Documentation Errors Result in Medicare Overpayment

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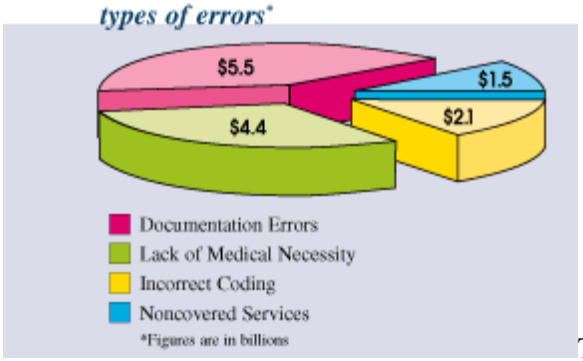
by Cheryl Hammen, RHIT

The objective of the Office of the Inspector General's (OIG) fiscal year 1999 audit was to determine whether medical fee-for-service claims complied with Medicare rules and regulations. The OIG examined claims for accurate documentation and coding, medical necessity, and to ensure that claims were provided by certified Medicare providers to eligible beneficiaries. The results, released in February, were based on a statistically valid sampling of 5,223 claims with a total reimbursement of $5.4 million. Of the sample, the OIG determined that 1,034 claims did not comply with Medicare rules and regulations. As a result, the OIG estimated that of the $169.5 billion paid for Medicare services in fiscal year 1999, $13.5 billion or 7.97 percent in overpayments were made.

Although this is almost $1 billion more than the $12.6 billion overpayment in fiscal year 1998, the OIG believes that the difference is a result of statistical variability rather than a true increase in errors. In other words, this year's sample of claims compared to last year's sample would result in a variation in dollar amounts.

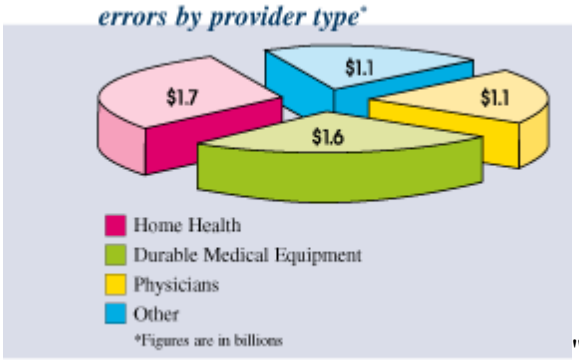
Examining the Errors



The $13.5 billion in overpayments were attributed to the errors identified in "Types of Errors,". Documentation errors represented $5.5 billion or 41 percent of all errors identified during the audit, which is a $3.4 billion increase in the dollar value of documentation errors in fiscal year 1998 ($2.1 billion).

The OIG classifies documentation errors according to whether the documentation to support the services provided was insufficient or nonexistent. According to Medicare regulation 42 CFR 482.24(c), providers are required to maintain sufficient documentation to support the diagnoses, admissions, treatments, and continued care of the patient. Of the $5.5 billion worth of errors, insufficient documentation accounted for $4.5 billion in overpayment, while $1 billion can be attributed to the absence of supporting documentation.

Documentation should include pertinent facts, findings, observations, history, physical examinations, tests, treatments, and outcomes to ensure high-quality care is provided to all Medicare beneficiaries. Continuity of care, communication among healthcare professionals, patient evaluation and treatment planning, and quality of care evaluations are important outcomes of good documentation.



"Errors by Provider Type," reveals that the majority of documentation errors came from physician, durable medical equipment, and home health claims, resulting in 80 percent of the documentation errors identified. Examples of these errors from the OIG's report appear in "Sample Errors from the OIG Audit Report,". No inpatient documentation errors were noted in the 1999 audit.

Providers were given the opportunity to provide additional documentation to support their Medicare claims, but in many instances, the provider did not respond to OIG staff. Thus, the reviewers had no choice but to determine that these claims resulted in overpayment.

Address Audit Issues Now

In its conclusion, the OIG recommended that HCFA expand provider training to ensure complete and accurate documentation. Providers should not wait until mandatory training is instituted, but should begin their efforts to improve documentation now. Policies and procedures should be developed so when deficiencies in documentation are identified, the next steps are clearly defined.

Education is the key to complying with both the government's initiatives and an organization's efforts. Providers should review the fiscal year 1999 audit results to obtain a clear understanding of the current documentation issues. A concentrated effort should be made to provide internal training to medical, ancillary service, and coding/billing staff to ensure that documentation will meet the demands of an external audit.

Reference

"Improper Fiscal Year 1999 Medicare Fee-For-Service Payments." Office of Inspector General, February 2000, report #A-17-99-01999. Available at www.hhs.gov/progorg/ oas/cats/hcfa.html.

Sample Errors From the OIG Audit Report

Home Health Agency

A home health agency was paid $309 for five skilled nursing visits. While four of the visits were adequately supported, one visit was not documented in the medical records. As a result, the medical reviewers denied the $61 payment for this visit.

Durable Medical Equipment Supplier

A supplier was paid $815 for an enteral feeding supply kit, a gastrostomy tube, and 380 units of enteral formula. The medical review staff concluded that the supplier's documentation was not sufficient to support the claim because records did not include physician's progress notes, laboratory values, radiological studies ordered, or weight charts. In addition, because the delivery ticket did not provide individual beneficiary information, medical reviewers were unable to determine what products were delivered and to whom. As a result, the total payment was denied.

Physician

A physician was paid $38 for interpreting an abdominal ultrasound. Based on the medical records, the reviewer found no evidence of an ultrasound or an interpretation of an ultrasound on this date of service. Therefore, the payment was denied.

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