

Medicare Fee-For-Service 2010 Improper Payment Report

FOREWORD

The 2010 Medicare Fee-for-Service (FFS) improper payment rate of 10.5 percent, as published in the 2010 Medicare FFS Improper Payment Rate Report, represented \$34.3 billion in improper payments. However, the 2010 published rate does not include the late documentation/appeals adjustment that was introduced during the 2011 report period. Information on the 2011 Medicare FFS improper payment rate and the late documentation/appeals adjustment will be presented in the 2011 Medicare FFS Improper Payment Rate Report.

Medicare Fee-For-Service 2010 Improper Payment Report

EXECUTIVE SUMMARY

The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010, requires the heads of Federal agencies, including the Department of Health and Human Services (HHS) to annually review programs it administers to:

- Identify programs that may be susceptible to significant improper payments,
- Estimate the amount of improper payments in those programs that are determined to be susceptible to significant improper payments,
- Submit those estimates to Congress, and
- Describe the actions the Agency is taking to reduce improper payments in those programs.¹

The Centers for Medicare & Medicaid Services (CMS) has identified the Medicare Fee-for-Service (FFS) program as a program at risk for significant erroneous payments. In 2010, the Medicare FFS paid claims error rate was 10.5 percent, or \$34.3 billion in improper payments. In 2010, CMS continued to review claims according to a significantly revised and improved methodology implemented in 2009. As a result of these improvements and a more complete accounting of improper payments, the 2009 and 2010 overall error rates were higher than the 2008 improper payment rate; 12.4 percent and 10.5 percent in 2009 and 2010 respectively, compared to 3.6 percent in 2008.

Between 2009 and 2010 CMS reduced the Medicare FFS error rate by 1.9 percent or \$1.1 billion. Had the error rate remained at 12.4 percent in 2010, there would have been \$40.5 billion in improper payments in Medicare FFS, \$6 billion more in improper payments than experienced. For purposes of setting an estimated baseline for future

¹ OMB M-06-23, Appendix C to OMB Circular A-123, August 10, 2006.

² The HHS 2009 Agency Financial Report (AFR) shows the Medicare FFS error rate as 7.8 percent, or \$24.1 billion in improper payments; however this rate reflects a combination of two different review methodologies; 1) that included errors determined using the old review process (which most of the claims were reviewed) and 2) that included errors determined using the newer more stringent review process. After publication of the 2009 AFR, HHS decided to use the error rate using the newer more stringent review process as the 2009 rate.

goals, as well as for consistency and comparability of data, CMS uses 12.4 percent as the 2009 improper payment rate throughout this report.²

During the analysis of improper payments identified in 2010, CMS found that the improper payments error rate for inpatient hospital claims had increased significantly from last year. A large number of the payment errors were due to clinical care and procedures provided in an acute inpatient hospital that should have been provided in an outpatient hospital or another less intensive setting, meaning the clinical service was medically necessary but the place of service was incorrect. Under the current Medicare statute, these claims must be denied in full. These inappropriate “place of service” errors accounted for projected improper payments of \$5.1 billion.

For inpatient hospital claims, a large percentage of medically unnecessary errors are related to hospital stays of short duration. In many cases, those services could have been rendered at a lower level of care, such as outpatient observation services. A smaller, but persistent amount of medically unnecessary payment errors are for inpatient hospital stays of three to five days, many of which resulted in a transfer to a skilled nursing facility (SNF). Some of these patients may have been admitted solely to satisfy the requirement for a minimum of three days as an inpatient in order to qualify for a SNF stay.

A portion of medical necessity errors for inpatient hospital claims is related to the denial of an invasive procedure that affected the Diagnosis Related Group (DRG) payment. If an invasive procedure did not meet the requirements of a Local Coverage Determination (LCD) or National Coverage Determination (NCD) and affected the DRG payment, the procedure was denied as a medically unnecessary service. In these cases, the DRG was reclassified after removing the medically unnecessary procedure. If the inpatient hospital stay included other Medicare covered services the improper payment amount was the difference between the billed DRG and the reclassified DRG; if no other covered services were provided the entire payment was considered improper.

