DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 9 1999

From June Gibbs Brown
Inspector General

Subject Improper Fiscal Year 1998 Medicare Fee-for-Service Payments (A-17-99-00099)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report on the results of our review of Fiscal Year (FY) 1998 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. This is the third year that the Office of Inspector General (OIG) has estimated these improper payments. As part of our analysis, we profiled all 3 years' results and identified specific trends where appropriate.

Based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1998 totaled $12.6 billion, or about 7.1 percent of the $176.1 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion. These improper payments, as with past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (90 percent) of these improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

While we do not have empirical evidence supporting a specific causal relationship between the error rate decline and corrective actions, we believe the decline is attributable to several factors: (1) HCFA's efforts under the Medicare Integrity Program, (2) fraud and abuse initiatives, (3) improved provider compliance with Medicare reimbursement rules, (4) HCFA/OIG outreach efforts emphasizing Medicare documentation requirements, and (5) implementation of HCFA's corrective action plan.

The HCFA has made substantial progress in reducing improper payments in the Medicare program. However, continued efforts are needed to reduce the current estimate of over $9 billion in errors due to the lack of medical necessity and incorrect coding. Our recommendations address the need for HCFA to continue its diligence in reducing past identified problems and to keep abreast of those issues that could negatively affect future error rates.

We have incorporated HCFA's comments on the draft report where appropriate. We appreciate the cooperation and assistance provided by you and your staff.

We would appreciate your views and information on the status of action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

To facilitate identification, please refer to Common Identification Number A-17-99-00099 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPROPER FISCAL YEAR 1998 MEDICARE FEE-FOR-SERVICE PAYMENTS

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1999
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Our review of 5,540 claims valued at $5.6 million disclosed that 915 did not comply with Medicare laws and regulations. Based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1998 totaled $12.6 billion, or about 7.1 percent of the $176.1 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion. These improper payments, as with past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (90 percent) of these improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

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While notable progress has been made in reducing the overall error rate, continued efforts are needed to reduce the current estimate of over $9 billion in errors due to the lack of medical necessity and incorrect coding.

BACKGROUND

The Medicare program (Title XVIII of the Social Security Act) was established by the Social Security Amendments of 1965 to cover the health care needs of people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. In FY 1998, about 39 million beneficiaries were enrolled in the program, and HCFA incurred about $210 billion nationwide in Medicare benefit payments. Fee-for-service payments accounted for about $176.1 billion of this total, while managed care expenditures accounted for about $33 billion.

Medicare is a combination of two programs, each with its own enrollment, coverage, and financing:

- Hospital insurance, also known as Medicare Part A, is usually provided automatically to people aged 65 and over and to most disabled people. It covers services rendered by participating hospitals (including prospective payment system (PPS) hospitals), skilled nursing facilities, home health agencies, and hospice providers.

- Supplementary medical insurance, also known as Medicare Part B, is available to nearly all people aged 65 and over and the disabled entitled to Part A. This optional insurance is subject to monthly premium payments by beneficiaries. Medicare Part B covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by Medicare Part A.

The HCFA pays contractors to process claims for services covered by both Parts A and B.

AUDIT OBJECTIVE

Our primary objective was to determine whether Medicare fee-for-service benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR). Specifically, we determined whether services were:

- furnished by certified Medicare providers to eligible beneficiaries;

- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and

- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

AUDIT SCOPE AND METHODOLOGY

Statistical Selection Method. To accomplish our objective, we used a stratified, multistage sample design. In the first stage, our sample frame consisted of 189 contractor quarters (47 contractors for 4 quarters and 1 contractor that processed claims for 1 quarter). We grouped the contractor quarters into two strata: stratum 1 included contractor quarters from the first, second, and third quarters of FY 1998, and stratum 2 included those from the fourth quarter. We based the selection within each stratum on probability-proportional-to-size using Rao, Hartley, Cochran methodology, and we used FY 1997 Medicare fee-for-service benefit payments as the selection weighting factors (size of each contractor quarter). Ten contractor quarters were selected from stratum 1 and two from stratum 2. Selecting two contractor quarters from stratum 2 (the fourth quarter) controlled the amount of audit work required to review fourth quarter claims.

The 12 contractor quarters included 12 contractors, of which 5 were fiscal intermediaries (FI); 1 was a carrier; 5 were both FIs and carriers; and 1 was an FI, a carrier, and a durable medical equipment regional carrier (DMERC). The FIs process payments for hospitals, skilled nursing facilities (SNF), home health agencies (HHA), rural health clinics, hospices, end stage renal disease facilities, and other institutional providers. Carriers process payments for physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers. The DMERCs process claims from suppliers of durable medical equipment (DME), prosthetics, orthotics, and supplies under the Medicare Part B program except those for items incident to physician services in rural health clinics or included in payments to such providers as hospitals, SNFs, and HHAs. A DMERC's claim processing jurisdiction is based on the beneficiary's State of permanent residence.

The second stage of our sample design consisted of a random sample of 50 beneficiaries from each of the 12 contractor quarters sorted into 4 strata by total payments for services. The random sample of 600 beneficiaries produced 5,540 claims valued at $5.6 million for review. To ensure the completeness of the claim data, we reconciled Medicare contractor claim data to the HCFA 1522 Monthly Financial Reports for the 12 contractor quarters selected. The HCFA used these reports in preparing the FY 1998 financial statements.

We used a variable appraisal program to estimate the dollar value of improper payments in the total population. The population represented $176.1 billion in fee-for-service payments.

