

Trend Report: Identifying The Top 5 CMS-Approved Medicare Billing Issue Areas That Put Taxpayer Dollars At Risk

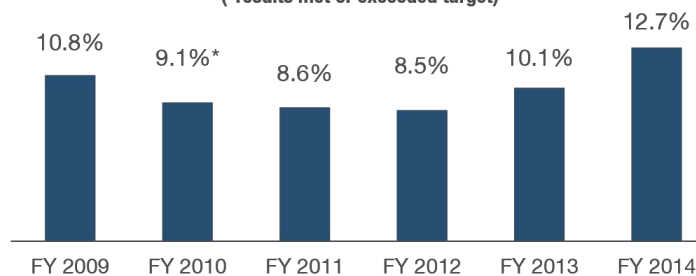
For the past several years, there's been a great deal of dialogue surrounding the issue of short, inpatient hospital stays, which historically have had a high rate of Medicare billing errors. The Centers for Medicare & Medicaid Services (CMS) reports that short, inpatient hospital stay billing errors account for 94% of all Medicare billing mistakes. Contrary to the hospital industry's passionate objections to oversight of this problematic billing area, Recovery Audit Contractors (RACs) have not reviewed a single hospital short stay claim since October 1, 2013, or two years, permitting providers to keep an estimated \$8 billion in improperly paid taxpayer dollars.

While short stay claims remain off the RAC review roster, there are still nearly 400 CMS-approved issues that Recovery Auditors currently do review to protect the solvency of the Medicare Trust Fund. This work continues to be vitally important due to the ever-rising trend of misbilling within Medicare.

According to a [recent Government Accountability Office \(GAO\) report](#), "The federal government continues to face an unsustainable long-term fiscal path. Changing this path will require difficult fiscal policy decisions to alter both long-term federal spending and revenue. In the near term, executive branch agencies and Congress can take action to improve the government's fiscal position by addressing two long-standing issues—improper payments and the tax gap."

The [GAO has reported](#) that Medicare and Medicaid improper payments rank highest government-wide. In FY2014, the Medicare FFS billing error rate reached the highest level in history—**12.7%**—which equates to a loss of \$46 billion that year alone. Unfortunately, this upward trend is expected to continue.

Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program
(*results met or exceeded target)



There is a misperception that the majority of improper payments are caused by simple clerical or coding errors, inflating the improper payment rate. This is not the case. According to the most

recent Comprehensive Error Rate Testing (CERT) report, insufficient documentation and a lack of medical necessity are the largest contributors to improper payments.

Fig.1: 2014 Projected Improper Payments (in Billions) by Type of Error and Clinical Setting

Error Category	DMEPOS	Home Health Agencies	Hospital Outpatient Departments	Inpatient PPS Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	\$0.03	\$0.03	\$0.02	\$0.03	\$0.18	\$0.00	\$0.00	\$0.30
Insufficient Documentation	\$4.71	\$8.46	\$5.36	\$1.41	\$5.64	\$2.00	\$1.92	\$29.49
Medical Necessity	\$0.18	\$0.84	\$0.22	\$11.30	\$0.06	\$0.09	\$0.19	\$12.87
Incorrect Coding	\$0.01	\$0.01	\$0.15	\$2.19	\$2.75	\$0.38	\$0.12	\$5.61
Other	\$0.16	\$0.06	\$0.03	\$0.17	\$0.21	\$0.18	\$0.01	\$0.82
Total	\$5.09	\$9.40	\$5.77	\$15.09	\$8.85	\$2.65	\$2.25	\$49.09

For example, a recent [Office of the Inspector General \(OIG\) report](#) has revealed that Medicare paid \$30 million for ambulance rides for which no record exists that patients got medical care at their destination. Additionally, [another recent OIG report](#) showed that Skilled Nursing Facilities increasingly billed for the highest level of therapy causing one-quarter of the industry’s 2009 claims to be improper and resulting in a loss of \$1.5 billion to the Medicare Trust Fund. Clearly, taxpayer dollars are being wasted at increasingly high rates, putting the future solvency of Medicare in question.

Top Issues Draining the Trust Fund

Among all Medicare billing issue areas currently approved by CMS to be audited, it’s possible to take a look at the types of claims currently misbilled most frequently, accounting for the highest waste of taxpayer funds.

This brief trend report seeks to identify and discuss five areas that most contribute to Medicare waste and those that, when audited, have the most potential to return significant amounts of improperly billed taxpayer dollars back to the Medicare Trust Fund.

