimination and Recovery Act of 2010 requires each agency's Office of Inspector General, including the HHS-OIG, to annually determine the compliance with the agency's improper payment requirements.

<sup>19</sup>Many improper payments can be identified only by manually reviewing documentation associated with claims to determine whether the claims met program coverage policies, such as medical necessity. Medical reviews are not conducted as part of normal processing of provider claims. For example, less than 1 percent of Medicare claims undergo such reviews.

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2015, 2016, and 2017 to estimate fiscal year 2017 improper payments.<sup>20</sup> Although IPIA, as amended, only requires agencies to develop one improper payment estimate for each identified program, both the CERT and PERM programs also estimate national service-specific improper payment amounts and rates to identify services at high risk for improper payment. Additionally, the PERM program estimates state-level improper payment rates based on the amounts of improper payments identified through medical reviews in each state.<sup>21</sup>

The CERT and PERM contractors conduct medical reviews to determine whether claims were paid or denied properly in accordance with program coverage policies—including coverage policies based on statutes, regulations, other CMS coverage rules, and each state’s coverage policies in the case of Medicaid.<sup>22</sup> To perform medical reviews, trained clinicians review documentation—such as progress notes, plans of care, certificates of medical necessity, and physician orders for services—to ensure that claims meet program coverage policies.

In general, Medicare and Medicaid documentation requirements define the documentation needed to ensure that services are medically necessary and demonstrate compliance with program coverage policies. For example, Medicare home health services must be supported by documentation demonstrating compliance with the coverage policy that beneficiaries be homebound, among other requirements.<sup>23</sup> Certain coverage policies and documentation requirements were implemented to help reduce the potential for fraud, waste, and abuse. For example,

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<sup>20</sup>The PERM contractor conducted 7,599 medical reviews in fiscal year 2015, 9,964 medical reviews in fiscal year 2016, and 13,367 medical reviews in fiscal year 2017. In fiscal year 2017, the number of claims subject to medical review in a state was tied to that state’s historical improper payment rates and payment variation. The number of claims subject to medical review per state ranged from 303 to 1,063. As a result, the total number of claims sampled nationally in a given year fluctuates based on the states reviewed that year. The PERM sampling methodology has since been updated under the final rule issued in 2017. See 82 Fed. Reg. 31,158 (July 5, 2017).

<sup>21</sup>The CERT program estimates improper payment rates for the geographic jurisdictions of Medicare Administrative Contractors, which process and pay claims, and perform program integrity activities in their jurisdictions.

<sup>22</sup>Other CMS coverage rules include Medicare national and local coverage determinations and coverage provisions in CMS interpretive manuals.

<sup>23</sup>To support homebound status, referring physician documentation must include clinical information documenting that beneficiaries meet certain criteria and generally detail the beneficiaries’ inability to leave their home.

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Medicare implemented a requirement that DME providers maintain documentation demonstrating proof of item delivery, to better ensure program integrity.<sup>24</sup> (Figure 1 presents an example of a progress note to support the medical necessity of Medicare home health services. See App. III for additional examples of provider documentation).

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<sup>24</sup>See 65 Fed. Reg. 60,366 (Oct. 11, 2000) (codified at 42 C.F.R. § 424.57(c)(12)).

**Figure 1: Example Progress Note to Support Medicare Home Health Services**

**Progress Notes**

**Patient:** Patient, John  
**DOB:** 07/20/1943  
**Address:** 321 Main St., Happyplace, MD 12345

**Provider:** Jane Doctor, M.D.  
**Date:** 04/29/2018

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**Subjective:**  
**CC:**  
1. Wound on left heel.

**HPI:**  
Pt is here for evaluation of wound on left heel. Patient reports his daughter noticed the wound on patient's heel when washing his feet. Patient states he has difficulty with reaching his feet and his daughter will sometimes clean them for him. He reports he uses a shoe horn to put on his shoes.

**ROS:**  
General: No weight change, no fever, no weakness, no fatigue.  
Cardiology: No chest pain, no palpitations, no dizziness, no shortness of breath.  
Skin: Wound on left lower heel, no pain.

**Medical History:** HTN, hyperlipidemia, hypothyroidism, DJD.  
**Medications:** Zolpidem 10 mg tablet 1 tab once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day.  
**Allergies:** NKDA

**Objective:**  
**Vitals:** Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"

**Examination:** General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

**Assessment:**  
1. Open wound left heel

**Plan:**  
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, he is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family for dressing changes.

**Follow Up:** Return office visit in 2 weeks.

*Jane Doctor, M.D. 4/29/2018*

**Provider:** Jane Doctor, M.D.

Source: Centers for Medicare & Medicaid Services. | GAO-19-277

The CERT and PERM contractors classify improper payments identified through medical review by the type of payment error. Two types of errors

are related to documentation—no documentation and insufficient documentation.<sup>25</sup>

- **No documentation:** Improper payments in which providers fail to submit requested documentation or respond that they do not have the requested documentation.
- **Insufficient documentation:** Improper payments in which providers submit documentation that is insufficient to determine whether a claim was proper, such as when there is insufficient documentation to determine if services were medically necessary, or when a specific, required documentation element, such as a signature, is missing.

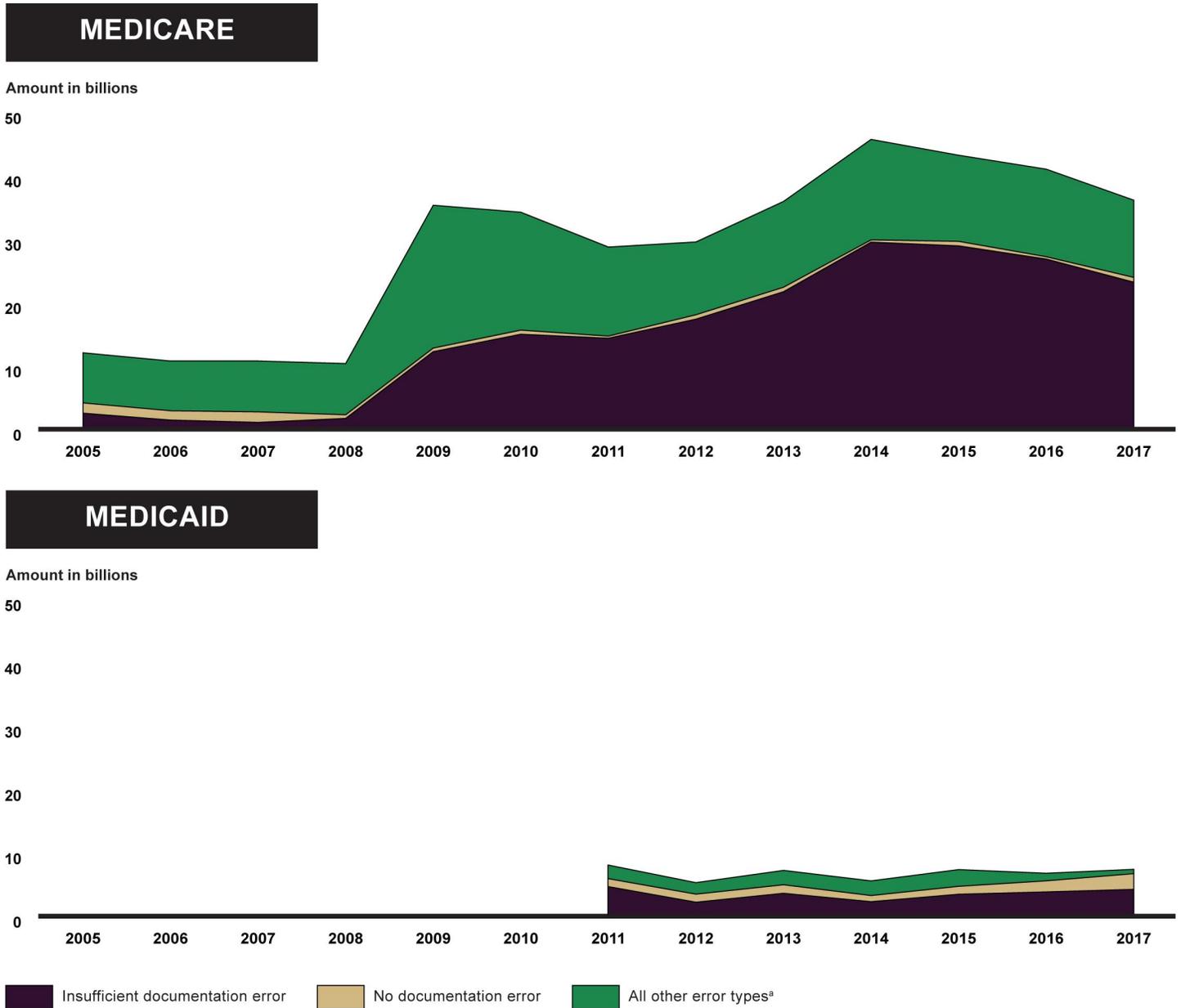
In fiscal year 2017, insufficient documentation comprised the majority of estimated FFS improper payments in both Medicare and Medicaid, with 64 percent of Medicare and 57 percent of Medicaid medical review improper payments. Improper payments stemming from insufficient documentation in Medicare FFS increased substantially starting in 2009, while insufficient documentation in Medicaid has remained relatively stable since 2011 (see Fig. 2).<sup>26</sup>

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<sup>25</sup>Other error types include improper payments due to incorrect procedure or service coding, and errors in which the service was determined to be not medically necessary based on program coverage policies.

<sup>26</sup>Prior to 2011, CMS did not separately report Medicaid improper payments for medical review error categories.

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



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.

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<sup>a</sup>All other error types include those not related to no or insufficient documentation, such as medical necessity, and incorrect coding errors.

CMS has attributed the increase in Medicare insufficient documentation since 2009 in part to changes made in CERT review criteria. Prior to 2009, CERT medical reviewers used “clinical inference” to determine that claims were proper even when specific documentation was missing if, based on other documentation and beneficiary claim histories, the reviewers could reasonably infer that the services were provided and medically necessary. Beginning with CMS’s fiscal year 2009 CERT report, in response to 2008 HHS-OIG recommendations, CMS revised the criteria for CERT medical reviews to no longer allow clinical inference and the use of claim histories as a source of review information.<sup>27</sup> More recent policy changes that added to Medicare documentation requirements may have also contributed to the increase in insufficient documentation in Medicare FFS.

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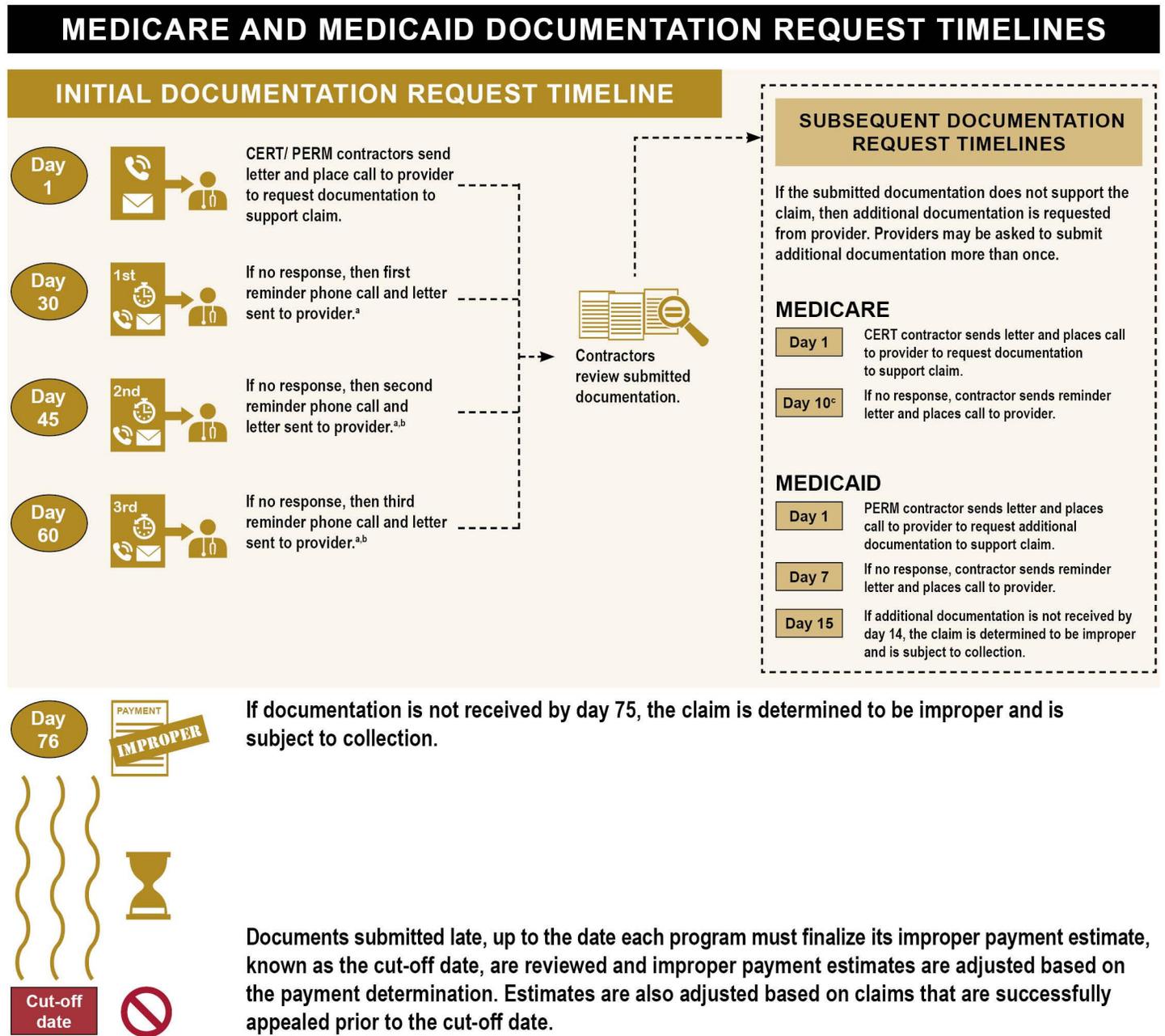
## CMS’s Medicare and Medicaid Contractors Make Multiple Attempts to Contact Providers to Obtain Documentation to Estimate Improper Payments