Audit Procedures. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. We contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response from our initial letter, we made numerous follow-up contacts by letter and, in most instances, by telephone calls. At selected providers, we also made onsite visits to collect requested documentation.

Medical review personnel from HCFA's Medicare contractors and peer review organizations (PRO) assessed the medical records to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded in accordance with Medicare reimbursement rules and regulations. We coordinated these reviews to ensure their consistency and accuracy. Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

In addition, we reviewed HCFA's corrective action plan addressing recommendations cited in our previous years' reports. We made this review in accordance with generally accepted government auditing standards and in conjunction with the audit of HCFA's FY 1998 financial statements. The results of our previous reviews of improper fee-for-service payments were included in our audit reports on HCFA's FY 1996 and 1997 financial statements. The Chief Financial Officers Act of 1990 requires Federal agencies to improve systems of financial management, accounting, and internal controls to ensure that they issue reliable financial information. Also, the Government Management Reform Act of 1994 requires full-scope audits of the financial statements of Federal agencies, including the Department of Health and Human Services.

RESULTS OF REVIEW

Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 5,540 fee-for-service claims processed for payment during FY 1998, we found that 915 claims did not comply with Medicare laws and regulations. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claim adjudication process.

Based on our statistical sample, the point estimate of improper Medicare benefit payments made during FY 1998 was $12.6 billion, or about 7.1 percent of the $176.1 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is $7.8 billion to $17.4 billion, or about 4.4 percent to 9.9 percent, respectively. This year's point estimate is $7.7 billion less than last year's point estimate of $20.3 billion and $10.6 billion less than the previous year's point estimate of $23.2 billion.

Decline in FY 1998 Improper Payments

We attribute the decline in FY 1998 improper payments to several efforts, as summarized below:

- ***HCFA efforts under the Medicare Integrity Program.*** The Medicare Integrity Program, under HCFA's direction, provides resources to expand contractor safeguard activities, including increased medical reviews, audits, provider education, and other special projects. As a result of previous OIG recommendations, HCFA has committed additional funding to strengthen contractor prepayment reviews. For instance, HCFA directed its contractors to conduct extensive prepayment reviews of certain types of physician claims that we had identified as vulnerable to improper payments. These types of reviews are essential for exposing program payment deficiencies, strengthening payment control edits, and revising Medicare guidelines.

- ***Fraud and abuse initiatives.*** Fraud and abuse initiatives on the part of the Administration and the Congress have had a significant impact. For example, Operation Restore Trust placed greater emphasis on more in-depth reviews of HHA claims. Also, the Health Insurance Portability and Accountability Act has provided both HCFA and OIG with a stable funding source for Medicare program payment safeguards, as well as fraud and abuse activities, for the next several years.

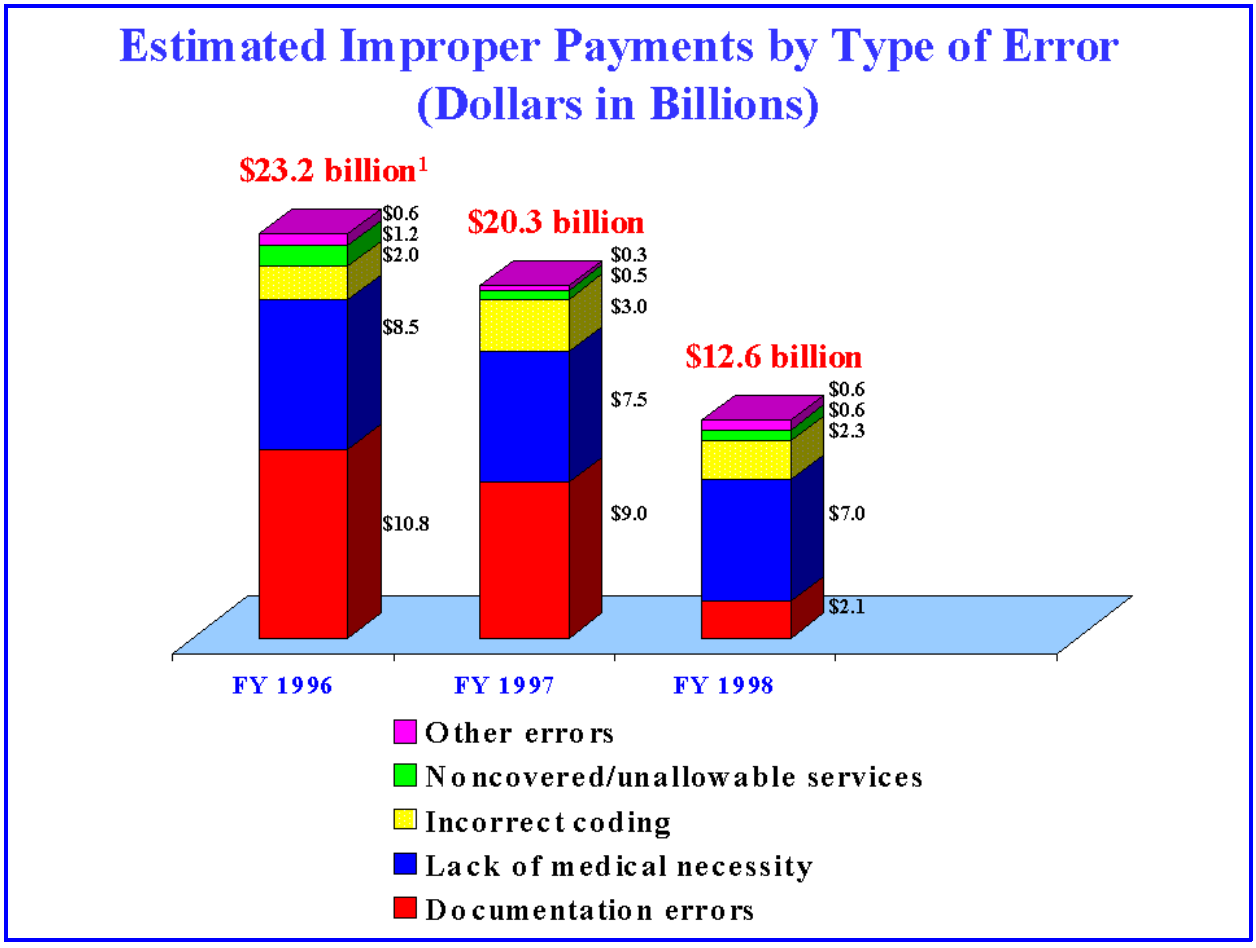
  The Health Care Fraud and Abuse Control Program, under the joint direction of the Attorney General and the Secretary (acting through the Inspector General), established a nationwide effort to coordinate Federal, State, and local law enforcement activities with respect to health care fraud. Other critical efforts include industry guidance (through formal advisory opinions and special fraud alerts), corporate integrity agreements with providers that settle allegations of fraud, beneficiary education and outreach, and pursuit of legislative changes to improve program administration and operation and reduce vulnerabilities to fraud.