We also found some notable decreases in certain areas due to enhanced educational efforts and policy clarifications related to Medicare signature requirements. The Part B error rate decreased from 18.9 percent in 2009 to 12.9 percent. The error rate for Part A non-inpatient hospital claims dropped from 8.8 percent in 2009 to 4.2 percent. While we are pleased with the decreases, we recognize that more is needed to further reduce errors throughout the Medicare FFS program.

Pursuant to the President’s directive to reduce improper payments, CMS established a goal to reduce the 2009 error rate by 50 percent, or 6.2 percent, by 2012. CMS strives to eliminate improper payments in the Medicare program, maintain the Medicare trust funds and protect its beneficiaries. To better account for improper payments, CMS refined the Comprehensive Error Rate Testing (CERT) process beginning in 2009 and required that medical review procedures adhere to a more strict enforcement of medical documentation and coverage policies. In addition, CMS continued to analyze the improper payment data

garnered from the CERT program to make changes in areas where programmatic weaknesses exist. CMS also works with its contractors to ensure that Medicare FFS claims receive a more vigilant review before being processed. To further reduce errors, CMS will continue its efforts to work closely with the healthcare industry to ensure that providers and suppliers understand and follow CMS' policies and medical record requirements.

CMS will also analyze the improper payment data to determine if there are geographic trends that will result in further refining corrective actions and/or developing new procedures that will address programmatic weaknesses that may exist. CMS will review trends by types of service to locate potential vulnerabilities. CMS will use this knowledge to design innovative approaches to reduce improper payments, particularly in high risk areas such as durable medical equipment and home health. The error rate is not a measure of fraud; however, it may be an indication of program weaknesses and vulnerabilities that require more monitoring, oversight and diligence by CMS.

Reducing improper payments is a high priority for CMS. We are working on multiple fronts to attack this issue in order to meet our goals including increased prepayment medical review, enhanced analytics, expanded education and outreach to the provider/supplier communities, and expanded review of paid claims by our Recovery Auditors. CMS will continue to assess error rate measurement procedures and will make improvements and modifications as necessary to ensure the most accurate accounting of improper payments. Together these efforts will result in more accurate claims payment and a reduction of waste and abuse in the Medicare FFS program. This report describes the Medicare FFS improper payments in 2010, and steps CMS is taking to address these errors.

OVERVIEW

Background

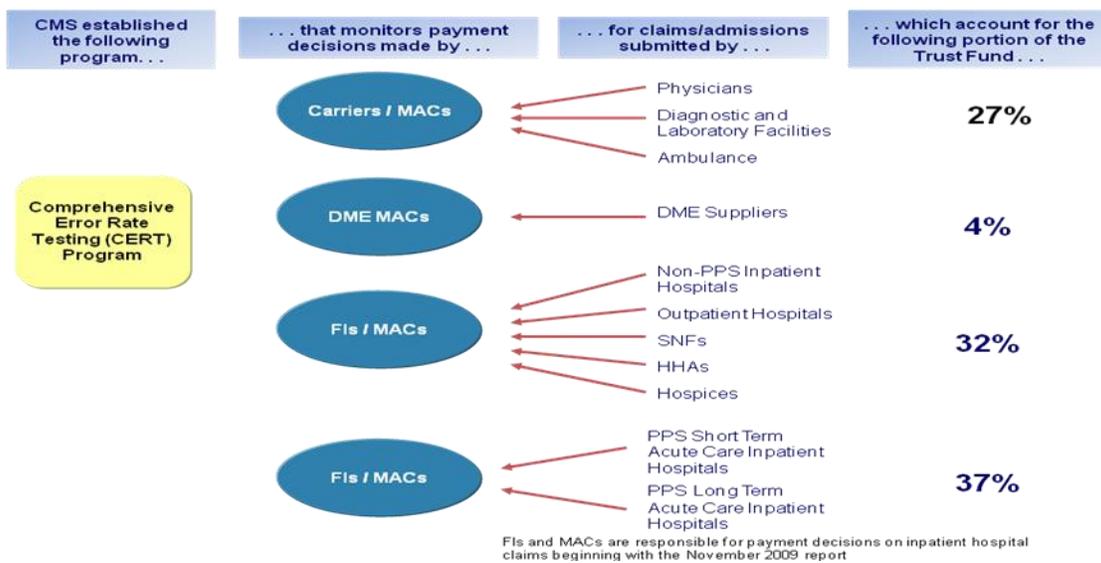
The Social Security Act established the Medicare program in 1965. Medicare currently covers the health care needs of people aged 65 or older, people under age 65 with certain disabilities, people of all ages with End Stage Renal Disease (ESRD), and certain others who elect to purchase Medicare coverage. Both Medicare costs and the number of Medicare beneficiaries have increased dramatically since 1965. In fiscal year (FY) 2009, approximately 46 million beneficiaries were enrolled in the Medicare program, and the total Medicare benefit outlay (both Medicare FFS and managed care payments) was