Medicare’s CERT and Medicaid’s PERM contractors make multiple attempts to contact providers to request medical record documentation for medical reviews, and review all documentation until they must finalize the FFS improper payment estimate. The CERT and PERM contractors allow providers 75 days to submit documentation, though providers can generally submit late documentation up to the date each program must finalize its improper payment estimate, known as the cut-off date (See Fig. 3.). Both programs also contact providers to subsequently request additional documentation if the initial documentation submitted by the providers does not meet program requirements.

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<sup>27</sup>HHS-OIG, *Medical Review of Claims for the Fiscal Year 2006 Comprehensive Error Rate Testing Program*, A-01-07-00508 (Washington D.C.: Aug. 2008). According to CMS and PERM contractor officials, PERM reviewers do not use clinical inference for Medicaid medical reviews.

Figure 3: Medicare and Medicaid Fee-for-Service Documentation Request Timelines to Estimate Improper Payments



Day 76





If documentation is not received by day 75, the claim is determined to be improper and is subject to collection.

Cut-off date



Documents submitted late, up to the date each program must finalize its improper payment estimate, known as the cut-off date, are reviewed and improper payment estimates are adjusted based on the payment determination. Estimates are also adjusted based on claims that are successfully appealed prior to the cut-off date.

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

Note: Medicare's Comprehensive Error Rate Testing (CERT) and Medicaid's Payment Error Rate Measurement (PERM) contractors estimate Medicare's and Medicaid's improper payment rates.

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<sup>a</sup>Reminder phone calls are placed around the time the letter is sent. For example, the CERT contractor places the first reminder call on day 25.

<sup>b</sup>Medicare providers are given 45 days to respond to the CERT contractor's documentation requests. However, providers are automatically given 15 day extensions on day 45 and day 60; claims are not determined to be improper until day 76.

<sup>c</sup>Unlike Medicaid, Medicare claims are not automatically determined to be improper after two weeks if additional documentation is not received. The CERT contractor told us that they may continue to contact providers to obtain additional documentation, though the claim will ultimately be determined to be improper if additional documentation is not provided.

**Initial documentation request:** The CERT and PERM contractors make initial requests for documentation by sending a letter and calling the provider. After the initial provider request, if there is no response, the contractors contact the provider at least three additional times to remind them to submit the required documentation. If there is no response, the claim is determined to be improper due to no documentation. Claims are also classified as improper due to no documentation when the provider responds but cannot produce the documentation, such as providers that do not have the beneficiary's documentation or records for the date of service, among other reasons (see Table 1). For referred services, such as home health, DME, and laboratory services, the CERT contractor also conducts outreach to referring physicians to request documentation.<sup>28</sup> For example, for a laboratory claim, the CERT contractor may contact the physician who ordered the laboratory test to request associated documentation, such as progress notes. Conversely, the PERM contractor told us they generally do not contact referring physicians to request documentation.

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<sup>28</sup>Certain nonphysician practitioners may refer for certain services. For example, nurse practitioners and physician assistants may refer for DME items. Additionally, institutional facilities refer for services, such as facilities that refer for home health services upon beneficiary discharge. For the purposes of this report, the term "referring physician" is inclusive of referring nonphysician practitioners and institutional facilities.

**Table 1: Medicare and Medicaid Estimated Fee-for-Service Improper Payments Due to No Documentation, by Cause, Fiscal Year 2017**

Program	Cause	Number of improper payments due to no documentation	Total estimated improper payments (in millions of dollars)
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	No medical records were submitted (e.g. only cover sheet, billing records, etc.) or provider did not respond	112	Not available (NA)
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	Provider said medical records not found for date of service or unable to locate records	49	NA
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	Provider said beneficiary is not their patient	16	NA
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	Provider no longer in business	4	NA
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	Provider said that a third-party provider has medical record	3	NA
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	Provider said that a different department within the provider fulfills documentation requests	2	NA
Medicare Comprehensive Error Rate Testing (CERT) <sup>a</sup> program	<b>CERT Total</b>	<b>186</b>	<b>613.2</b>
Medicaid Payment Error Rate Measurement (PERM) program	Provider did not respond to request	188	947.3
Medicaid Payment Error Rate Measurement (PERM) program	Provider said services not provided on date requested	41	895.0
Medicaid Payment Error Rate Measurement (PERM) program	Provider under fraud investigation <sup>b</sup>	27	85.7

Program	Cause	Number of improper payments due to no documentation	Total estimated improper payments (in millions of dollars)
Medicaid Payment Error Rate Measurement (PERM) program	Provider said beneficiary not on file or in system	16	141.3
Medicaid Payment Error Rate Measurement (PERM) program	Provider billed in error	12	112.3
Medicaid Payment Error Rate Measurement (PERM) program	State could not locate provider	12	60.2
Medicaid Payment Error Rate Measurement (PERM) program	Other <sup>c</sup>	32	244.1
Medicaid Payment Error Rate Measurement (PERM) program	<b>PERM Total</b>	<b>328</b>	<b>2,485.9</b>

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

<sup>a</sup>The number of Medicare FFS improper payments may include the entire claim or a line-item within a claim for a service; a single claim or line-item within a claim may include multiple error causes. CMS does not project dollar amounts by cause for Medicare FFS because one claim or line-item could have more than one error cause.

<sup>b</sup>If a state notifies the PERM contractor that documentation for a specific provider is not available due to an ongoing investigation, the PERM stops requesting documentation from the provider, and the claim is cited as a no documentation error.

<sup>c</sup>Includes causes of no documentation errors with fewer than 10 improper payments, including instances where the provider said they could not locate the records; billed for the wrong beneficiary; are no longer in business; submitted documentation for the wrong date of service; or submitted only billing information.

**Subsequent documentation request:** If a provider initially submits documentation that is insufficient to support a claim, then the CERT and PERM contractors subsequently request additional documentation.

- In fiscal year 2017, of the 50,000 claims in the CERT sample, the contractor requested additional documentation from 22,815 providers.<sup>29</sup> Providers did not submit additional documentation to sufficiently support 56 percent of the associated claims.

<sup>29</sup>Includes requests for documentation sent to both billing providers and referring physicians for the same claim. Accordingly, the number of claims subject to subsequent documentation requests is less than the number of providers.

- For the 3 years that comprise the 2017 Medicaid improper payment rate, of the nearly 31,000 claims in the PERM sample, the contractor requested additional documentation for 5,448, and providers did not submit additional documentation to sufficiently support about 8 percent of the 5,448 claims.

In addition to having similar outreach to providers for obtaining documentation, the CERT and PERM contractors also have processes to refer suspected fraud to the appropriate program integrity entity, to ensure the accuracy of medical reviews, and to allow providers to dispute improper payment determinations.

**Suspected fraud:** When CERT and PERM contractors identify claims with evidence of suspected fraud, they are required to refer the claims to other program integrity entities that are responsible for investigating suspected fraud.<sup>30</sup> CERT and PERM contractor officials said that in 2017, the CERT contractor referred 35 claims, and the PERM contractor did not make any referrals.

**Interrater reliability (IRR) reviews:** As a part of their medical review processes, both the CERT and PERM contractors conduct IRR reviews, where two reviewers conduct medical reviews on the same claim and compare their medical review determinations. These IRR reviews ensure the consistency of medical review determinations and processes for resolving differences identified through the IRR reviews. CMS staff said that they also review a sample of the CERT and PERM contractors' payment determinations to ensure their accuracy.

- **CERT:** The contractor performs IRR reviews for at least 300 claims each month, including claims with and without improper payment determinations.
- **PERM:** The contractor conducts IRR reviews of all improper payment determinations, except improper payments due to no documentation, and 10 percent of all correctly paid claims in the sample, which combined was about 3,600 claims for the fiscal year 2017 national

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<sup>30</sup>The CERT and PERM contractors do not estimate fraud in the programs, and their medical reviews are not intended or well-suited to detecting fraud. The CERT and PERM contractors review a random sample of claims and, according to CMS officials, generally only review a single claim for a given provider. Identifying suspected fraud requires activities specifically designed to detect the intent to defraud, such as identifying suspicious billing patterns of a particular provider.

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improper payment rate.<sup>31</sup>

**Disputing improper payment determinations:** Both CERT and PERM contractors have processes in place for disputing the CERT or PERM contractor's improper payment determinations. These processes involve reviewing the claim, including any newly submitted documentation, and may result in upholding or overturning the initial improper payment determination. Improper payment determinations that are overturned prior to the CERT and PERM contractors' cut-off dates are no longer considered improper, and estimated improper payment amounts and rates are adjusted appropriately.<sup>32</sup>

- **CERT:** Medicare Administrative Contractors, which process and pay claims, may dispute the CERT contractor's improper payment determinations first with the CERT contractors and then, if desired, with CMS. Additionally, Medicare providers can appeal the CERT contractor's improper payment determinations through the Medicare appeals process.<sup>33</sup>
- **PERM:** State Medicaid officials may dispute the PERM contractor's improper payment determinations first with the PERM contractor and then, if desired, with CMS. Providers are not directly involved in this process; instead, providers can contact the state to appeal the improper payment determination.

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## Differing Medicare and Medicaid Documentation Requirements May Result in Inconsistent Assessments of Program Risks

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<sup>31</sup>The PERM contractor does not conduct IRR reviews on improper payment determinations due to no documentation.