  Also, the OIG, in consultation with HCFA, the Department of Justice, and the provider community, has developed guidance for specific health care industry sectors on how they may improve adherence to Medicare rules by establishing voluntary, comprehensive compliance programs. The adoption of such programs works to prevent fraud, waste, and abuse in the health care industry; helps efforts to provide quality care to patients; and assists health care entities in developing effective internal controls that reduce or eliminate submission of false or inaccurate claims.

- ***Improved provider compliance.*** Virtually all major provider groups, i.e., inpatient PPS, physicians, outpatient services, and home health agencies, had

significant error reductions from FY 1996. The provider community has been working aggressively with HCFA to ensure proper billings for services rendered, thereby ensuring compliance with Medicare program reimbursement rules.

The following chart, along with appendix 1, demonstrates the trends in improper payments by the major categories of errors we have identified over the last 3 years: (1) documentation errors, (2) lack of medical necessity, (3) incorrect coding, and (4) noncovered/unallowable services.



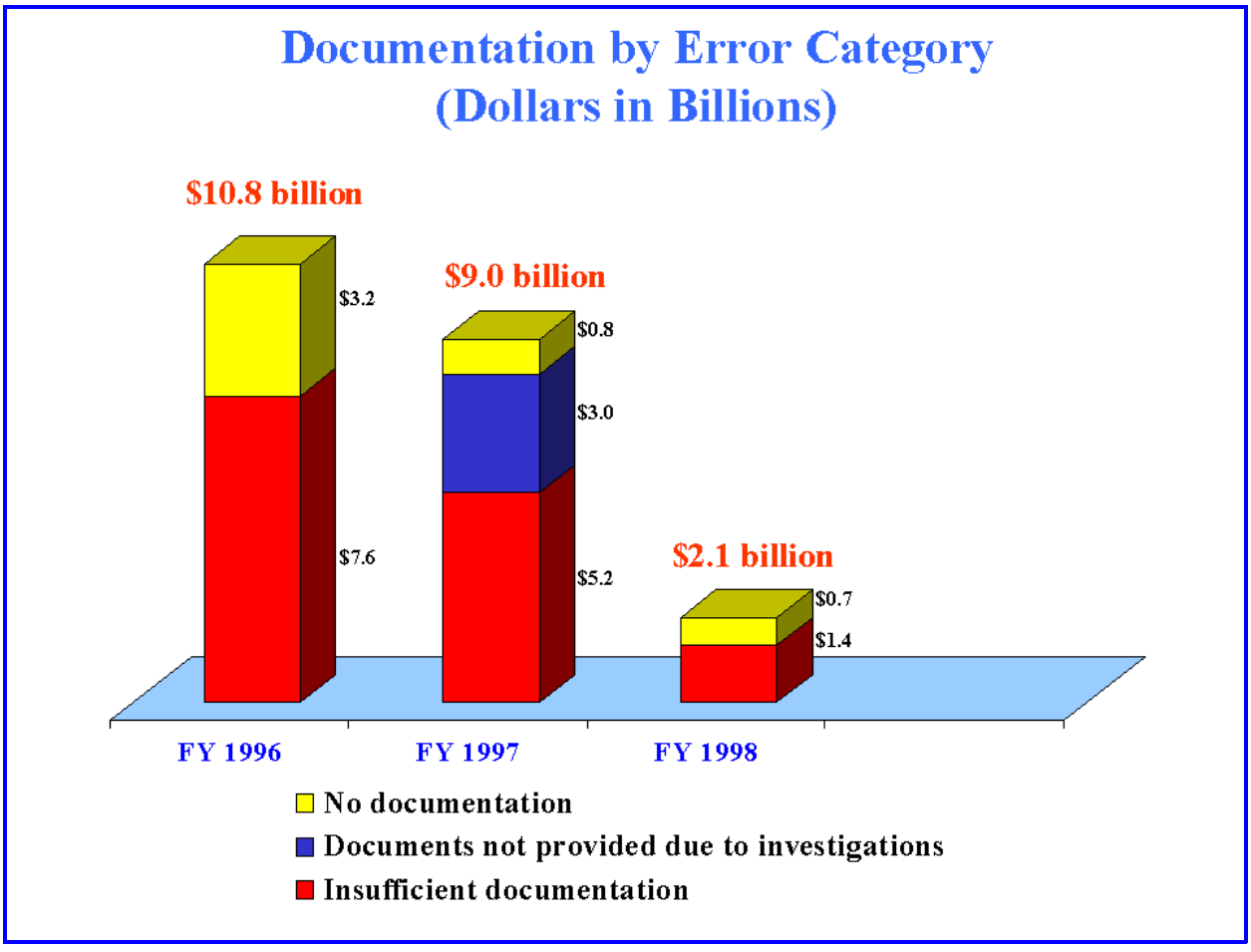
[1]*Does not add to total due to rounding.*

