Common Errors That Lead to Improper Payments for Habilitation and Waiver Programs

The Centers for Medicare & Medicaid Services (CMS) and the States are increasing educational outreach about Home and Community-Based Services (HCBS) to enhance awareness of and engage providers and beneficiaries in efforts to reduce payment errors and fraud, waste, and abuse in the Medicaid program.

The Medicaid Integrity Program, established under the Deficit Reduction Act of 2005, and the President's November 2009 Executive Order 13520 Reducing Improper Payments and Eliminating Waste in Federal Programs are two comprehensive strategies that protect the integrity of the Medicaid program.

As part of these programs, CMS has analyzed data produced by the Payment Error Rate Measurement (PERM) program to identify areas that may be at high risk for improper payments and to target root causes for errors. Due to these PERM-identified payment errors, CMS implemented a supplemental measure to further assess HCBS. Through its analysis, CMS identified multiple payment errors and root causes.

This fact sheet has been developed to educate beneficiaries and providers about the major causes of payment errors and to maintain program integrity.

These are the key terms used in this document:

- **Beneficiary:** includes the person receiving Medicaid HCBS and their legal guardian, family member, or other support;
- **Provider:** includes physician; nurse practitioner; registered nurse; licensed practical nurse; aide; private or not-for-profit agency; case manager; State Medicaid agency or State sister agency; Medicaid durable medical equipment, supplies, and devices supplier; home modification business; or other providers of HCBS; and
- **Person-centered plan:** synonymous with plan of care, care plan, individual service plan (ISP), individual education plan (IEP), or other terms used to describe a written individual plan that includes HCBS.

This fact sheet summarizes the Medicaid benefit regarding Habilitation and Waiver programs and common documentation errors identified during PERM analysis. After reading this fact sheet, providers should be able to describe:

- Common Habilitation and Waiver program documentation errors that were identified during PERM analysis;
- Promising practices to reduce or eliminate these errors; and
- Where to go for additional resources.

Overview of Habilitation and Waiver Programs

In 1981, Congress authorized the waiver of certain Federal requirements, enabling States to provide Medicaid to eligible individuals to allow them to live in the home and community as an alternative to institutionalization under section 1915(c) of the Social Security Act.[1] These waivers, also called HCBS waivers, enable States to design programs that meet the needs of targeted populations with specific needs who reside within their State.

A State can create multiple waiver programs to serve people in multiple areas with multiple conditions. Populations served by HCBS waivers include individuals with physical, mental, and intellectual disabilities, the aged, or people with chronic conditions. States can offer a variety of unlimited services under a waiver; however, the services must be necessary to avoid institutionalization, and they must be approved by CMS.[2] Services are provided in a recipient's residence, which could be an assisted living facility, residential rehabilitation program, or group home, and in the community through programs such as outpatient day habilitation programs or adult day care.

Overview of Common Errors

Improper payments for habilitation and waiver services may occur when Medicaid funds are paid to the wrong entity, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the person-centered plan. PERM data was analyzed to determine the root cause of payment errors for habilitation and waiver services. The analysis identified three common errors: insufficient documentation, no documentation, and number of units error.

Insufficient Documentation

Insufficient documentation errors occur when the documentation submitted by a provider does not fully support the procedure code billed. Common documentation errors for habilitation and waiver services include:

- Service logs were missing the care provider's name, dates of service delivery, time spent, and activities performed. In addition, the logs were not signed by the personal care aide, the beneficiary, or both, as required;
- Progress notes were not legible, were not signed, were missing for the date of service, or did not indicate if the services billed were provided;
- For services provided in another venue (adult day care, day habilation, assisted living, residential habilitation program), there were no records submitted to show that the beneficiary was present to receive the services;
- Documentation provided did not support necessity of the service;
- Person-centered plans, assessments, or reassessments were not completed, and person-centered plans were not current and in effect at the time the services were provided;
- Physician orders were missing or out of date (not always required, check your State Medicaid agency provider website); and
- Services billed were not authorized in the person-centered plan.

No Documentation

Sometimes providers do not submit any documentation at all. The root causes of missing documentation in habilitation and waiver services include:

- Providers did not respond to the request for documentation to support the claim;
- Providers did not follow documentation retention requirements and destroyed the documentation;
- Providers were unable to locate the documentation; and
- Providers submitted documentation for the wrong beneficiary.

Number of Units Error

Number of units errors occur when a provider bills for an incorrect number of units for a procedure code. Common errors for habilitation and waiver services include.

- Codes that were incomplete (no modifier) or incorrect;
- Documentation provided did not support the number of units billed;
- The number of units billed was not authorized in the person-centered plan;
- The number of units of service provided during the overnight shifts was not separated into two dates of service;

- The number of units authorized, documented, and billed exceeded the beneficiary's budget; and
- The number of units was not calculated correctly. If the provider is supposed to bill by the hour, two hours would equal two units; but instead, if the provider calculates the units in 15 minute increments, the provider may have submitted a bill for eight units of treatment.

  For example, a provider billed 208 units (52 hours in 15 minute increments) of procedure code T1024-Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to severely handicapped children, per encounter for dates of service 07/01–07/31/2010. Documentation provided supports 52 units (52 encounters) of procedure code T1024 provided.

Promising Practices

There are some promising practices that can be integrated into daily practice to correct most of the errors found. They include:

- Quality control on services:
  - Check to make sure the staff person providing the service is authorized to provide the service;
  - Check documentation to make sure services provided are documented;
  - Check documentation to be sure it is complete (with care provider's name, dates of service delivery, time spent, activities performed, signatures in place); and
  - If services are provided in another venue, make sure attendance logs reflect beneficiary attendance on the date of service.
- Quality control on beneficiary records:
  - Check for required forms in the record;
  - Check to make sure person-centered plan, assessments or reassessments, and physician orders, if required, are current; and
  - Check for beneficiary identifier on each document.
- Quality control for claims processing:
  - Check the number of units billed against documentation;
  - Check the procedure code;
  - Check to make sure the dates of service entered match the dates of service in the documentation; and
  - Check the calculation of units.

Conclusion

States design their Habilitation and Waiver programs with the intent to provide Medicaid to eligible individuals to allow them to live in the home and community as an alternative to institutionalization. Populations served by HCBS waivers include individuals with disabilities, the aged, or those who have chronic conditions. Improper payments for habilitation and waiver services may occur when Medicaid funds are paid to the wrong entity, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the person-centered plan. The analysis identified three common types of errors: insufficient documentation, no documentation, and number of units error.

Providers can play a significant role in the fight against Medicaid fraud, waste and abuse. CMS hopes you share its commitment to eliminate payment errors and fraud, waste and abuse in the Medicaid program. By increasing your awareness of common errors and applying remedies in your daily practice, you will help strengthen the

integrity of the Medicaid program and reduce improper payments. For further information, review the toolkits about HCBS at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

Additional Resources

Links to State Medicaid agency websites are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html on the Medicaid website.

Information about Medicaid HCBS is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html on the Medicaid website.

Information about payment accuracy and improper payments is available at https://paymentaccuracy.gov/about-improper-payments on the Internet.

Information about the PERM program is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM on the CMS website.

To see the electronic version of this fact sheet and the other products included in the "Home and Community-Based Services" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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References

1 U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. (2010). Understanding Medicaid Home and Community Services: A Primer. 2010 Edition. Retrieved September 10, 2015, from http://aspe.hhs.gov/sites/default/files/pdf/76201/primer10.pdf

2 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual, Chapter 4, Section 4442.3, Definition of Services. Retrieved September 10, 2015, from https://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

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