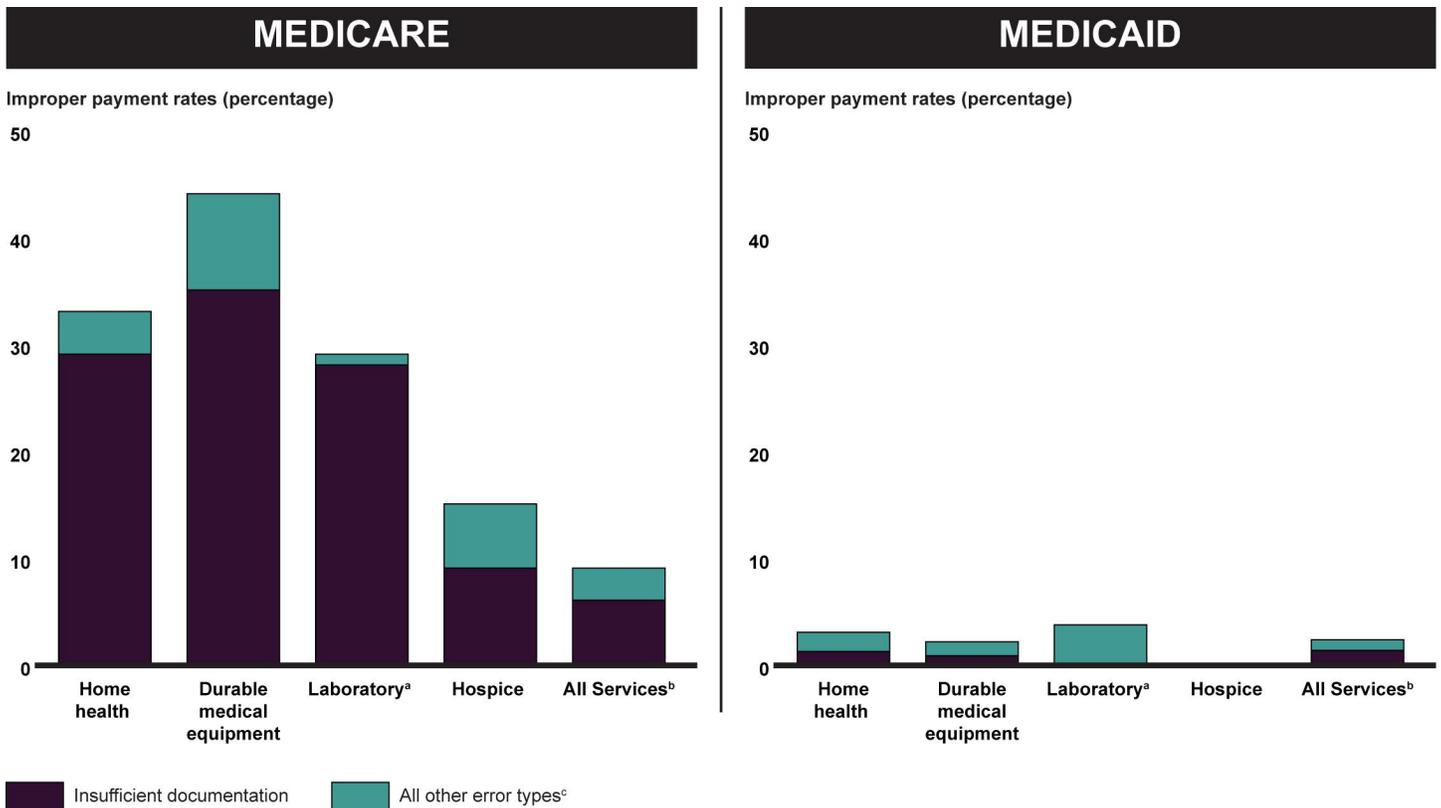
<sup>32</sup>Because the PERM operates on a 3-year review cycle, improper payment determinations that are successfully overturned after the PERM cutoff date are not considered improper in subsequent year's improper payment estimates.

<sup>33</sup>For more information on Medicare's appeals process, see GAO, *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process*, [GAO-16-366](#) (Washington, D.C.: May 10, 2016).

## Differences in Documentation Requirements for Medicare and Medicaid May Result in Differing Improper Payment Rates and Assessments of Program Risks

We found that Medicare, relative to Medicaid, had a higher estimated FFS improper payment rate primarily due to insufficient documentation in fiscal year 2017. According to CMS data, across all services in fiscal year 2017, the rate of insufficient documentation was 6.1 percent for Medicare and 1.3 percent in Medicaid, substantially greater than the difference in rates for all other types of errors, which were 3.4 and 1.0 percent, respectively. For home health, DME, and laboratory services, the insufficient documentation rate was at least 27 percentage points greater for Medicare than for Medicaid, and for hospice services, the rate was 9 percentage points greater (see Fig. 4).

**Figure 4: Estimated Medical Review Improper Payment Rates in Medicare and Medicaid Fee-for-Service by Selected Service Categories, Fiscal Year 2017**



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

Note: Medical review refers to the process through which trained reviewers manually examine medical record documentation associated with provider claims to identify improper payments.

<sup>a</sup>The Medicare laboratory service category is specific to laboratories that are clinically independent and bill Medicare Part B, while the Medicaid laboratory service category includes laboratory, X-ray, and imaging services. While the categories are not directly comparable, the magnitude of the differences in rates illustrates substantial differences in improper payments due to insufficient documentation for laboratory services.

<sup>b</sup>Totals are for all Medicare and Medicaid services, not only the services in the figure.

<sup>c</sup>All other error types include no documentation, medical necessity, incorrect coding, and other error categories.

Differences between Medicare and Medicaid coverage policies and documentation requirements likely contributed to the substantial variation in the programs' insufficient documentation rates for the services we examined. Among the services we examined, there are four notable differences in coverage policy and documentation requirements that likely affected how the programs conducted medical reviews: face-to-face examinations; prior authorization; signature requirements; and documentation from referring physicians for referred services, as discussed below.

**Face-to-face examinations.** In part to better ensure program integrity, the Patient Protection and Affordable Care Act established a requirement for referring physicians to conduct a face-to-face examination of beneficiaries as a condition of payment for certain Medicare and Medicaid services.<sup>34</sup> States were still in the process of implementing the policies for Medicaid in fiscal year 2017.

**Examples of insufficient documentation in Medicare hospice**

- Certification document did not include narrative information that sufficiently supported that the beneficiary had a life expectancy of less than 6 months.
- Certification document did not include the certification date span.

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<sup>34</sup>CMS implemented face-to-face examination requirements for certain services based on provisions in the Patient Protection and Affordable Care Act. See Pub. L. No. 111-148, §§ 3132, 6407, 124 Stat. 119, 430, 769 (2010) (codified as amended at 42 U.S.C. §§ 1395f, 1395f note, 1395n).

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- Medicare requires home health and DME providers to submit documentation supporting that the referring physician conducted an examination when certifying the medical necessity of the service. Hospice providers must submit documentation of a face-to-face examination when recertifying the medical necessity of hospice services for beneficiaries who receive care beyond 6 months after their date of admission.<sup>35</sup> (See sidebar for examples of insufficient documentation in Medicare hospice services.) CMS officials told us that documentation requirements for the face-to-face examination policy for home health services in particular led to an increase in insufficient documentation. When initially implemented in April 2011, home health providers had to submit separate documentation from the referring physician detailing the examination and the need for home health services. Beginning January 2015, CMS changed the requirement to allow home health providers to instead use documentation from the referring physician, such as progress notes, to support the examinations. CMS and several stakeholders attributed recent decreases in the home health improper payment rate to the amended documentation requirement (see Fig. 5).
- CMS implemented a similar face-to-face examination policy for home health and DME services in Medicaid in 2016; however, the requirement likely did not apply to many claims subject to fiscal year 2017 PERM medical reviews.<sup>36</sup> Medicaid does not have a face-to-face policy for hospice services, and most states we interviewed did not have such policies. (See sidebar for examples of insufficient documentation in Medicaid.)

**Examples of insufficient documentation in Medicaid**

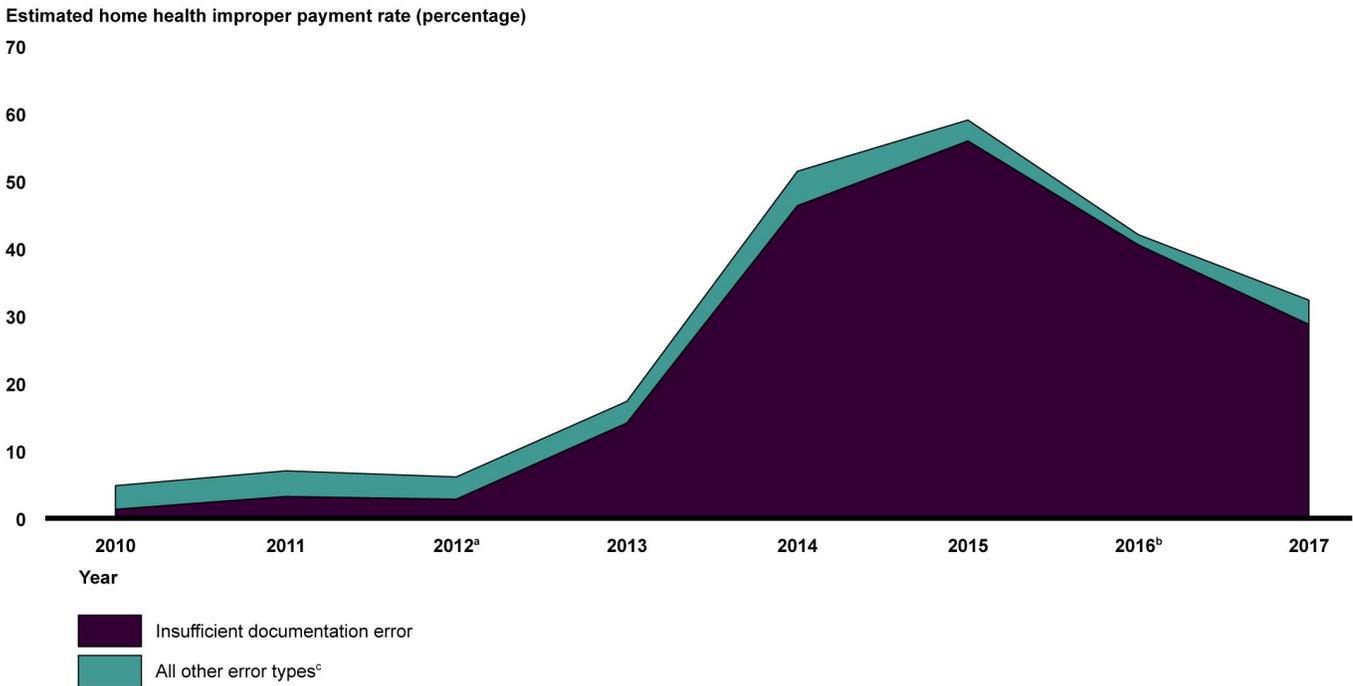
- Durable medical equipment provider did not submit physician order or proof of delivery for item.
- Plan of care submitted by home health agency did not apply to the sampled day of care associated with the claim.

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<sup>35</sup>Medicare covers hospice services for beneficiaries with terminal illnesses who have been certified by a physician as having a life expectancy of 6 months or less, and recertified every 60 days for care beyond 6 months; each recertification must include a face-to-face examination. See 42 C.F.R. § 418.22(a)(4) (2017).

<sup>36</sup>In February 2016, CMS issued a final rule implementing the home health and DME requirement for Medicaid effective July 1, 2016. However, CMS delayed the compliance date for certain states for up to 2 years. See 81 Fed. Reg. 5530 (Feb. 2, 2016). Because of the requirements' delayed compliance date, Medicaid's 2017 improper payment estimate for home health and DME services likely did not include many claims subject to the face-to-face requirement.

**Figure 5: Medicare Fee-for-Service Estimated Improper Payment Rate for Home Health Services, FY 2010-2017**



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

<sup>a</sup>The Medicare sample for fiscal year 2012, which included claims from July 1, 2010 through June 30, 2011, was the first partial year in which claims subject to the documentation requirements associated with the face-to-face examination policy were reviewed.

<sup>b</sup>The Medicare sample for fiscal year 2016, which included claims from July 1, 2014 through June 30, 2015, was the first partial year in which claims subject to the amended documentation requirements were reviewed.

<sup>c</sup>All other error types include no documentation, medical necessity, incorrect coding, and other error categories.

**Prior authorization.** Medicare does not have the same broad authority as state Medicaid agencies to implement prior authorization, which can be used to review documentation and verify the need for coverage prior to services being rendered. State Medicaid agencies we spoke with credit prior authorization with preventing improper payments from being paid in the first place.

- CMS has used prior authorization in Medicare for certain services through temporary demonstration projects and models, as well as one permanent program. In April 2018, we found that savings from a series of Medicare temporary demonstrations and models that began in 2012 could be as high as about \$1.1 to \$1.9 billion as of March

2017. We recommended that CMS take steps, based on its evaluations of the demonstrations, to continue prior authorization.<sup>37</sup>

- All six of our selected states use prior authorization in Medicaid for at least one of the four services we examined. In particular, all six selected states require prior authorization for DME, and five require prior authorization for home health.<sup>38</sup> Officials from several states noted that they often apply prior authorization to services at high risk for improper payments, and most told us that prior authorization screens potential improper payments before services are rendered. We did not evaluate the effectiveness of states' use of prior authorization, or review the documentation required by states for prior authorization. (See Fig 6 for an example state Medicaid prior authorization form.)