While the reduction in documentation errors is especially significant, errors due to the lack of medical necessity, incorrect coding, and noncovered or unallowable services remain matters of concern. The trends in these errors, including the various types of providers that accounted for the majority of the errors, are discussed below. (Also see appendix 2 for details.)

Significant Drop in Documentation Errors

The $10.6 billion reduction in improper payments since FY 1996 is primarily due to an $8.7 billion drop in documentation errors.

Of the four principal error categories, the reduction in documentation errors is most dramatic--dropping from $10.8 billion in FY 1996 to $2.1 billion in FY 1998, as noted in the chart below. These errors had represented the most pervasive problems in our samples for both FYs 1996 and 1997.



The overall category of documentation for FY 1998 includes two components: (1) insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. In FY 1997, we included an additional component within the documentation category to identify situations where providers were under investigation and the OIG could not obtain medical records to support billed services. In this regard, our FY 1997 sample included 151 claims being investigated by the OIG Office of Investigations and 16 claims being investigated by the Medicare contractors' fraud and abuse units. Because we were prohibited from requesting the medical records for these claims, which

amounted to $3 billion, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. In contrast, working with our Office of Investigations and the Department of Justice to satisfy legal concerns, we obtained all medical records on FY 1998 claims under investigation.

Medicare, like other insurers, makes payments based on a standard claim form. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If providers failed to provide documentation or submitted insufficient documentation, the contractors or OIG staff generally requested supporting medical records at least three times before determining the payment to be improper. Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries or the extent of services performed. It should be noted that HCFA subsequently upheld almost 99 percent of all past overpayments and recovered approximately 94 percent.

We believe that substantial improvement in documentation has been achieved primarily because of:

- ***HCFA and OIG outreach efforts.*** With the release of our FY 1996 report, OIG and HCFA together briefed providers on the audit results and Medicare documentation requirements. For example, HCFA hosted informational meetings with major professional organizations representing various physician specialties, the home health care industry, skilled nursing facilities, hospitals, and other providers. The purpose of these meetings was to familiarize the organizations with our findings and to explore opportunities for collaborating on educational efforts. As a result, various organizations agreed to publicize our audit findings and documentation guidelines in newsletters and other materials issued to their members.

- ***Implementation of HCFA's corrective action plan.*** Since the OIG released its FY 1996 audit results, HCFA developed and initiated several corrective actions designed to reduce Medicare payment errors. For example, in FY 1998, HCFA asked its contractors to perform prepayment reviews on selected claims for evaluation and management codes. In addition, HCFA asked contractors to increase their overall level of claims review (pre-pay and post-pay), including the review of supporting documentation. The HCFA dedicated approximately $14 million to increase the level of claims review in accordance with its corrective action plan. An additional $10 million was focused on medical reviews and audits of a provider group with aberrant billing practices.

Even with the notable reduction in documentation errors this year, we estimate that these errors total $2.1 billion. Continued efforts are therefore needed to reinforce to providers the need to maintain medical records supporting their claims.

Some examples of continuing documentation problems follow:

- **Physician**. Medicare paid a physician $871 for 40 hospital visits. The medical records, however, supported only 18 visits. Therefore, payment of $479 for the 22 visits without supporting documentation was denied.

- **Outpatient.** A hospital was paid for two hemodialysis sessions, but the medical records supported only one session. Therefore, the provider was denied the $111 payment for the second session.

- **Physician.** An ophthalmologist was paid $87 for an examination and treatment of a Medicare patient. However, the medical records submitted by the ophthalmologist identified neither the beneficiary nor the date of service. The Medicare contractor's records indicated that this patient was hospitalized for major abdominal surgery a week earlier and remained hospitalized until the day after this office visit. Therefore, the $87 payment was denied.