estimated at about \$454 billion². The Medicare budget represents almost 15 percent of the total Federal budget.

The Centers for Medicare & Medicaid Services (CMS) uses several types of contractors to prevent improper payments in the Medicare program including: Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries (FIs).

The following figure depicts the flow of claims by provider and supplier types through the Medicare contractor claims processing entities.

Figure 1: Flow of Claims by Provider and Supplier Types through the Medicare Contractor Claims Processing Entities



The primary goal of each Medicare contractor is to "Pay it Right" - that is, to pay the right amount to the right provider for covered and correctly coded services. Contractors cannot medically review every claim that comes through; thus, they must choose carefully which claims to review. It is through the detailed review of medical records that errors and non-compliance with CMS policies are detected. To improve provider compliance, contractors must also determine how best to educate providers about Medicare rules and implement the most effective methods for accurately answering coverage and coding questions.

As part of our IPIA³ compliance efforts, and to better assist the Medicare FFS contractors in focusing their review and education efforts, CMS established the Comprehensive Error

² 2010 CMS Statistics: U.S. Department of Health and Human Services, CMS Pub. No. 03455, June 2010

³ The Improper Payments Information Act of 2002 (IPIA) was amended by the Improper Payments Elimination and Recovery Act (IPERA) in July 2010.

Rate Testing (CERT) program to randomly sample and review claims submitted to and paid by the Medicare program. The CERT program considers any claim that was paid that should not have been paid or that was paid at an incorrect amount to be an improper payment, including both overpayments and underpayments. Since the IPIA requires the CERT program to use random claim selection, reviewers cannot develop provider billing patterns or trends that may indicate potential fraud. Thus the CERT program does not, and cannot, label a claim fraudulent.

History of Error Rate Measurement

The HHS Office of Inspector General (OIG) estimated the Medicare FFS error rate from 1996 through 2002. The OIG designed its sampling method to estimate a national Medicare FFS paid claims error rate. Due to the sample size – approximately 6,000 claims – the OIG was unable to produce error rates by contractor type, specific contractor, service type, or provider type. Following recommendations from the OIG, the sample size was increased for the CERT program when CMS began producing the Medicare FFS error rate for the November 2003 Report.

With the passage of the IPIA, CMS took responsibility for the error rate program beginning with FY 2003. One of the key tenets of the IPIA was that error rate measurement programs should be a critical part of an agency's internal controls. The IPIA also ushered in the notion that agencies should use this key internal control to inform decision makers about program vulnerabilities and drive corrective actions for reducing future errors. When the program was transitioned to CMS, the sample size for the CERT program was increased to approximately 120,000 claims. The increase in sample size allowed CMS to project not only a national error rate, but also allowed for contractor and service level error rates. It was believed that these additional error rates would allow CMS to develop more robust corrective actions and would provide CMS and its contractors with valuable information to assist in the development of specific corrective actions to reduce errors from occurring in the future.