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<sup>37</sup>See GAO, *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*, [GAO-18-341](#) (Apr 20, 2018). CMS neither agreed nor disagreed with our recommendation but said it would continue to evaluate the potential use of prior authorization in Medicare.

<sup>38</sup>These states may only subject certain services, such as specific DME items, to prior authorization.

**Figure 6: Example State Medicaid Agency Prior Authorization Form**

1.1 Prior Authorization Request Form and Supplies		
<p><b>Prior Authorization Request Form – General Instructions</b></p> <ul style="list-style-type: none"> <li>• Submit all requests 2 weeks prior to scheduled date of service.</li> <li>• Incomplete forms will be returned and may delay the authorization process.</li> <li>• Documentation related to the service(s) requested should be sent with the request.</li> <li>• FAX or mail completed forms to the FAX number/address at right.</li> </ul> <p>The Delaware Medical Assistance Program manuals are available for instructions and form downloads at <a href="https://medicaid.dhss.delaware.gov">https://medicaid.dhss.delaware.gov</a>.</p> <p>For questions, contact Provider Services at 800-999-3371.</p>	<p><b>Fax To: 1-302-255-4481</b></p> <p>Department of Health &amp; Social Services Division of Medicaid &amp; Medical Assistance 1901 N. Dupont Hwy, Lewis Building P.O. Box 906 New Castle, DE 19720</p> <p>Date Received: _____ FFS Eligibility Effective Date: _____</p>	
<b>A. MEMBER INFORMATION</b>		
Name:	Member ID:	D.O.B.:
Address:		Phone:
<b>Other Health Insurance (OHI) Information</b>		
Name of OHI:	Policy #:	
Policyholder Name:	Policyholder SSN:	
<b>B. ORDERING PROVIDER INFORMATION</b>		
Name:	FAX #:	
Address:		
Person Completing Form:	Telephone #:	
NPI (National Provider ID) + Taxonomy:		
<b>C. PRIMARY PHYSICIAN INFORMATION</b>		
Name:	FAX #:	
NPI (National Provider ID) + Taxonomy:	Telephone #:	
<b>D. DME / HHC INFORMATION</b>		
Name:	Telephone #:	
NPI (National Provider ID) + Taxonomy:		
<b>E. SERVICE INFORMATION</b>		
Service Dates: FROM:	TO:	Continuation of Service <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diagnosis(es) / Service(s) / Procedure(s)</b>		
Diagnosis(es) / ICD-9 & ICD-10:		
CPT / HCPCS Codes:		
<b>F. PLACE OF SERVICE:</b> <span style="float: right;">Out of State Provider: Yes <input type="checkbox"/> No <input type="checkbox"/></span>		
Name:	Telephone #:	
NPI (National Provider ID) + Taxonomy:	FAX #:	
<b>CHECK SERVICES REQUESTED</b>		
<input type="checkbox"/> Durable Medical Equipment (DME) specify	<input type="checkbox"/> Surgery / Diagnostic Testing / Other	<input type="checkbox"/> Home Health Care (HHC) Service(s) – Please
<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> Skilled Nursing Visits	<input type="checkbox"/> Home Health Aid (if greater than two hours per day)
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy
Comments:		
<b>DO NOT WRITE BELOW THIS LINE</b>		
Date Received:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Incomplete	Authorization #:
Comments:		
<input checked="" type="checkbox"/> Signature:	Date:	

Source: Delaware Department of Health and Social Services. | GAO-19-277

**Example of insufficient documentation in Medicare home health**

- Documentation did not include actual clinical notes for the face-to-face encounter visit examination.

**Example of insufficient documentation in**

**Medicare durable medical equipment**

- Documentation from the referring physician did not support the medical necessity for the specific type of catheter ordered.

**Examples of insufficient documentation in Medicare laboratory**

- Documentation from the referring physician did not support the order or an intent to order the billed laboratory tests.
- Documentation from the referring physician did not support that the beneficiary's currently has diabetes for a billed laboratory test for the management and control of diabetes.

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**Physician signatures:** While both Medicare and state Medicaid agencies require signatures on provider documents to ensure their validity, Medicare has detailed standards for what constitutes a valid signature.

- Medicare's signature standards address the validity of signatures in a variety of situations. For example, illegible signatures and initials on their own are generally invalid, though they are valid when over a printed name.<sup>39</sup>
- In Medicaid, PERM contractor staff told us that state agencies generally have not set detailed standards for valid signatures, and that reviewers generally rely on their judgment to assess signature validity.

**Documentation for referred services.** Medicare requires documentation from referring physicians to support the medical necessity of the referred services that we examined—home health, DME, and laboratory services—but Medicaid generally does not require such documentation.

- Medicare generally requires documentation from the referring physician, such as progress notes, to support the medical necessity of referred services.<sup>40</sup> CMS officials told us that Medicare requires such documentation from referring physicians to ensure that medical necessity determinations are independent of the financial incentive to provide the referred service, particularly as certain referred services are high risk for fraud, waste, and abuse.<sup>41</sup> (See sidebar for examples of insufficient documentation in Medicare home health, DME, and laboratory services.)

<sup>39</sup>For information on Medicare signature requirements, see CMS, Chapter 3, "Verifying Potential Errors and Taking Corrective Actions," *Medicare Program Integrity Manual*, accessed Nov. 2, 2018, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf>.

<sup>40</sup>Documentation generated by home health agencies, such as plans of care, can be used to support medical necessity in Medicare under certain conditions. See 42 U.S.C. § 1395f(a). Referring physicians must sign and incorporate the home health agencies' documentation into their medical records, and the home health agencies' documentation must be corroborated by the referring physicians' other medical records.

<sup>41</sup>We have previously reported on concerns related to improper payments in Medicare home health and DME services. See GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009) and GAO, *Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs*, GAO-05-43 (Washington, D.C.: Nov. 17, 2004).

- In Medicaid, documentation requirements to support the medical necessity of referred services are primarily established by states, and states generally do not require documentation, such as progress notes from referring physicians, to support medical necessity. Further, PERM contractor staff told us that they generally do not review such documentation when conducting medical reviews of claims for referred services.<sup>42</sup>

Officials from CMS, the CERT contractor, and provider associations told us that Medicare's documentation requirements for referred services present challenges for providers of referred services to submit sufficient documentation since they are dependent on referring physician documentation to support medical necessity. Some officials further stated that referring physicians may lack incentive to ensure the sufficiency of such documentation, as they do not experience financial repercussions when payments for referred services are determined to be improper. Officials told us that:

- It is generally not standard administrative practice for laboratories or DME providers to obtain referring physician documentation, and referring physicians may not submit them when the referred services are subject to medical review. For example, laboratories generally render services based solely on physician orders for specific tests, and generally do not obtain associated physician medical records.
- Referring physicians may not document their medical records in a way that meets Medicare documentation requirements to support the medical necessity of referred services. Officials from a physician organization told us that physicians refer beneficiaries for a broad array of services, and face challenges documenting their medical records to comply with Medicare documentation requirements for various referred services. We previously reported on CMS provider education efforts and recommended that CMS take steps to focus education on services at high risk for improper payments and to better educate referring physicians on documentation requirements for DME and home health services.<sup>43</sup> CMS agreed with and has fully addressed our recommendation.

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<sup>42</sup>The PERM contractor does not instruct providers of referred services to submit documentation, such as progress notes from referring physicians, to support medical necessity.

<sup>43</sup>See GAO, *Medicare Provider Education: Oversight of Efforts to Reduce Improper Billing Needs Improvement*, [GAO-17-290](#) (Washington, D.C.: Mar 10, 2017).

Medicare and Medicaid pay for many of the same services, to some of the same providers, and likely face many of the same underlying program risks.<sup>44</sup> However, because of differences in documentation requirements between the two programs, the same documentation for the same service can be sufficient in one program but not the other. The substantial variation in the programs' improper payment rates raise questions about how well their documentation requirements help in determining whether services comply with program coverage policies, and accordingly help identify causes of program risks. This is inconsistent with federal internal control standards, which require agencies to identify, analyze, and respond to program risks.<sup>45</sup>

CMS officials attributed any differences in the two programs' documentation requirements to the role played by the states in establishing such requirements under Medicaid, and told us that they have not assessed the implications of how differing requirements between the programs may lead to differing assessments of the programs' risks. CMS relies on improper payment estimates to help develop strategies to reduce improper payments, such as informing Medicare's use of routine medical reviews, educational outreach to providers, and efforts to address fraud.<sup>46</sup> Without a better understanding of how documentation requirements affect estimates of improper payments, CMS may not have the information it needs to effectively identify and analyze program risks, and develop strategies to protect the integrity of the Medicare and Medicaid programs.

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<sup>44</sup>In recent years CMS has made efforts to align Medicare FFS and Medicaid program integrity efforts, indicating CMS's recognition of the overlaps and similarities of the risks faced by the two programs. For example, in 2010, CMS created the Center for Program Integrity, which consolidated the agency's program integrity functions for Medicare and Medicaid.

<sup>45</sup>See [GAO-14-704G](#).

<sup>46</sup>CMS conducts routine medical reviews on Medicare claims as part of its strategy to reduce improper payments. For additional information on Medicare medical review efforts, see GAO, *Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data*, [GAO-16-394](#) (Washington, D.C.: Apr 13, 2016). For additional information on Medicare provider education, see [GAO-17-290](#). For additional information on Medicare efforts to combat fraud, see GAO, *Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud*, [GAO-17-710](#) (Washington, D.C.: Aug 30, 2017).

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## CMS Has Ongoing Efforts to Examine Insufficient Documentation in Medicare and Revise Documentation Requirements

CMS's Patients over Paperwork initiative is an ongoing effort to simplify provider processes for complying with Medicare FFS requirements, including documentation requirements. Although CMS officials said this initiative is intended to help providers meet documentation requirements in both Medicare and Medicaid, current efforts only address Medicare documentation requirements. As part of the initiative, CMS solicited comments from stakeholders through proposed rulemaking on documentation requirements that often lead to insufficient documentation, and CMS officials stated that they have met with provider associations to obtain feedback. The initiative is generally focused on reviewing documentation requirements the agency has the authority to easily update, namely requirements that are based on CMS coverage rules, as opposed to requirements based on statute. Through this initiative, CMS has clarified and amended several Medicare documentation requirements. For example, CMS clarified Medicare documentation requirements for DME providers to support proof of item delivery.<sup>47</sup>

As part of another initiative to examine insufficient documentation in Medicare, CMS found that 3 percent of improper payments due to insufficient documentation were clerical in nature in fiscal year 2018.<sup>48</sup> For the CERT's fiscal year 2018 medical reviews, the CERT contractor classified whether improper payments due to insufficient documentation were clerical in nature—meaning the documentation supported that the service was covered and necessary, had been rendered, and was paid correctly, but did not comply with all Medicare documentation requirements. Such errors would not result in an improper payment determination if the documentation had been corrected. For example,

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<sup>47</sup>The documentation component of the Patients over Paperwork initiative is also known as the Documentation Requirements Simplification initiative. For a list of documentation requirements that have been updated, see <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/SimplifyingRequirements.html> (accessed December 21, 2018).

<sup>48</sup>For the purposes of our report, we refer to these errors as "clerical". CMS refers to these errors as "documentation non-compliance errors." For additional information on such errors, see *Department of Health and Human Services: FY2018 Agency Financial Report* (Washington, D.C., Nov. 14, 2018).

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such clerical errors may involve missing documentation elements that may be found elsewhere within the medical records.<sup>49</sup>

According to CMS officials, the information gathered on clerical errors may inform efforts to simplify documentation requirements. Specifically, CMS plans to use this information to help identify requirements that may not be needed to demonstrate medical necessity or compliance with coverage policies. CMS said that it does not plan to engage in similar efforts to examine insufficient documentation errors in Medicaid because of challenges associated with variations in state Medicaid documentation requirements and the additional burden it would place on states.

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## Medicaid Medical Reviews May Not Provide Actionable Information for States, and Other Practices May Compromise Fraud Investigations

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### Medicaid Medical Reviews Do Not Provide Robust State-Specific Information; Resulting Corrective Actions May Not Address the Most Prevalent Causes of Improper Payments

On a national basis, CMS's PERM program generates statistically valid improper payment estimates for the Medicaid FFS program. At the state level, however, CMS officials told us that the PERM contractor's medical reviews do not generate statistically generalizable information about improper payments by service type and, as a result, they do not provide robust state-specific information on the corrective actions needed to address the underlying causes of improper payments.