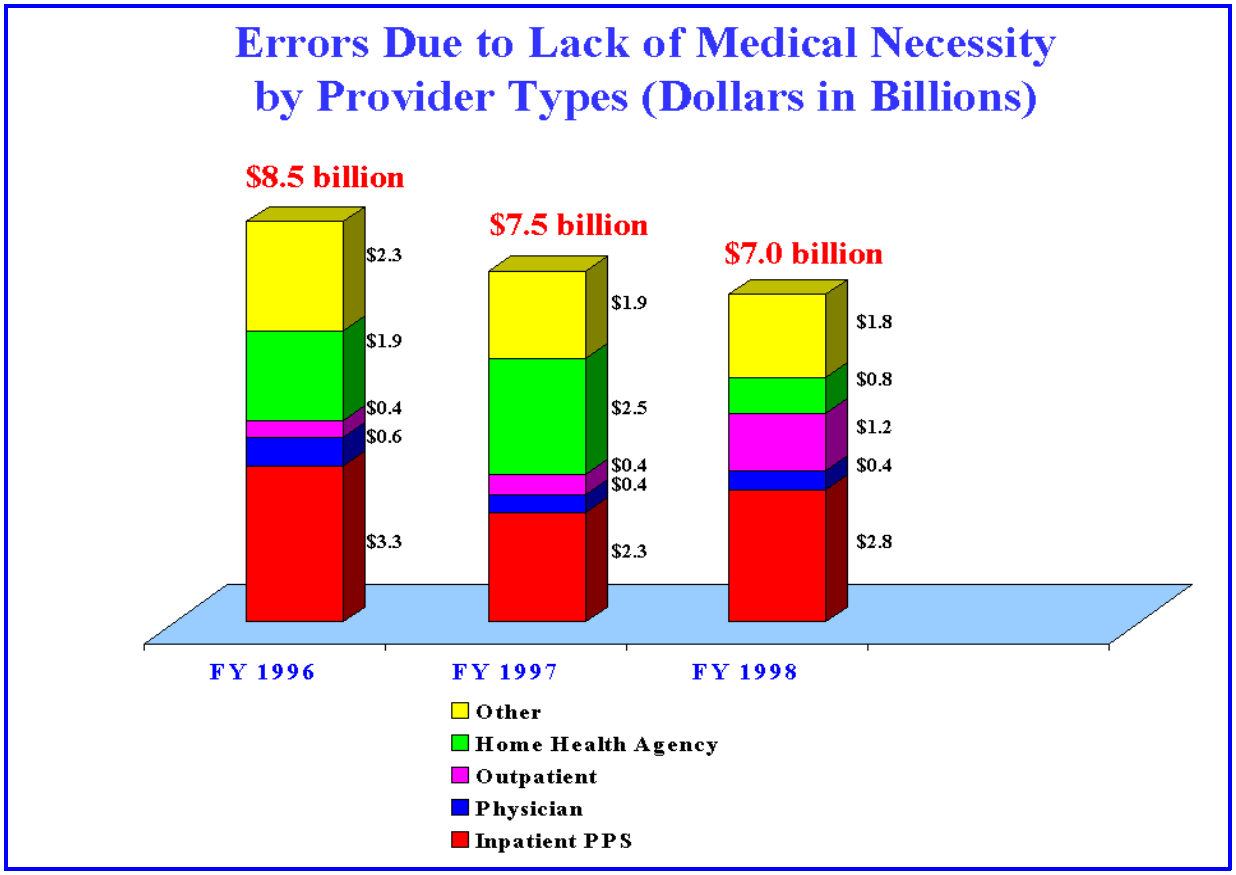
- **HHA.** An HHA was paid $64 for skilled nursing visits. There was no documentation in the medical records to support the visits. As a result, the medical reviewers denied payment.

Errors Due to Lack of Medical Necessity

Errors due to the lack of medical necessity represent the highest error category in FY 1998.

This error category covers situations where the medical records contained sufficient documentation to allow the medical review staff to make an informed decision that the medical services or products received were not medically necessary. **As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the Medicare claims.

The lack of medical necessity was the highest error category this year and the second highest for both FYs 1996 and 1997. As noted in the following chart, these types of errors in inpatient PPS claims have been consistently significant in all 3 years (FY 1996 - about $3.3 billion of the total $8.5 billion; FY 1997 - about $2.3 billion of the total $7.5 billion; and FY 1998 - about $2.8 billion of the total $7 billion).



In the case of outpatient services, we noted a major shift of errors this year from the documentation category to errors due to the lack of medical necessity. For example, in FY 1996, errors in outpatient claims totaled an estimated $2.8 billion, of which $2.3 billion was attributable to documentation concerns. For FY 1998, errors in outpatient claims totaled $1.7 billion, of which $1.2 billion was due to the lack of medical necessity.

Following are examples of services that were found not medically necessary:

- **Hospital inpatient**. A beneficiary was admitted to an acute care hospital for a trachea resection surgical procedure. The beneficiary was discharged without having the procedure, and the hospital was paid $15,625. The beneficiary was subsequently readmitted to the same hospital, and the procedure was performed during the second admission. Based on a review of the medical records, the PRO concluded that the procedure should have been completed during the initial hospital stay and that the beneficiary was prematurely discharged at that time. As a result, the second admission was determined not medically necessary and the total payment of $21,284 for that admission was denied.

- **HHA**. An HHA was paid for 25 skilled nursing visits totaling $1,198. Although documentation from the HHA indicated that the beneficiary was homebound, our interview with the beneficiary determined that she continued to drive an automobile and thus was not homebound. As a result, she was not entitled to Medicare coverage of home health services, and the $1,198 payment was denied.

- **Community Mental Health Center**. A community mental health center was paid $21,421 for a beneficiary who received services under the partial hospitalization program. This program is designed to treat patients who exhibit severe or disabling problems related to acute psychiatric/psychological conditions. The medical reviewers determined that the beneficiary had already achieved sufficient stabilization and that the services provided were therefore medically unnecessary. The entire payment was denied.

- **Transportation**. An ambulance company was paid $201 for transporting a patient from a hospital to a skilled nursing facility 5 miles away. The medical review staff determined that transportation by ambulance was not medically necessary based on medical evidence that the patient displayed stable vital signs and required no medical intervention during the transfer to the skilled nursing facility. Therefore, the $201 payment was denied.