CMS originally established two programs to monitor the accuracy of the Medicare FFS program: the CERT program and the Hospital Payment Monitoring Program (HPMP). The HPMP measured the error rate for inpatient hospital claims only and the CERT program measured the error rate for the other claim types, including outpatient hospital and durable medical equipment claims. Beginning with the FY 2009 reporting, the CERT program became fully responsible for sampling and reviewing **all** Medicare FFS claims, including inpatient and outpatient hospital claims, and durable medical equipment claims for purposes of measuring improper payments.

Each year the Medicare FFS error rate is reported in the annual financial reports of both CMS and HHS. The HHS Agency Financial Reports can be found at <http://www.hhs.gov/afr>. As part of the annual CMS Chief Financial Officer's (CFO) audit, the OIG conducts an audit of the CERT process and provides recommendations to

CMS for consideration in refining the error rate process. In 2010, the OIG performed a more extensive review of improper payments identified during the CERT program reviews in 2009. Based on the OIG's recommendations, CMS has incorporated a more in depth analysis in this report in order to identify specific reasons for errors, as well as potential vulnerabilities.

Table 1 summarizes the overpayments, underpayments, and error rates by year.

Table 1: National Error Rates by Year (Dollars in Billions) ⁴

Year	Total Dollars Paid	Overpayments		Underpayments		Overpayments + Underpayments	
		Payment	Rate	Payment	Rate	Improper Payments	Rate
1996	\$168.1	\$23.5	14.0%	\$0.3	0.2%	\$23.8	14.2%
1997	\$177.9	\$20.6	11.6%	\$0.3	0.2%	\$20.9	11.8%
1998	\$177.0	\$13.8	7.8%	\$1.2	0.6%	\$14.9	8.4%
1999	\$168.9	\$14.0	8.3%	\$0.5	0.3%	\$14.5	8.6%
2000	\$174.6	\$14.1	8.1%	\$2.3	1.3%	\$16.4	9.4%
2001	\$191.3	\$14.4	7.5%	\$2.4	1.3%	\$16.8	8.8%
2002	\$212.8	\$15.2	7.1%	\$1.9	0.9%	\$17.1	8.0%
2003	\$199.1	\$20.5	10.3%	\$0.9	0.5%	\$12.7	6.4%
2004	\$213.5	\$20.8	9.7%	\$0.9	0.4%	\$21.7	10.1%
2005	\$234.1	\$11.2	4.8%	\$0.9	0.4%	\$12.1	5.2%
2006	\$246.8	\$9.8	4.0%	\$1.0	0.4%	\$10.8	4.4%
2007	\$276.2	\$9.8	3.6%	\$1.0	0.4%	\$10.8	3.9%
2008	\$288.2	\$9.5	3.3%	\$0.9	0.3%	\$10.4	3.6%
2009	\$285.1	\$34.2	12.0%	\$1.2	0.4%	\$35.4	12.4%
2010	\$326.4	\$33.2	10.2%	\$1.1	0.3%	\$34.3	10.5%

The error rate in 2009 is not comparable to previous years' error rates due to a change in review methodology, specifically a strict adherence to policy documentation requirements, the removal of claims history as a valid source for review information, and the determination that medical record documentation created by a supplier is insufficient to substantiate a claim. CMS continued this review methodology for 2010 and was successful in reducing the error rate by 1.9 percent or \$1.1 billion between 2009 and 2010.

⁴ Some columns and/or rows may not sum correctly due to rounding.

The CERT Process

Methodology Overview

The CERT contractor randomly selects a sample of claims submitted to the various Medicare contractors (Carriers, FIs, and MACs) during the reporting period. After the selected claims have been paid or denied, the CERT contractor requests supporting medical records from the health care providers and suppliers that submitted the claims in the sample.