According to CMS, the number of improper payments identified through medical reviews is too small to generate robust state-specific results. In fiscal year 2017, the PERM contractor identified 918 improper payments

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<sup>49</sup>Claims for referred services that were determined to be improper because of issues with referring physician medical record documentation were not considered clerical errors because such payments do not sufficiently document the medical necessity of the referred services.

nationwide out of nearly 31,000 claims subjected to medical reviews.<sup>50</sup> More than half of all states had 10 or fewer improper payments identified through medical reviews in fiscal year 2017, and these made up about 7 percent of total sample improper payments identified through medical reviews (see Table 2).

**Table 2: Number of Improper Medicaid Fee-for-Service Payments Identified through the Payment Error Rate Measurement (PERM) Program’s Medical Reviews, Fiscal Year 2017**

Number of Improper Payments Identified through Medical Reviews <sup>a</sup>	Number of States in Range	Amount of Improper Payments <sup>b</sup> (dollars)	Percent of Improper Payments <sup>c</sup>
1-10	27	97,491	7
11-25	10	141,201	10
26-40	6	476,261	34
41-55	5	431,630	31
56-67	3	255,791	18
<b>Total 918</b>	<b>51</b>	<b>1,402,374</b>	<b>100</b>

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

Note: Table includes data from all 50 states and the District of Columbia.

<sup>a</sup>Medical review refers to the process through which trained reviewers manually examine medical record documentation associated with provider claims to identify improper payments. The total presented includes 40 medical technical deficiencies that do not result in an improper payment, such as an incorrect date of service that is less than 7 calendar days before or after the actual date of service.

<sup>b</sup>Amount of improper payments is the aggregated total dollars identified through medical reviews of a sample of claims. It is not the projected amount of improper payments in Medicaid fee-for-service.

<sup>c</sup>Percent of improper payments represents the percent of the sample subjected to medical reviews. It is not the percent of all improper payments in Medicaid fee-for-service.

According to CMS officials, estimating improper payments for specific service types within each state with the same precision as the national estimate would involve substantially expanding the number of medical reviews conducted and commensurately increasing PERM program costs. CMS officials also estimated federal spending on PERM Medicaid FFS medical reviews at about \$8 million each year, which does not include state costs, the federal share of the state costs, or providers’ costs.<sup>51</sup> Of our six selected states, officials from one state said that data on service-specific improper payment rates at the state level would be

<sup>50</sup>This total includes 40 medical technical deficiencies which do not result in an improper payment, such as an incorrect date of service that is less than 7 calendar days before or after the actual date of service.

<sup>51</sup>CMS estimates that the PERM medical reviews cost providers \$93,192 annually.

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useful, though officials had reservations about increasing sample sizes because of the resources involved in doing so.<sup>52</sup>

CMS requires state Medicaid agencies to develop corrective actions to rectify each improper payment identified. However, since the Medicaid review sample in a state typically is not large enough to be statistically generalizable by service type, the identified improper payments may not be representative of the prevalence of improper payments associated with different services within the state. Accordingly, corrective actions designed to rectify specific individual improper payments may not address the most prevalent underlying causes of improper payments. For example, state Medicaid officials in four of our six states said that most improper payments identified through PERM medical reviews are unique one-time events. Federal internal control standards require agencies to identify and analyze program risks so they can effectively respond to such risks, and OMB expects agencies to implement corrective actions that address underlying causes of improper payments.<sup>53</sup> Without estimates that provide information on the most prevalent underlying causes of improper payments within a state, particularly by service type, a state Medicaid agency may not be able to develop appropriate corrective actions or prioritize activities to effectively address program risks. Corrective actions that do not address the underlying causes of improper payments are unlikely to be an effective use of state resources.

Increasing sample sizes of the PERM is one approach that could improve the usefulness of the medical reviews for states—but other options also exist. For example, PERM findings could be augmented with data from other sources—such as findings from other CMS program integrity efforts, state auditors, and HHS-OIG reports. States conduct their own program integrity efforts, including medical reviews, to identify improper payments and state Medicaid officials we spoke with in four of our six selected states said that they largely rely on such efforts to identify program risks. One state’s Medicaid officials said that state-led audits allow them to more effectively identify—and subsequently monitor—services that are at risk for improper payments in the state. CMS also could use data from other sources on state-specific program risks to help design states’

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<sup>52</sup>None of the six states we spoke with formally tracked their state’s spending on PERM medical reviews.

<sup>53</sup>See [GAO-14-704G](#).

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PERM samples.<sup>54</sup> These options could help CMS and the states better identify the most prevalent causes of improper payments and more effectively focus corrective actions and program integrity strategies to address program risks.<sup>55</sup>

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## CMS Policy May Limit State Identification of Medicaid Providers Under Fraud Investigation

State Medicaid agencies may, but are not required to, determine whether providers included in the PERM sample are under fraud investigation and notify the PERM contractor. Under CMS policy, when a state notifies the PERM contractor of a provider under investigation, the contractor will end all contact with the provider to avoid compromising the fraud investigation, and the claim will be determined to be improper, due to no documentation.<sup>56</sup> In fiscal year 2017, of the 328 Medicaid improper payments due to no documentation, 27 (8 percent) from five states, according to CMS, were because the provider was under fraud investigation.

If a state Medicaid agency does not notify the PERM contractor about providers under fraud investigation, the PERM contractor will conduct its medical review, which involves contacting the provider to obtain documentation as a part of its normal process, and communicate about improper payment determinations. Contacting providers that are under fraud investigation as part of PERM reviews could interfere with an ongoing investigation, such as in the following ways we identified based

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<sup>54</sup>Several state and federal entities are responsible for identifying and addressing improper payments in Medicaid. For example, state Medicaid agencies typically have designated entities responsible for ensuring Medicaid program integrity, and states are generally required to establish Medicaid Fraud Control Units. In addition, state auditors are responsible for assessing financial management and accountability in state government agencies and programs. On the federal level, CMS provides states with guidance related to statutory and regulatory requirements, technical assistance, and education about program integrity best practices, and HHS-OIG helps oversee Medicaid program integrity through its audits, investigations, and program evaluations.

<sup>55</sup>We previously recommended that CMS take steps to mitigate risks in Medicaid managed care that are not measured in the PERM. CMS agreed with this recommendation but has not yet taken steps to address it. See GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, [GAO-18-291](#) (Washington, D.C.: May 7, 2018).

<sup>56</sup>This is similar to Medicare, where claims that are not reviewed because the provider is under fraud investigation, are also considered improper due to no documentation.

on information from the Association of Certified Fraud Examiners and others.

- The contact by the PERM contractor to request documentation, although unrelated to the fraud investigation, may give the impression that the provider is under heightened scrutiny. This could prompt the provider to change its behavior, or to destroy, falsify, or create evidence. These actions could in turn disrupt or complicate law enforcement efforts to build a criminal or civil case.
- The PERM contractor's communication about improper payment determinations may prompt states to conduct educational outreach to the provider about proper billing procedures. This may inadvertently change the billing practices of a fraudulent provider for whom law enforcement is trying to establish a pattern of behavior.

We found that states may not have processes to determine whether providers included in the PERM sample are under fraud investigation. Of the six states we spoke with, officials from two states said they did not have a mechanism in place to identify providers under fraud investigation. However, it is a best practice for investigative and review entities to communicate and coordinate with one another to determine if multiple entities are reviewing the same provider and for investigators to work discreetly without disrupting the normal course of business, based on our analysis of information from the Association of Certified Fraud Examiners and others. Accordingly, investigators should be aware of other government entities that are in contact with providers under investigation, such as the PERM contractor, who may contact providers multiple times to request documentation, and refer identified improper payments for recovery. If multiple entities are reviewing the same provider, one entity may be directed to pause or cease its activities, such as a PERM medical review, to reduce the risk of compromising an active fraud investigation. CMS has stated that it is not the agency's intention to negatively impact states' provider fraud investigations and, therefore, it has provided states the option to notify the PERM contractor of any providers under

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investigation to avoid compromising investigations.<sup>57</sup> However, CMS does not require states to determine whether providers under PERM medical reviews are also under fraud investigation, which creates the potential that PERM reviews could interfere with ongoing investigations.

State Medicaid agencies may not have incentives to notify the PERM contractor of providers under fraud investigation, as doing so will automatically result in a no documentation error, which increases states' improper payment rates. Medicaid officials from one state we spoke with said that while they check whether providers subject to PERM reviews are under investigation for fraud, they do not report these instances to the PERM contractor because the PERM contractor would find a no documentation error and the claim would be cited as improper, increasing the state's improper payment rate. Officials from another state said this policy penalizes states, in the form of higher state-level improper payment rates that may reflect poorly on states. Additionally, officials from this state were reluctant to develop corrective actions for improper payments stemming from such no documentation errors.

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## Conclusions

CMS and states need information about the underlying causes of improper payments to develop corrective actions that will effectively prevent or reduce future improper payments in Medicare and Medicaid FFS. The substantial variation in Medicare and Medicaid estimated improper payment rates for the services we examined raise questions about how well the programs' documentation requirements ensure that services were rendered in accordance with program coverage policies. While our study focused on certain services with high rates of insufficient documentation, differences in documentation requirements between the programs may apply to other services as well. Without examining how the

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<sup>57</sup> CMS also stated that the agency does not believe that PERM reviews will compromise investigations because requests for medical records are routine and should be expected by providers participating in Medicaid. The agency also noted that it is not necessarily the case that the claims selected for PERM review are the subject of the ongoing investigation. See 72 Fed. Reg. 50,490, 50,495 (Aug. 31, 2007); 75 Fed. Reg. 48,816, 48,821 (Aug. 11, 2010). Officials from the National Association of Medicaid Fraud Control Units noted that medical reviews are an expected part of Medicaid participation and that contacting providers may have limited impact on fraud investigations. However, they also said that some providers under fraud investigation may be sensitive to any contact by reviewers and may change their behaviors in response.

programs' differing documentation requirements affect their improper payment rates, CMS's ability to better identify and address FFS program risks and design strategies to assist providers with meeting requirements may be hindered.

At the state level, PERM medical reviews do not provide robust information to individual states. CMS's requirements to address individual improper payments may lead states to take corrective actions that may not fully address underlying causes of improper payments identified through medical review, and may misdirect state efforts to reduce improper payments. Absent a more comprehensive review of existing sources of information on the underlying causes of Medicaid improper payments, CMS and states are missing an opportunity to improve their ability to address program risks. In addition, the lack of a requirement for state Medicaid agencies to determine whether providers whose claims are selected for PERM medical reviews are also under fraud investigation risks compromising ongoing investigations. Further, citing such claims as improper payments in states' estimated improper payment rates may discourage state Medicaid agencies from notifying the PERM contractor that a provider is under investigation.

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## Recommendations

We are making the following four recommendations to CMS:

- The Administrator of CMS should institute a process to routinely assess, and take steps to ensure, as appropriate, that Medicare and Medicaid documentation requirements are necessary and effective at demonstrating compliance with coverage policies while appropriately addressing program risks. (Recommendation 1)
- The Administrator of CMS should take steps to ensure that Medicaid medical reviews provide robust information about and result in corrective actions that effectively address the underlying causes of improper payments. Such steps could include adjusting the sampling approach to reflect state-specific program risks, and working with state Medicaid agencies to leverage other sources of information, such as state auditor and HHS-OIG findings (Recommendation 2)
- The Administrator of CMS should take steps to minimize the potential for PERM medical reviews to compromise fraud investigations, such as by directing states to determine whether providers selected for PERM medical reviews are also under fraud investigation and to

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assess whether such reviews could compromise investigations. (Recommendation 3)

- The Administrator of CMS should address disincentives for state Medicaid agencies to notify the PERM contractor of providers under fraud investigation. This could include educating state officials about the benefits of reporting providers under fraud investigation, and taking actions such as revising how claims from providers under fraud investigation are accounted for in state-specific FFS improper payment rates, or the need for corrective actions in such cases. (Recommendation 4)

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment, and its comments are reprinted in appendix I. HHS also provided us with technical comments, which we incorporated in the report as appropriate.