- **SNF**. A SNF was paid $10,428 for a 51-day skilled nursing stay. However, the patient's medical records documented that the patient received only maintenance-level (nonskilled) nursing home care, such as routine occupational therapy and the continuation of routine medication. Because Medicare does not reimburse for nonskilled services, the entire payment was denied.

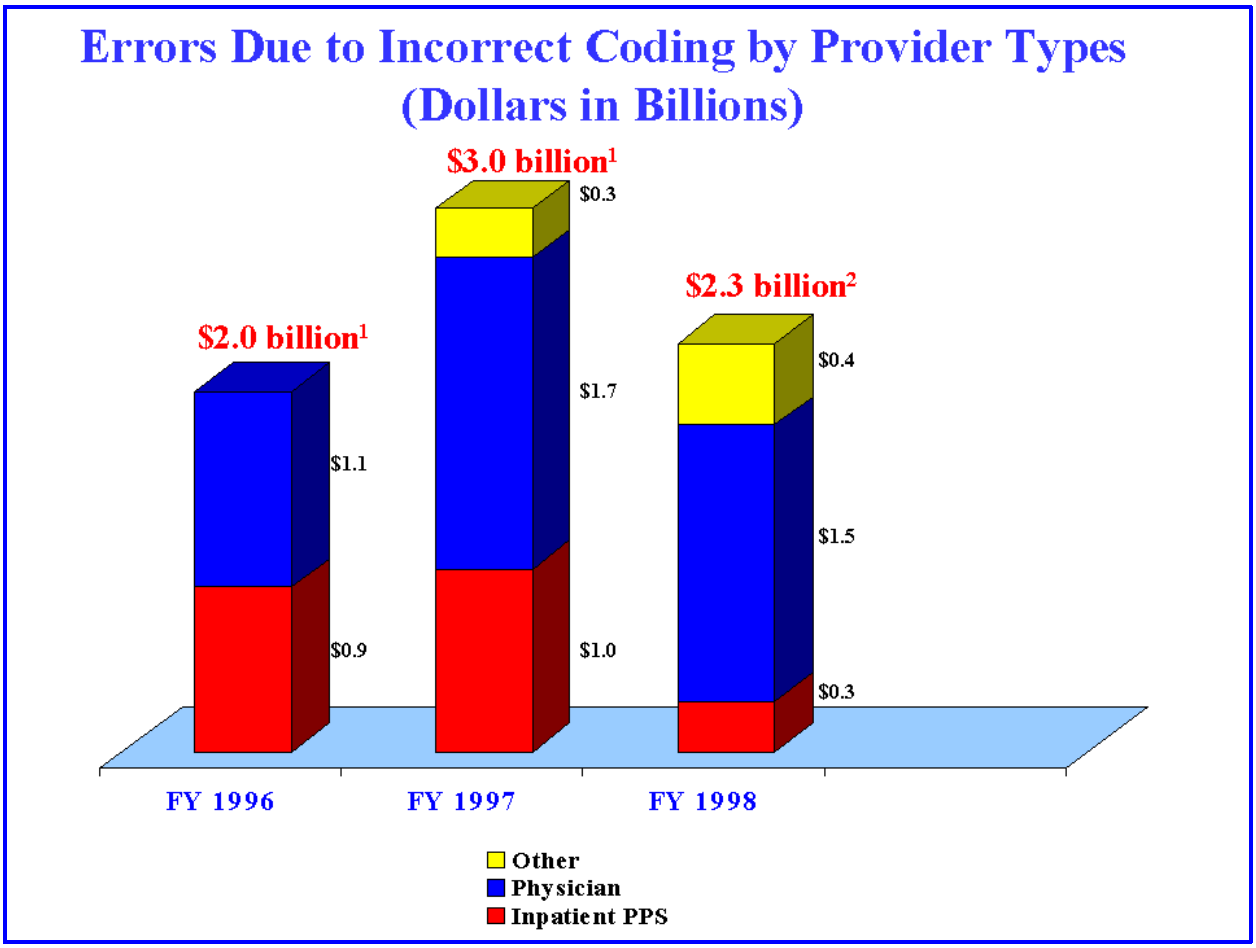
- **Outpatient.** An outpatient rehabilitation facility was paid $237 for speech therapy services. The medical review staff determined that the services performed were of a routine nature and did not require the services of a skilled speech therapist. The reviewer denied the entire payment as medically unnecessary.

Errors Due to Incorrect Coding

Over 80 percent of the coding errors have been found in physician and inpatient PPS claims over the last 3 years.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the contractor medical review staff determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Incorrect coding is the second highest error category this year, representing $2.3 billion, or almost 18 percent, of the total improper payments. As illustrated in the following chart, physician and inpatient PPS claims accounted for over 80 percent of the coding errors in FYs 1996, 1997, and 1998.



[1] *Includes insignificant errors by other provider types.*
[2] *Does not add to total due to rounding and insignificant errors by other provider types.*

Some examples of incorrect coding follow:

- **Hospital.** A hospital was paid $33,380 for performing a partial thyroidectomy to remove part of the patient's thyroid gland. Based on the medical records, the surgical procedure actually performed was a less complex partial parathyroidectomy to remove small glands and tissues located near the thyroid gland. The PRO's correction of the procedure code produced a lesser valued diagnosis-related group (DRG) of $19,695, resulting in denial of $13,685 of the payment.

- **Hospital.** A hospital was paid $8,431 for treatment of pneumonia based on the principal and secondary diagnosis codes submitted on the claim. The medical records indicated that the principal diagnosis should be changed from a general bacteria description to the specific bacteria (H. Influenza) that caused the pneumonia. This change produced a less

extensive DRG which paid $5,444 for the services. Therefore, $2,987 of the payment was denied.