- Durable Medical Equipment (DME).** This area of Medicare billing has consistently had an incredibly high rate of billing errors – frequently billed incorrectly at a higher rate – causing an overpayment. According to the CMS Comprehensive Error Rate Testing (CERT) program, [in FY2014](#), the error rate among DME billing was 53.1%, accounting for \$5 billion in improper payments that year.

Within the category of DME, three particular issue areas seem to be putting the solvency of the Medicare Trust Fund in the greatest jeopardy, they include:

- **DME services entwined with hospital or hospice care.** When this occurs, there's a great propensity for billing errors. These claims are reviewed to determine if the services provided should, according to Medicare policy, be billed as DME separately or bundled within a hospital's bill.
 - **Orthotics.** This service is often billed to improper Medicare billing codes.
 - **Hospice care provided during an inpatient hospital stay.** This issue has also caused a large number of billing errors. Any sort of inpatient services provided to beneficiaries while in hospice care should be bundled and billed by hospice. Overall, the [FY2014 improper payment rate for hospice services was 3.8%](#), equating to a loss to Medicare of \$471.1 million.
- **Home Health Claims.** The Medicare Fee For Service (FFS) home health benefit pays for certain health care services in the home setting. This area includes skilled nursing care, medical social services, medical supplies and physical, occupational and speech-language therapies. Improper billing in this area also tends to be linked to home health care billed after a patient's death or overlapping with hospital or skilled nursing facility care.

In [FY2014](#), CMS reported that the billing error rate for this issue area was 51.4%, accounting for 19% of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during FY2014 was \$9.4 billion.

The improper payment rate for skilled nursing facility (SNF) services was 6.9%, accounting for 5.4% of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2014 report period was \$2.6 billion.

Home Health claims undergo automated RAC review and are then adjusted up or down based on the claim's adherence to Medicare billing policy. CMS has found that even a small number of errors can add up to an incredible loss to the Medicare Trust Fund, which is supported now by the OIG's reporting.

- **Medicare Part A and B Pharmacy Claims.** The review of Medicare Part A and B drug claims is also an issue area greatly damaging Medicare solvency. For example, CMS has approved RACs to review these claims to compare the number of units of a medication billed to the number of units documented as actually administered in the medical record. This billing area is highly prone to errors and both Medicare overpayments and underpayments are found in this category and corrected.
- **Diagnosis Related Group (DRG) Validation.** This claim type requires that RACs look at medical records to ensure DRG assignment on a provider's claim is coded correctly. As directed by CMS, Recovery Auditors review the clinical documentation to determine if the claim is coded correctly or needs to be assigned a different, correct code.

The majority of corrections of this type are Medicare overpayments, but approximately 25% of these claim reviews uncover Medicare *underpayments*, allowing RACs to correct the record and ensure the provider is fully and fairly compensated for the work performed.

- **Therapy Cap Reviews.** In 2014, President Obama signed into law the *Protecting Access to Medicare Act* that included a number of provisions affecting outpatient therapy caps. Recovery Auditors are tasked by CMS to review these claims to ensure services provided are

within the stated Medicare threshold. Unfortunately, a great deal of the time service is provided above the threshold.

Recommendations:

In a recent Senate Finance Committee hearing, Comptroller General of the United States, Gene Dodaro testified that, "Federal spending in Medicare and Medicaid is expected to significantly increase, so it is critical that actions are taken to reduce improper payments in these programs." He shared that the Centers for Medicare and Medicaid Services has not implemented many of his office's recommendations for reducing misbilling.

Ensuring the solvency of the Medicare Trust Fund absolutely must be made a top priority. A stronger focus on reducing improper payments is not negotiable if we want the program to be in place in the future.

Medicare Trustees are reporting that the program's funds will be depleted by 2030 (just 15 years from now). All work that can be done now to reduce improper payments and more efficiently expend the taxpayer dollars that fund Medicare is vitally important to extend the life of the program.

The Council for Medicare Integrity (CMI) recommends that lawmakers take active steps to ensure Medicare solvency remains top of mind during their discussions about the program and urges their renewed support to champion the integrity programs they put in place to identify and return to Medicare the billions of taxpayer dollars improperly paid each year.

The government's absolute goal in this regard should be to use all tools at their disposal to aggressively reduce Medicare improper payments. This should include getting Recovery Auditors back to work at previous auditing levels to reduce the Medicare improper payment rate.

About The Council For Medicare Integrity:

The Council for Medicare Integrity is a 501(c)(6) non-profit organization. The Council's mission is to educate policymakers and other stakeholders regarding the importance of healthcare integrity programs that help Medicare identify and correct improper payments.

About This Report:

The trend information shared in this report was generated by the recovery auditing industry based on their work reviewing post-payment Medicare claims.