HHS concurred with our first recommendation that CMS institute a process to routinely assess and ensure that Medicare and Medicaid documentation requirements are necessary and effective. HHS stated that CMS's Patients over Paperwork initiative is focused on simplifying Medicare documentation requirements and noted that for the Medicaid program, CMS will identify and share documentation best practices with state Medicaid agencies. CMS's Patients over Paperwork initiative may help CMS streamline Medicare documentation requirements. However, we believe CMS should take steps to assess documentation requirements in both programs to better understand the variation in the programs' requirements and their effect on estimated improper payment rates. Without an assessment of how the programs' documentation requirements affect estimates of improper payments, CMS may not have the information it needs to ensure that Medicare and Medicaid documentation requirements are effective at demonstrating compliance and appropriately address program risks.

HHS did not concur with our second recommendation that CMS ensure that Medicaid medical reviews provide robust information about and result in corrective actions that effectively address the underlying causes of improper payments. HHS noted that increasing the PERM sample size would involve increasing costs and state Medicaid agencies' burden, and that incorporating other sources of information into the PERM sample design could jeopardize the sample's statistical validity. HHS also commented that it already uses a variety of sources to identify and take

corrective actions to address underlying causes of improper Medicaid payments. We acknowledge that increasing the sample size would increase the costs of the PERM medical review program, though the level of improper payments warrants continued action. Further, under the current approach, we found that CMS and state Medicaid agencies are expending time and resources developing and implementing corrective actions that may not be representative of the underlying causes of improper payments in their states. It is important that corrective actions effectively and efficiently address the most prevalent causes of improper payments, and our report presents options that could improve the usefulness of the PERM's medical reviews—such as augmenting medical reviews with other sources of information during the development of corrective actions. We continue to believe that corrective actions based on more robust information would help CMS and state Medicaid agencies more effectively address Medicaid program risks.

HHS concurred with our third and fourth recommendations that CMS minimize the potential for PERM medical reviews to compromise fraud investigations and address disincentives for state Medicaid agencies to notify the PERM contractor of providers under fraud investigation. In its comments HHS described the actions it has taken and is considering taking to implement these recommendations.

We are sending copies of this report to appropriate congressional committees, to the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114, or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov) or [yocomc@gao.gov](mailto:yocomc@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 IV.



James Cosgrove  
Director, Health Care

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Carolyn L. Yocom  
Director, Health Care

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*List of Addressees*

The Honorable Charles E. Grassley  
Chair  
The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Richard Neal  
Chair  
The Honorable Kevin Brady  
Ranking Member  
Committee on Ways and Means  
House of Representatives

The Honorable Devin Nunes  
Ranking Member  
Committee on Ways and Means  
Subcommittee on Health  
House of Representatives

The Honorable Mike Kelly  
Ranking Member  
Committee on Ways and Means  
Subcommittee on Oversight  
House of Representatives

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# Appendix I: Comments from the Department of Health and Human Services

**Appendix I: 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

MAR 08 2019

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

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments*" (GAO-19-277).

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

Sincerely,

A handwritten signature in cursive script that reads "Matthew D. Bassett".

Matthew D. Bassett  
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 AND MEDICAID: CMS SHOULD ASSESS DOCUMENTATION NECESSARY TO IDENTIFY IMPROPER PAYMENTS (GAO-19-277)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity efforts in the Medicare and Medicaid programs.

As part of its program integrity efforts, HHS uses the Comprehensive Error Rate Testing (CERT) and Payment Error Rate Measurement (PERM) programs to estimate the Medicare Fee-For-Service (FFS) and Medicaid improper payment rates, respectively. It is important to note the improper payment rates are not "fraud rates" but simply a measurement of payments made (including both underpayments and overpayments) that did not meet statutory, regulatory, or administrative requirements. Both the CERT and PERM programs include reviews of medical records to determine whether claims were paid or denied properly in accordance with Federal and, in the case of Medicaid, state requirements. These reviews can be time-consuming for HHS, states, and providers; involve documentation requirements that can be complex and for which the source of legal authority may be distributed among multiple statutes, regulations, and subregulatory guidance and manuals; and often require several interactions with the provider to make sure required documentation has been provided.

As part of HHS' initiative to put patients first and reduce unnecessary provider burden in the Medicare FFS program, in 2017 HHS launched the Patients over Paperwork Initiative. This initiative includes the evaluation of potential ways to streamline regulations and other policies with the goals of reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience. As part of Patients over Paperwork, HHS implemented the Documentation Requirements Simplification Initiative, which is a process to simplify documentation requirements and eliminate any that are no longer needed. As part of this initiative, HHS is inviting feedback from providers and other stakeholders; reviewing current regulatory requirements and sub-regulatory guidance; analyzing medical review findings, such as findings from the Targeted Probe and Educate program; and undertaking conversations with internal stakeholders. Through this initiative, HHS has already clarified and amended several Medicare documentation requirements.<sup>1</sup>

HHS is also developing a Provider Documentation Manual, which will eventually list all of the documentation required for Medicare payment in one central location. The purpose of the Provider Documentation Manual is to reduce the need for providers and suppliers to reference multiple HHS documents by providing checklists that providers or suppliers can use to ensure their documentation is complete. The Provider Documentation Manual does not replace policy and coverage manuals and does not create any new requirements. HHS is posting draft sections of the manual on our website and accepting comments on these.<sup>2</sup>

<sup>1</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/SimplifyingRequirements.html>

<sup>2</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/ReducingProviderBurden.html>

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE AND MEDICAID: CMS SHOULD ASSESS DOCUMENTATION NECESSARY TO IDENTIFY IMPROPER PAYMENTS (GAO-19-277)**

For the Medicaid program, a state generally establishes documentation requirements in regulations and other guidance documents, based on its coverage policies and an individualized determination of what requirements are appropriate in that state. As the Government Accountability Office (GAO) notes in its report, the Medicaid program is a federal-state partnership that allows states the flexibility to establish and effectively manage their Medicaid programs, along with HHS oversight to ensure that federal statutory and regulatory requirements are met. Because documentation requirements can differ based on the structure of a Medicaid program and each state's determination of appropriate policy, HHS believes the states are better suited than the Federal Government to establish such documentation requirements. Lastly, requiring a state to revise its documentation requirements could also impose a significant burden on both the state and Medicaid providers.

HHS already uses a variety of sources that can help to identify the root causes of improper payments and target corrective actions to reduce improper payments. These sources include, but are not limited to, CERT, PERM, and Medicaid Eligibility Quality Control program results; Corrective Action Plans that are developed from improper payment measurement data; data analysis performed on Medicare and Medicaid claims; state program integrity reviews and site visits; and feedback from stakeholders, including state Medicaid agencies, GAO, and the HHS Office of Inspector General (OIG).

In recent years, these efforts have led to a reduction in the Medicare FFS and Medicaid improper payment rates. The 2018 Medicare FFS improper payment rate is 8.12 percent, which is the lowest such rate since 2010. The 2018 Medicaid improper payment rate is 9.79 percent; it has fallen since 2016, when it was 10.48 percent. HHS continues to explore additional opportunities to reduce the improper payment rates.

We remain committed to collaborating across HHS and with stakeholders to address potential vulnerabilities, strengthen our program integrity efforts, and minimize unnecessary administrative burden for our partners.

GAO's recommendations and HHS' responses are below.

**GAO Recommendation**

The Administrator of CMS should institute a process to routinely assess, and take steps to ensure, as appropriate, that Medicare and Medicaid documentation requirements are necessary and effective at demonstrating compliance with coverage policies while appropriately addressing program risks.

**HHS Response**

HHS concurs with GAO's recommendation.

In fact, as GAO notes in its report, HHS has already established this process. As mentioned above, the Documentation Requirements Simplification Initiative aims to simplify documentation requirements and eliminate requirements that are no longer needed. Through this initiative, HHS has already clarified and amended several Medicare documentation requirements.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE AND MEDICAID: CMS SHOULD ASSESS DOCUMENTATION NECESSARY TO IDENTIFY IMPROPER PAYMENTS (GAO-19-277)**

HHS concurs with GAO's recommendation for Medicaid. Medicaid is a federal-state partnership, and states generally establish documentation requirements in regulations and other guidance documents based on coverage policies and an individualized determination of what requirements are appropriate in that state. CMS will work to identify best practices for documentation requirements and share those with states.

**GAO Recommendation**

The Administrator of CMS should take steps to ensure that Medicaid medical reviews provide robust information about and result in corrective actions that effectively address the underlying causes of improper payments. Such steps could include adjusting the sampling approach to reflect state-specific program risks, and working with state Medicaid agencies to leverage other sources of information, such as state auditor and HHS-OIG findings.

**HHS Response**

HHS does not concur with this recommendation.

As stated above, HHS uses a variety of sources to identify the root causes of improper payments and target corrective actions to reduce improper payments. HHS can encourage states to utilize findings from all sources when developing corrective actions to address identified root causes of improper payments. However, using data from other sources, such as state auditor and OIG findings, on state-specific program risks to adjust the PERM sampling approach could jeopardize the statistical validity of the PERM program.

Under the PERM program in FY 2017, HHS subjected nearly 31,000 Medicaid FFS claims to medical reviews at a cost of nearly \$8 million. Those costs did not include state costs, the federal share of state costs, or provider costs. As GAO notes in its report, estimating improper payments for specific service types within states with the same precision as the national estimate would require substantially expanding the number of medical reviews conducted and lead to an increase in PERM costs and burden on states and providers.

**GAO Recommendation**

The Administrator of CMS should take steps to minimize the potential for PERM medical reviews to compromise fraud investigations, such as by directing states to determine whether providers selected for PERM medical reviews are also under fraud investigation and to assess whether such reviews could compromise investigations.

**HHS Response**

HHS concurs with GAO's recommendation.

Regarding current policy, HHS already provides guidance in the January 2018 PERM Manual to states to determine whether providers included in the PERM sample are under fraud investigation.<sup>3</sup> Should states determine that PERM medical reviews could compromise an investigation, they may

<sup>3</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/FY17PERMManual.pdf>

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE AND MEDICAID: CMS SHOULD ASSESS DOCUMENTATION NECESSARY TO IDENTIFY IMPROPER PAYMENTS (GAO-19-277)**

notify the PERM contractor and the contractor will end all contact with the provider. HHS will consider clarifying our policy to help ensure that such providers are not contacted in the first instance.

HHS will explore additional actions it can take to minimize the potential for PERM medical reviews to compromise fraud investigations.

**GAO Recommendation**

The Administrator of CMS should address disincentives for state Medicaid agencies to notify the PERM contractor of providers under fraud investigation. This could include educating state officials about the benefits of reporting providers under fraud investigation, and taking actions such as revising how payments from providers under fraud investigation are accounted for in state-specific FFS improper payment rates, or the need for corrective actions in such cases.

**HHS Response**

HHS concurs with this recommendation.

HHS will consider actions to minimize the negative impact on states of reporting providers under fraud investigation, such as increasing education to states about the minimal impact of any associated PERM errors and eliminating the requirement to develop corrective actions to address these errors.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

# Appendix II: Fiscal year 2018 Medicare Improper Payment Data

During the period of our review, fiscal year 2017 data represented the most recent, complete data for both Medicare and Medicaid fee-for-service (FFS) estimated improper payment amounts and rates. As of March 2019, the Centers for Medicare & Medicaid Services published the fiscal year 2018 Medicare FFS Supplemental Improper Payment Data report, but had not published the 2018 Medicaid FFS Supplemental Improper Payment Data report. The Centers for Medicare & Medicaid Services estimated Medicare FFS spending of \$389 billion, and \$32 billion in improper payments.

Table 3 below presents updated fiscal year 2018 data for the Medicare improper payment data by the services examined in our report.

**Table 3: Medicare Fee-for-Service Estimated Improper Payment Amounts and Rates by Selected Service Categories, Fiscal Year 2018**

Service	Improper payments (dollars in billions)	Improper payment rate (percentage)	Improper payments due to insufficient documentation (dollars in billions)	Insufficient documentation improper payment rate (percentage) <sup>a</sup>	Improper payments due to all other error types (dollars in billions) <sup>b</sup>	All other error types improper payment rate (percentage) <sup>c</sup>
Home health	3.2	17.6	2.0	10.9	1.2	6.7
Durable medical equipment	2.6	35.5	2.0	27.7	.6	7.8
Laboratory <sup>d</sup>	1.0	28.2	.9	25.8	.1	2.4
Hospice	2.1	11.7	1.2	7.0	.8	4.6
All services <sup>e</sup>	31.6	8.1	18.3	4.7	13.3	3.4

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

Note: Totals may not sum due to rounding.