- ❑ **Physician.** A physician was paid $103 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the medical review staff determined that the provider's documentation supported a less complex, expanded problem-focused history, expanded problem-focused examination, and straightforward medical decisionmaking. As a result, $46 of the payment was denied.

- ❑ **Physician.** A physician was paid $108 for a hospital visit which included a detailed interval history, a detailed examination, and medical decisionmaking of high complexity. The medical review staff determined that the level of service actually provided supported a lower level procedure code of focused interval history and decisionmaking of moderate complexity. Because the provider should have billed a lower level of care, $30 of the payment was denied.

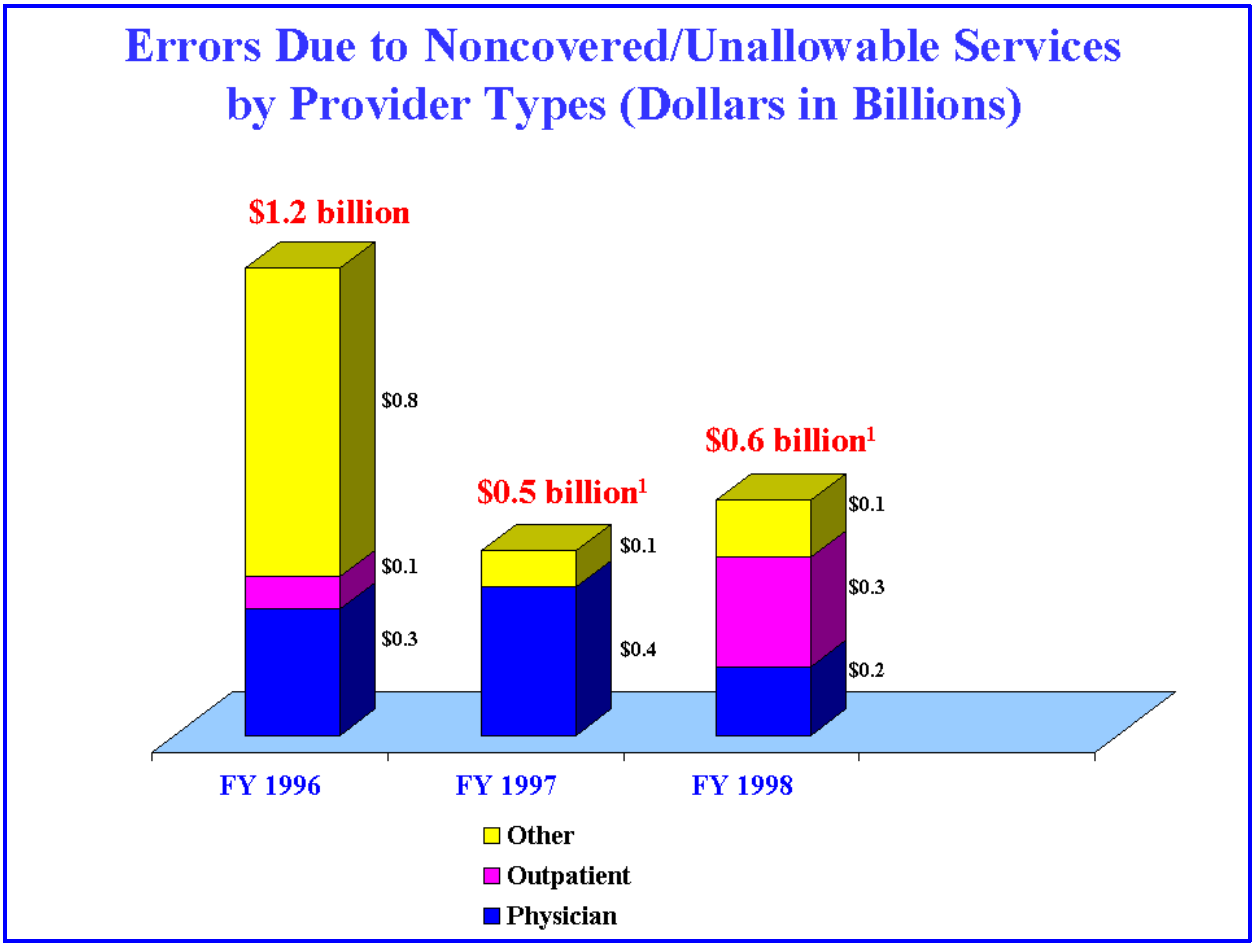
Errors Due to Noncovered or Unallowable Services

We noted some improvement in errors due to noncovered or unallowable services since FY 1996.

Errors due to noncovered or unallowable services have consistently constituted the smallest error category. For the last 2 years, the majority of errors in this category were attributable to physician and outpatient claims, as noted in the chart on the next page.

Unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the *Medicare Handbook*, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;
- eye and ear examinations to prescribe or to fit glasses or hearing aids;
- most prescription drugs;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray.



[1] *Includes insignificant errors by other provider types.*

Following are some examples of noncovered or unallowable services identified during our review:

- **Outpatient.** An outpatient provider was paid $56 for laboratory work which, according to the medical records, was part of a routine physical examination. Since Medicare does not cover such examinations, the payment was denied.

- **Physician.** A physician was paid a total of $34 for two claims for treatment deemed experimental. Medical review follow-up determined that the treatment involved bioelectric medicine. Since this procedure is considered experimental and is not covered by Medicare, the total payment was denied.