When medical records are submitted by the provider, the CERT contractor reviews the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules. If not, the CERT contractor assigns the erroneous claims to the appropriate error category. When medical records are not submitted by the provider, the CERT contractor classifies the sampled claim as a no documentation claim and counts it as an error.

For any identified payment errors, the CERT contractor notifies the appropriate Medicare contractor that processed the claim so they may recoup the overpayment from the provider, or reimburse the provider for any underpayment. Finally, the CERT contractor calculates the projected improper payment rate based on the actual erroneous claims identified in the sample.

CERT reports a paid claims error rate which is based on the amount paid after the Medicare contractor made its payment decision on the claim. This rate includes fully denied claims. The paid claims error rate is the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied and is a good indicator of how claim errors in the Medicare FFS program impact the trust fund. CMS calculated the gross rate by adding underpayments to overpayments and dividing that sum by the total dollars paid.

Medical Record Requests

The CERT contractor requested the associated medical records with the sampled claim from the provider that submitted the claim. The initial request for medical records is made via letter. If the provider fails to respond to the initial request after 30 days, the CERT contractor will send at least three subsequent letters as well as place follow-up phone calls to the provider in order to attempt to collect the medical records.

In cases where no documentation was received from the provider after 75 days from the initial request, the case is considered to be a “no documentation” claim and counted as an error. Any documentation received after the 75th day is considered “late

documentation.” If late documentation was received prior to the documentation cut-off date for this report, the records are reviewed and, if justified, the error in each rate is revised. If late documentation was received after the cut-off date for this report, the CERT contractor will make every effort to attempt to complete the review process before the final production of the report.

For durable medical equipment (DME) claims and Part A and Part B claims for clinical diagnostic laboratory services, additional documentation requests were made to the referring provider who ordered the item or service whenever the billing party does not have complete medical records to support the medical necessity of the services.

Sampling Methodology

For FY 2010 reporting, the CERT contractor randomly sampled approximately 82,000 claims; less than were sampled in previous years. Specifically, for each Medicare claims processing contractor (e.g. MACs), the CERT contractor conducted a random sample by claim type: Part A (excluding acute inpatient hospital services), Part A (acute inpatient hospital services only), Part B, and DME. On a daily basis, a random sample of claims, stratified by claim type, was selected from all of the claims submitted to a given Medicare claims processing contractor. A small portion of the claims sampled from the universe were unreviewable because they never completed the claim adjudication process (e.g., the claim was returned to the provider), leaving the final CERT sample comprised of claims that were either paid or denied by the Medicare claims processing contractor. This sampling methodology complies with all IPPIA requirements and OMB guidance. The aggregate number of claims sampled and the number of claims reviewed for each claim type is provided below in Table 2.

Table 2: Sample Sizes by Claim Type

Claim Type	Number of Sampled Claims	Number of Claims Reviewed
Part A (Excluding Acute Inpatient Hospital)	35,313	34,458
Part A (Acute Inpatient Hospital)	2,454	2,453
Part B	31,766	30,965
DME	12,172	11,996
Total	81,705	79,872

Review of Claims

Upon receipt of medical records, the CERT contractor's clinicians conduct a review of the claims and submitted documentation to identify any improper payments. They check the CMS eligibility system, the Common Working File (CWF) to confirm that the person receiving the services was an eligible Medicare beneficiary; to determine whether the claim was a duplicate and to ensure that no other entity was responsible for paying the

claim (is Medicare the primary insurer). When performing these reviews, the CERT contractor follows Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective Local Coverage Determinations (LCDs) and articles.

Error Categories

Based on the review of the medical records, claim errors are categorized into five different error categories. The five categories of error under the CERT program are described below.

No documentation—Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medical records in support of the claim or the provider responded that they do not have the requested records.

Insufficient documentation—Claims are placed into this category when the medical documentation submitted is inconclusive to support the rendered service (medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or medically necessary).