<sup>a</sup>The rate at which all payments for the service were improper because of insufficient documentation errors.

<sup>b</sup>All other error types includes no documentation, medical necessity, incorrect coding, and other error categories.

<sup>c</sup>The rate at which all payments for the service were improper because of all other error types, which includes no documentation, medical necessity, incorrect coding, and other error categories.

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**Appendix II: Fiscal year 2018 Medicare  
Improper Payment Data**

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<sup>d</sup>The Medicare laboratory service category is specific to laboratories that are clinically independent and bill Medicare Part B.

<sup>e</sup>Total for all Medicare services, not just services in the table.

# Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers

Medicare and state Medicaid agencies have released template medical record documentation, such as certificates of medical necessity and plans of care that providers may use to document information necessary to ensure compliance with coverage policies. This appendix presents examples of such templates.

Figure 7 presents a Medicare template that referring physicians can use to certify beneficiary need for home health services.

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

**Figure 7: Medicare Home Health Services Certification Draft Template**

DRAFT

Use of this template is voluntary / optional

Home Health Plan of Care / Certification			
Patient information			
Last name: _____		First name: _____ MI: ____	
DOB (MM/DD/YYYY): _____		Gender: __M__F__Other Medicare ID: _____	
F2F evaluation information			
Date of F2F visit (MM/DD/YYYY): _____			
Other relevant information			
Patient HI Claim No: _____		Medical Record Number: _____	
Initial start of care date (MM/DD/YYYY): _____			
For recertification: start/end of this episode of care (MM/DD/YYYY): _____ / _____			
Advanced Directives: ____ Yes ____ No <i>If yes, describe:</i> _____			
Pertinent diagnoses (status: acute, chronic, acute-chronic, resolved, resolving, managed)			
ICD-10-CM	Description	Start date	Status
Relevant procedures (e.g. surgical) (include code from ICD-10-PCS, HCPCS, CPT when available)			
Code	Description	Date Performed	

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Source: Centers for Medicare & Medicaid Services. | GAO-19-277

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

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Pertinent medications (Status: N=New, A=Active, C=Changed, D=Discontinued) (include RxNorm if known)					
RxNorm	Description	Dose	Frequency	Route	Status
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (all) (include RxNorm for medication allergies when known)			
RxNorm	Description	RxNorm	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Functional assessment:

Functional limitations (check all that apply):  Amputation,  Bowel/bladder (Incontinence),  Contracture,  Hearing,  Paralysis,  Endurance,  Speech,  Legally blind,  Dyspnea with minimal exertion,  Angina with minimal exertion or at rest,  CVA/hemiparalysis/paralysis/dysphonia,  Confined to wheelchair,  Fall risk

Other functional limitations: \_\_\_\_\_

Activities permitted (check all that apply):  Complete bedrest,  Bedrest BRP,  Up as tolerated,  Transfer bed/chair,  Partial weight bearing,  Independent at home,  Crutches,  Cane,  Wheelchair,  Walker,  No restrictions

Other activities permitted: \_\_\_\_\_

Mental status (check all that apply)  Oriented,  Comatose,  Forgetful,  Depressed,  Disoriented,  Lethargic,  Agitated

Other mental, psychosocial, and cognitive status observations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Source: Centers for Medicare & Medicaid Services. | GAO-19-277 Part 2 of 6

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

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DME and supplies: \_\_\_\_\_  
 \_\_\_\_\_

Safety measures: \_\_\_\_\_  
 \_\_\_\_\_

Nutritional requirements: \_\_\_\_\_  
 \_\_\_\_\_

Prognosis: \_\_\_ Poor, \_\_\_ Guarded, \_\_\_ Fair, \_\_\_ Good, \_\_\_ Excellent

Additional clarification: \_\_\_\_\_  
 \_\_\_\_\_

Description of risk for emergency department visits and hospital readmission and all necessary interventions to address risk: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient and caregiver education and training to facilitate timely discharge: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient-specific interventions and education: measurable outcomes, goals and status identified by the HHA and patient. Status: Proposed, Accepted, Planned, In Progress, On Target, Ahead of Target, Behind Target, Sustaining, Achieved, On Hold, Cancelled, Rejected

Intervention/Education	Measurable Outcomes /Goals	Status
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Home Health Services Plan of Care / Certification Template Draft R2.0 7/9/2018 Page 3 of 6

Source: Centers for Medicare & Medicaid Services. | GAO-19-277 Part 3 of 6

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

DRAFT

Orders (may be satisfied with an attached, signed order template)

Intermittent skilled nursing services (*complete all that are required*)

<i>Administration of medications</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Tube feeding</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Wound care</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Catheters</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Ostomy care</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>NG and tracheostomy aspiration/care</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Psychiatric evaluation and therapy</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Teaching/training</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Observe/assess</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Complex care plan management</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Rehabilitation nursing</i>	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Other:</i> _____	<i>Frequency:</i> _____	<i>Duration:</i> _____
<i>Other:</i> _____	<i>Frequency:</i> _____	<i>Duration:</i> _____

*Justification and signature if the patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan or complex care plan management):*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Therapy services (*complete all that are required*)

Physical therapy

<i>Restore patient function</i>	_____
<i>Perform maintenance therapy</i>	_____
<i>Therapeutic exercises</i>	<i>Frequency:</i> _____ <i>Duration:</i> _____
<i>Gait and balance training</i>	<i>Frequency:</i> _____ <i>Duration:</i> _____
<i>ADL training</i>	<i>Frequency:</i> _____ <i>Duration:</i> _____
<i>Other:</i> _____	<i>Frequency:</i> _____ <i>Duration:</i> _____

Occupational therapy

<i>Restore patient function</i>	_____
<i>Perform maintenance therapy</i>	_____
<i>Therapeutic exercises</i>	<i>Frequency:</i> _____ <i>Duration:</i> _____
<i>ADL training</i>	<i>Frequency:</i> _____ <i>Duration:</i> _____
<i>Other:</i> _____	<i>Frequency:</i> _____ <i>Duration:</i> _____

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

DRAFT

<i>Speech-language pathology</i>	
<i>Restore language function</i>	_____
<i>Restore cognitive function</i>	_____
<i>Swallowing</i>	Frequency: _____ Duration: _____
<i>Perform maintenance therapy</i>	Frequency: _____ Duration: _____
<i>Other: _____</i>	Frequency: _____ Duration: _____
<i>Other Services</i>	
<i>Home health aide services</i>	Frequency: _____ Duration: _____
<i>Medical social services</i>	Frequency: _____ Duration: _____

<b>Verbal Orders</b>		
<i>Date/time</i>	<i>Order</i>	<i>Taken by</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b>Frequency, Duration and Purpose of Visits:</b>		
Frequency	Duration	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Additional Items from the HHA and/or physician:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Rehabilitation potential</b>	
Service/Intervention	Rehabilitation potential
_____	_____
_____	_____
_____	_____

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Source: Centers for Medicare & Medicaid Services. | GAO-19-277

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

DRAFT

Discharge plans \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Communicated to primary care physician:*  
 Provider name \_\_\_\_\_ Date: \_\_\_\_\_ By: \_\_\_\_\_

Preparer signature: \_\_\_\_\_  
 Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_ Suffix: \_\_\_\_\_  
 Date (MM/DD/YYYY): \_\_\_\_\_

Signature, Name, Date and NPI of physician signing the POC/Certification:  
 If this is a subsequent episode:  
 How much longer will skilled services be needed? \_\_\_\_\_  
*I certify that this patient is confined to his/her home (as outlined in section 30.1.1 in Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-02)) and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with an allowed provider type and the encounter was related to the primary reason for home health care.*  
 I authenticate that the verbal orders recorded above are accurate.  
 Signature: \_\_\_\_\_  
 Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_ Suffix: \_\_\_\_\_  
 Date (MM/DD/YYYY): \_\_\_\_\_ NPI: \_\_\_\_\_

Date physician signed POC was received by the HHA (MM/DD/YYYY): \_\_\_\_\_

*Revisions of the POC communicated to:*

Role	Name	Date	By
Patient/Caregiver	_____	_____	_____
Certifying Provider	_____	_____	_____
Ordering Provider	_____	_____	_____
Ordering Provider	_____	_____	_____
Ordering Provider	_____	_____	_____

Home Health Services Plan of Care / Certification Template Draft R2.0 7/9/2018 Page 6 of 6

Source: Centers for Medicare & Medicaid Services. | GAO-19-277

Part 6 of 6

Figure 8 presents a Medicare template that referring physicians can use to certify beneficiary need for home oxygen supplies.

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

**Figure 8: Medicare Certificate of Medical Necessity Template for Oxygen Supplies**

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		Form Approved OMB No. 0938-0679 Expires 02/2020	
<b>CERTIFICATE OF MEDICAL NECESSITY CMS-484 OXYGEN</b>		<b>DME 484.03</b>	
<b>SECTION A: Certification Type/Date:</b> INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___			
PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID  (___) ___-___-___ Medicare ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #  (___) ___-___-___ NSC or NPI #	
PLACE OF SERVICE	Supply Item/Service Procedure Code(s):	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___ (in) Wt. ___	
NAME and ADDRESS of FACILITY If applicable (see reverse)		PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI #  (___) ___-___-___ UPIN or NPI #	
<b>SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.</b>			
EST. LENGTH OF NEED (# OF MONTHS): ___ 1-99 (99=LIFETIME)		DIAGNOSIS CODES: _____	
<b>ANSWERS</b>	<b>ANSWER QUESTIONS 1-9. (Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)</b>		
a) ___ mm Hg b) ___ % c) ___/___/___	1. Enter the result of recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.		
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?		
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	3. Check the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, check D.		
___ LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".		
a) ___ mm Hg b) ___ % c) ___/___/___	6. If greater than 4 LPM is prescribed, enter results of recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).		
<b>ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1</b>			
<input type="checkbox"/> Y <input type="checkbox"/> N	7. Does the patient have dependent edema due to congestive heart failure?		
<input type="checkbox"/> Y <input type="checkbox"/> N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement.		
<input type="checkbox"/> Y <input type="checkbox"/> N	9. Does the patient have a hematocrit greater than 56%?		
<b>NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):</b> NAME _____ TITLE _____ EMPLOYER _____			
<b>SECTION C: Narrative Description of Equipment and Cost</b> (1) Narrative description of all items, accessories and option ordered; (2) Suppliers charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option (see instructions on back)			
<b>SECTION D: PHYSICIAN Attestation and Signature/Date</b> I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ Signature and Date Stamps Are Not Acceptable.			
Form CMS-484 (02/17)			

Source: Centers for Medicare & Medicaid Services. | GAO-19-277

Figure 9 presents a template from the Indiana Medicaid program that hospices may use to document beneficiary plans of care.