- **Physician**. A physician was paid $47 for services which, according to the medical records, were for a routine annual physical examination. The total amount was denied because Medicare does not cover routine physical examinations.

CONCLUSIONS AND RECOMMENDATIONS

Based on our FY 1998 sample, we estimate that this year's Medicare fee-for-service payment error rate is 7.1 percent, or $12.6 billion. This error rate is $10.6 billion less than that for FY 1996, when we developed the first national error rate. We attribute this reduction to HCFA's efforts under the Medicare Integrity Program, fraud and abuse initiatives, improved provider compliance with Medicare reimbursement rules, HCFA/OIG efforts to emphasize provider compliance with Medicare documentation requirements to support services billed, and implementation of HCFA's corrective action plan.

The HCFA has made substantial progress in reducing improper payments in the Medicare program. We found positive indications that fee-for-service payment errors are declining and that health care providers are doing a better job in reducing the number of unsupported services to Medicare beneficiaries. However, our audit results for the 3-year period clearly demonstrate that the Medicare program remains inherently vulnerable to improper payments. In this regard, the FY 1998 improper payments relating to medically unnecessary services ($7 billion) and improperly coded services ($2.3 billion) are of significant concern. The HCFA needs to continue its diligence to ensure progress in reducing past identified problems.

A number of issues could negatively affect future error rates:

- ***Substantial Year 2000 initiatives.*** More than 100 claim processing systems are being renovated/changed to comply with millennium requirements.

- ***Instability of Medicare contractors***. The HCFA has experienced a record number of contractor terminations and consolidations.

- ***Legislative requirements.*** Additional requirements resulting from the Balanced Budget Act of 1997 must be implemented and enforced.

To keep abreast of the continuing changes in the health care area while adequately safeguarding the Medicare Trust Fund, we recommend that HCFA:

- Continue to update its systems' capabilities to keep pace with questionable billing practices.

- Ensure that adequate program safeguards are in place for those Medicare contractors that transition out of the Medicare program.

- Enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare payments.

- Continue to direct that the Medicare contractors expand provider training to further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare for services provided.

- Ensure that contractors recover the improper payments identified in our review.

- Direct its PROs to identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews. We believe these types of reviews are essential to reduce improper Medicare payments and to ensure continued provider integrity.

- Continue to refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented.

- Continue to encourage health care providers to adopt compliance plans which promote adherence to applicable Federal program requirements and laws.

The HCFA officials generally concurred with our findings and recommendations, and their comments have been incorporated where appropriate.

Appendices

APPENDIX 1

Estimated Improper Payments by Type of Error
(Dollars in Millions)

Type of Error	1996		1997		1998		Increase (Decrease) from 1996 to 1998	
Documentation	$10,846	46.77%	$ 8,994	44.35%	$2,115	16.83%	($8,731)	(80.50%)
Insufficient documentation	*$7,596*		*$5,203*		*$1,403*		*($6,193)*	
Documents not provided due to investigations			*$2,941*					
No documentation	*$3,250*		*$ 850*		*$ 712*		*($2,538)*	
Lack of medical necessity	$8,529	36.78%	$7,480	36.88%	$6,981	55.56%	($1,548)	(18.15%)
Incorrect coding	$1,978	8.53%	$2,975	14.67%	$2,256	17.96%	$278	14.05%
Noncovered or not allowable services	$1,219	5.25%	$ 530	2.61%	$618	4.92%	($601)	(49.30)
Other	$620	2.67%	$303	1.49%	$594	4.73%	($26)	(4.19%)
Total	**$23,192**	**100%**	**$20,282**	**100%**	**$12,564**	**100%**	**($10,628)**	

APPENDIX 2

The following table shows the types of errors and provider claims included in the $12.6 billion improper payments estimate for FY 1998. About 78 percent of these improper payments occurred within the first four provider types highlighted below:

Types of Errors (dollars in millions)								
Type of Provider	*Lack of Medical Necessity*	*Incorrect Coding*	*Insufficient Documentation*	*No Documentation*	*Non-Covered or Not Allowable*	*All Other Errors*	*Total*	*Percentage of Improper Payments*[1]
Inpatient PPS	$2,811	$278	$107		$6	$82	$3,284	26.14%
Physician	394	1,510	393	554	178	178	3,207	25.53%
Outpatient	1,221	27	63	77	285	1	1,674	13.32%
HHA	781	1	795	5			1,582	12.59%
Subtotal	$5,207	$1,816	$1,358	$636	$469	$261	$9,747	77.58%
SNF	$878						$878	6.99%
Inpatient Non-PPS	396	452					848	6.75%
Laboratory	327	(19)[2]	26	70	146		550	4.38%
End Stage Renal Disease	19	4	9	6		347	385	3.06%
Transportation	76		10				86	0.69%
Ambulatory Surgery	43						43	0.34%
DME	35	3				(14)[3]	24	0.19%
Hospice					3		3	0.02%
Total	$6,981	$2,256	$1,403	$712	$618	$594	$12,564[4]	100.00%
Percentage of Improper Payments	55.56%	17.96%	11.17%	5.66%	4.92%	4.73%		

[1] Percentage of the overall estimate of $12.564 billion by type of claim.

[2] Negative dollars represent claims where the medical review determined that the provider was underpaid.

[3] Negative dollars represent claims for which the number of services billed was less than the number of services provided.

[4] The range of improper payments at the 95 percent confidence level is $7.755 billion to $17.372 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all dollars equals the overall estimate of $12.564 billion.