Medically unnecessary service—Claims are placed into this category when claim review staff receive enough documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies.

Incorrect coding—Claims are placed into this category when providers submit medical documentation that supports a different code than the code billed, the service was done by someone other than the billing provider, the billed service was unbundled, or a beneficiary was discharged to a site other than the one coded on a claim).

Other—This category includes claims that do not fit into any of the other categories (e.g., duplicate payment error, non covered or unallowable service).

Weighting and Determining the Final Results

The error rates were weighted so that each contractor's contribution to the error rate was in proportion to the percent of allowed charges for which they were responsible. The confidence interval is an expression of the numeric range of values into which CMS is 95 percent certain that the mean values for the improper payment estimates will fall. As required by the IPIA, the CERT program has included an additional calculation of the 90 percent confidence interval for the national error rate calculation. The size of the associated confidence interval, which represents the extent of variability, should always be considered when evaluating estimated payment error rates.

After the claims have been reviewed for improper payments, the sample is projected to the universe statistically using a combination of sampling weights and universe expenditure amounts.

Appeal of Claims

Providers can appeal denials (including no documentation denials) through the normal appeal processes by submitting documentation supporting their claims to the appropriate contractor. Appeals are tracked and all overturned final appeal determinations are entered into the appeals tracking system to ensure the accuracy of the error rates. After the calculation of the final error rate, appeal decisions cannot be considered. For FY 2010, \$3.1 billion in projected appeals reversals were deducted from the national improper payment projections contained in this report.

Overpayments/Underpayments

In the CERT program, contractors are notified of detected overpayments and underpayments so they can implement the necessary payment adjustments. Sampled claims for which providers failed to submit documentation were considered overpayments.

Medicare contractors only recover actual overpayments identified in the CERT sample. The CERT program identified \$5,057,759 in actual overpayments and, as of the publication date of this report, CMS has collected \$3,814,177 of those overpayments. CMS and its contractors will never collect a small amount of the identified overpayments. The following lists the primary reasons why some overpayments cannot be collected; this list is not all inclusive:

- The provider appealed the overpayment and the outcome of the appeal overturned the CERT decision, however the decision was made after the error rate was final; or
- The provider has gone out of business and CMS cannot locate the provider after multiple attempts.

However, for all other situations, CMS' Medicare contractors continue their attempts to collect the overpayments identified during the CERT process.

Error Rate Reduction Targets

Based on the CERT program results for 2009, CMS established the following error rate goal under the Government Performance and Results Act (GPRA).

Reduce the percentage of improper payments made by the Medicare FFS program.

- By November 30, 2010, reduce the percent of improper payments under Medicare FFS to 9.5 percent.

Status: This goal was not met. The national paid claims error rate for the November 2010 reporting period was 10.5 percent.

- By November 30, 2011, reduce the percent of improper payments under Medicare FFS to 8.5 percent.
- By November 30, 2012, reduce the percent of improper payments under Medicare FFS to 6.2 percent.

FINDINGS

National Medicare FFS Error Rate

As mentioned in the previous section, the estimated national paid claims error rate in the Medicare FFS program was 10.5 percent. The 95 percent confidence interval was 9.8 percent - 11.2 percent. The 90 percent confidence interval (required to be reported by IPIA) was 9.9 percent - 11.1 percent. The total amount projected to be in error was \$34.3 billion.

Table 3 summarizes the overall improper payment error rates by claim types: Part A—Inpatient Hospital Services; Part B – Outpatient Services; and DME. Claims for DME supplies have the highest error rate—73.8 percent, while Part A has the most dollars in error--\$16 billion.