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

**Figure 9: Indiana Hospice Plan of Care Template**



**MEDICAID HOSPICE PLAN OF CARE**  
State Form 48731 (R3 / 2-09) / OMPP 0011

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

Reset Form

**A. RECIPIENT INFORMATION**

Name of recipient ( <i>last, first, middle initial</i> )	Primary hospice diagnosis ( <i>ICD-#</i> ):
Recipient's Social Security number	Recipient's Medicaid number

**B. HOSPICE PROVIDER INFORMATION**

Name of hospice provider	Hospice provider number
--------------------------	-------------------------

**C. ASSESSMENT:** Complete the following using the problem severity code listed at the bottom of the chart.

ASSESSMENT	PROBLEM SEVERITY CODE	ASSESSMENT	PROBLEM SEVERITY CODE
Altered Physical Comfort		Altered Urinary Elimination	
Altered Respiratory Status		Altered Bowel Elimination	
Altered Cardiovascular Status		Altered Sleep Pattern	
Altered Nutritional Status		Altered Grief/Spiritual ( <i>patient</i> )	
Altered Skin Integrity		Altered Grief/Spiritual ( <i>family</i> )	
Altered Mobility Status		Altered Oral Mucosa	
ACTIVITIES OF DAILY LIVING	PROBLEM SEVERITY CODE	ACTIVITIES OF DAILY LIVING	PROBLEM SEVERITY CODE
Eating / Feeding		Toileting	
Grooming / Hygiene		Continence	
Bathing		Transferring	
Dressing		Mobility	

**PROBLEM SEVERITY CODE**

0 = None: no problem present	3 = Moderate: able to function with support
1 = Problem: controlled at time of assessment	4 = Marked: able to function only with daily intervention
2 = Mild: function could be improved.	5 = Severe: incapacitated by the problem

**D. SERVICES:** Document the proposed services for this benefit period (*include frequency and expected outcome*).

Services Required	Frequency	Expected Outlook
Skilled Nursing		

(Continued on the reverse side)

Source: Indiana Family and Social Services Administration. | GAO-19-277

Part 1 of 2

**Appendix III: Selected Examples of Medical Record Templates for Medicare and Medicaid Providers**

<b>E. SERVICES (continued)</b>		
<b>Services Required</b>	<b>Frequency</b>	<b>Expected Outlook</b>
Home Health		
Therapy		
DME		
Pharmacy		
Spiritual		
Other enhanced services		

<b>F. SIGNATURES: Date and sign the following. Signatures must represent the Medical Director as well as two signatures from any of the other disciplines listed above.</b>		
Signature	Title	Date (month, day, year)
Signature	Title	Date (month, day, year)
Signature	Title	Date (month, day, year)

Source: Indiana Family and Social Services Administration. | GAO-19-277

Part 2 of 2

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# Appendix IV: GAO Contacts and Staff Acknowledgments

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## GAO Contacts:

James Cosgrove, (202) 512-7114, [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov) and Carolyn L. Yocom, (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Leslie V. Gordon (Assistant Director), Michael Erhardt (Analyst-in-Charge), Arushi Kumar, and Dawn Nelson made key contributions to this report. Also contributing were Sam Amrhein, Vikki Porter, and Jennifer Rudisill.

# Appendix V: Accessible Data

## Data Tables

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

**Medicare:**

Year	Insufficient (in billions)	None (in billions)	all others (in billions)
2005	2.5596199036	1.6288499832	7.9115400314
2006	1.4727299213	1.4727299213	7.8545498848
2007	1.1076899767	1.6615399122	8.0307693481
2008	1.7333300114	0.5777779818	8.0888900757
2009	12.2757997513	0.5709679723	22.5531997681
2010	15.0267000198	0.6533330083	18.6199989319
2011	14.4000005722	0.3348839879	14.0650997162
2012	17.4118003845	0.6964709759	11.4917993546
2013	21.7425994873	0.7128710151	13.5445995331
2014	29.5716991425	0.3606300056	15.8676996231
2015	28.9860019684	0.7157019973	13.5982999802
2016	26.9018001556	0.3736360073	13.8245000839
2017	23.2441997528	0.7621049881	12.1936998367

**Medicaid:**

Year	Insufficient (in billions)	None (in billions)	all others (in billions)
2005	N/A	N/A	N/A
2006	N/A	N/A	N/A
2007	N/A	N/A	N/A
2008	N/A	N/A	N/A
2009	N/A	N/A	N/A
2010	N/A	N/A	N/A
2011	4.6990003586	1.2551000118	2.1461000443
2012	2.2400999069	1.2728999853	1.8130000830
2013	3.6470000744	1.3480999470	2.2690000534
2014	2.3220000267	0.9704999924	2.3162999153

Year	Insufficient (in billions)	None (in billions)	all others (in billions)
2015	3.4981999397	1.2506999969	2.6404998302
2016	3.8644998074	1.7488999367	1.1998000145
2017	4.2660999298	2.4858999252	0.6776999831

**Accessible Data for Figure 4: Estimated Medical Review Improper Payment Rates in Medicare and Medicaid Fee-for-Service by Selected Service Categories, Fiscal Year 2017**

**Medicare:**

Category	Insufficient (percentage)	other errors (percentage)
Home health	29.0000000000	4.0000000000
Durable medical equipment	35.0000000000	9.0000000000
Laboratorya	28.0000000000	1.0000000000
Hospice	9.0000000000	6.0000000000
All Servicesb	6.0000000000	3.0000000000

**Medicaid:**

Category	Insufficient (percentage)	other errors (percentage)
Home health	1.2000000477	1.8000000715
Durable medical equipment	0.8000000119	1.3000000715
Laboratorya	0.0000000000	3.7000000477
Hospice	0.0000000000	0.0000000000
All Servicesb	1.3000000715	1.0000000000

**Accessible Data for Figure 5: Medicare Fee-for-Service Estimated Improper Payment Rate for Home Health Services, FY 2010-2017**

Year	Insufficient documentation error	Other error types
2010	1.3	3.5
2011	3.2	3.8
2012a	2.8	3.3
2013	14.1	3.2
2014	46.3	5.1
2015	55.9	3.1

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Year	Insufficient documentation error	Other error types
2016b	40.5	1.5
2017	28.7	3.6

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## Agency Comment Letter

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### Accessible Text for Appendix I Comments from the Department of Health and Human Services

Page 1

MAR 08 2019

Carolyn Yocom

Director, Health Care

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments" (GAO-19-277).

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

Sincerely,

Matthew D. Bassett

Assistant Secretary for Legislation

Attachment

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Page 2

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity efforts in the Medicare and Medicaid programs.

As part of its program integrity efforts, HHS uses the Comprehensive Error Rate Testing (CERT) and Payment Error Rate Measurement (PERM) programs to estimate the Medicare Fee-For-Service (FFS) and Medicaid improper payment rates, respectively. It is important to note the improper payment rates are not "fraud rates" but simply a measurement of payments made (including both underpayments and overpayments) that did not meet statutory, regulatory, or administrative requirements. Both the CERT and PERM programs include reviews of medical records to determine whether claims were paid or denied properly in accordance with Federal and, in the case of Medicaid, state requirements. These reviews can be time-consuming for HHS, states, and providers; involve documentation requirements that can be complex and for which the source of legal authority may be distributed among multiple statutes, regulations, and subregulatory guidance and manuals; and often require several interactions with the provider to make sure required documentation has been provided.

As part of HHS' initiative to put patients first and reduce unnecessary provider burden in the Medicare FFS program, in 2017 HHS launched the Patients over Paperwork Initiative. This initiative includes the evaluation of potential ways to streamline regulations and other policies with the goals of reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience. As part of Patients over Paperwork, HHS implemented the Documentation Requirements Simplification Initiative, which is a process to simplify documentation requirements and eliminate any that are no longer needed. As part of this initiative, HHS is inviting feedback from providers and other stakeholders; reviewing current regulatory requirements and sub-regulatory guidance; analyzing medical review findings, such as findings from the Targeted Probe and Educate program; and undertaking conversations with internal stakeholders. Through this initiative, HHS has already clarified and amended several Medicare documentation requirements.<sup>1</sup>

HHS is also developing a Provider Documentation Manual, which will eventually list all of the documentation required for Medicare payment in one central location. The purpose of the Provider Documentation Manual

is to reduce the need for providers and suppliers to reference multiple HHS documents by providing checklists that providers or suppliers can use to ensure their documentation is complete. The Provider Documentation Manual does not replace policy and coverage manuals and does not create any new requirements. HHS is posting draft sections of the manual on our website and accepting comments on these.<sup>2</sup>

<sup>1</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/SimplifyingRequirements.html>

<sup>2</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/ReducingProviderBurden.html>

### Page 3

For the Medicaid program, a state generally establishes documentation requirements in regulations and other guidance documents, based on its coverage policies and an individualized determination of what requirements are appropriate in that state. As the Government Accountability Office (GAO) notes in its report, the Medicaid program is a federal-state partnership that allows states the flexibility to establish and effectively manage their Medicaid programs, along with HHS oversight to ensure that federal statutory and regulatory requirements are met. Because documentation requirements can differ based on the structure of a Medicaid program and each state's determination of appropriate policy, HHS believes the states are better suited than the Federal Government to establish such documentation requirements. Lastly, requiring a state to revise its documentation requirements could also impose a significant burden on both the state and Medicaid providers.

HHS already uses a variety of sources that can help to identify the root causes of improper payments and target corrective actions to reduce improper payments. These sources include, but are not limited to, CERT, PERM, and Medicaid Eligibility Quality Control program results; Corrective Action Plans that are developed from improper payment measurement data; data analysis performed on Medicare and Medicaid claims; state program integrity reviews and site visits; and feedback from stakeholders, including state Medicaid agencies, GAO, and the HHS Office of Inspector General (OIG).

In recent years, these efforts have led to a reduction in the Medicare FFS and Medicaid improper payment rates. The 2018 Medicare FFS improper payment rate is 8.12 percent, which is the lowest such rate since 2010. The 2018 Medicaid improper payment rate is 9.79 percent; it has fallen

since 2016, when it was 10.48 percent. HHS continues to explore additional opportunities to reduce the improper payment rates.

We remain committed to collaborating across HHS and with stakeholders to address potential vulnerabilities, strengthen our program integrity efforts, and minimize unnecessary administrative burden for our partners.

GAO's recommendations and HHS' responses are below.

#### GAO Recommendation

The Administrator of CMS should institute a process to routinely assess, and take steps to ensure, as appropriate, that Medicare and Medicaid documentation requirements are necessary and effective at demonstrating compliance with coverage policies while appropriately addressing program risks.

#### HHS Response

HHS concurs with GAO's recommendation.

In fact, as GAO notes in its report, HHS has already established this process. As mentioned above, the Documentation Requirements Simplification Initiative aims to simplify documentation requirements and eliminate requirements that are no longer needed. Through this initiative, HHS has already clarified and amended several Medicare documentation requirements.

#### Page 4

HHS concurs with GAO's recommendation for Medicaid. Medicaid is a federal-state partnership, and states generally establish documentation requirements in regulations and other guidance documents based on coverage policies and an individualized determination of what requirements are appropriate in that state. CMS will work to identify best practices for documentation requirements and share those with states.

#### GAO Recommendation

The Administrator of CMS should take steps to ensure that Medicaid medical reviews provide robust information about and result in corrective actions that effectively address the underlying causes of improper payments. Such steps could include adjusting the sampling approach to

reflect state-specific program risks, and working with state Medicaid agencies to leverage other sources of information, such as state auditor and HHS-OIG findings.

#### HHS Response

HHS does not concur with this recommendation.

As stated above, HHS uses a variety of sources to identify the root causes of improper payments and target corrective actions to reduce improper payments. HHS can encourage states to utilize findings from all sources when developing corrective actions to address identified root causes of improper payments. However, using data from other sources, such as state auditor and OIG findings, on state-specific program risks to adjust the PERM sampling approach could jeopardize the statistical validity of the PERM program.

Under the PERM program in FY 2017, HHS subjected nearly 31,000 Medicaid FFS claims to medical reviews at a cost of nearly \$8 million. Those costs did not include state costs, the federal share of state costs, or provider costs. As GAO notes in its report, estimating improper payments for specific service types within states with the same precision as the national estimate would require substantially expanding the number of medical reviews conducted and lead to an increase in PERM costs and burden on states and providers.

#### GAO Recommendation

The Administrator of CMS should take steps to minimize the potential for PERM medical reviews to compromise fraud investigations, such as by directing states to determine whether providers selected for PERM medical reviews are also under fraud investigation and to assess whether such reviews could compromise investigations.

#### HHS Response

HHS concurs with GAO's recommendation.

Regarding current policy, HHS already provides guidance in the January 2018 PERM Manual to states to determine whether providers included in the PERM sample are under fraud investigation.<sup>3</sup> Should states determine that PERM medical reviews could compromise an investigation, they may

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<sup>3</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/FY17PERMManual.pdf>

## Page 5

notify the PERM contractor and the contractor will end all contact with the provider. HHS will consider clarifying our policy to help ensure that such providers are not contacted in the first instance.

HHS will explore additional actions it can take to minimize the potential for PERM medical reviews to compromise fraud investigations.

### GAO Recommendation

The Administrator of CMS should address disincentives for state Medicaid agencies to notify the PERM contractor of providers under fraud investigation. This could include educating state officials about the benefits of reporting providers under fraud investigation, and taking actions such as revising how payments from providers under fraud investigation are accounted for in state-specific FFS improper payment rates, or the need for corrective actions in such cases.

### HHS Response

HHS concurs with this recommendation.

HHS will consider actions to minimize the negative impact on states of reporting providers under fraud investigation, such as increasing education to states about the minimal impact of any associated PERM errors and eliminating the requirement to develop corrective actions to address these errors.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

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