Table 3: Error Rate and Projected Improper Payment by Claim Type (Dollars in Billions)⁵

Claim Type	Total Paid Amount	Overall Improper Payment		
		Improper Payment	Paid Claim Error Rate	95% Confidence Interval
Part A (total)	\$232.0	\$16.1	6.9%	6.0% - 7.9%
Part A (Excluding Acute Inpatient Hospital)	\$112.6	\$4.7	4.2%	3.7% - 4.7%
Part A (Acute Inpatient Hospital)	\$119.4	\$11.3	9.5%	7.8% - 11.2%
Part B	\$84.5	\$10.9	12.9%	12.1% - 13.8%
DME	\$9.8	\$7.3	73.8%	71.5% - 76.1%
Overall	\$326.4	\$34.3	10.5%	9.8% - 11.2%

⁵ Some columns and/or rows may not sum correctly due to rounding.

Summarization of Errors Due to DME Supplies

The DME error rate (73.8 percent) was the highest among all of the claim types. While DME accounts for less than 4 percent of all Medicare FFS expenditures, these services resulted in 21 percent of total projected improper payments in 2010. Of the total DME errors, 45.3 percent were due to insufficient documentation and 27.3 percent were due to a lack of medical necessity for the item. Therefore, nearly half of all DME errors were the result of inadequate documentation—meaning the provider/supplier did not submit a complete medical record and we could not make an informed decision about medical necessity of the DME service. Approximately a quarter of the errors were “medically unnecessary”—meaning the medical records submitted contained adequate documentation to determine that the services billed and paid for were not medically necessary and the DME service should not have been provided.

Medicare pays for DME only if the patient’s medical record contains sufficient documentation of the patient’s medical condition to substantiate the necessity for the type or quantity of items ordered. In other words, the submitted documentation must support that the item(s) was medically necessary. CMS recently clarified that documentation created by the supplier alone is insufficient to warrant payment of the claim. It is often difficult to obtain proper documentation for DME claims because the supplier who billed for the item must obtain detailed documentation from the medical professional who ordered the item. As such, the involvement of multiple parties can contribute to situations of missing or incomplete documentation and delays in documentation receipt.

Insufficient documentation errors are found when the medical documentation does not include pertinent facts about the patient’s condition that are necessary to make an informed decision about medical necessity. For the 2010 review cycle, the primary causes of insufficient documentation errors for DME claims included:

- Missing physician orders,
- Missing diagnostic laboratory test results (e.g., an arterial blood gas for home oxygen therapy), and
- Missing or incomplete documentation of the Face-to-Face examination for power wheelchairs.

With regard to medical necessity, errors of medical necessity are found when the submitted documentation does not support the beneficiary’s need for the DME item based on criteria established by NCDs or LCDs. The lack of supporting documentation was most notable for power wheelchair claims. For example, the documentation supplied for the patient assessment should paint a picture of the patient’s functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient’s ambulatory difficulty or impact on the patient’s ambulatory ability. Although patients who qualify for coverage of a power mobility device may use that device outside

the home, because Medicare's coverage of a wheelchair or power operated vehicle (scooter) is determined solely by the patient's mobility needs within the home, the examination must clearly distinguish the patient's abilities and needs within the home from any additional needs for use outside the home. In many cases, the submitted documentation did not validate that the beneficiary needed a wheelchair to support them in activities of daily living.

Given the importance of receiving medical record documentation to substantiate the necessity for DME items billed, beginning in 2011, CMS will notify the physician when a DME item ordered by that physician is selected for CERT review. The notification reminds physicians of their responsibility to maintain documentation of medical necessity for the DME item and submit requested documentation to the supplier. A more in-depth explanation of the primary causes of DME improper payments for the 2010 review cycle is provided in the next section.

Primary Causes of DME Improper Payments

Within DME, oxygen supplies, glucose monitoring supplies, and power wheelchairs have the highest improper payments, accounting for 3.6 percent, 3.3 percent, and 2.4 percent of the total projected improper payments in Medicare FFS, respectively. These three DME groups account for approximately 44 percent of the DME improper payments. The determination of improper payments for oxygen supplies, glucose monitoring supplies and power wheelchairs are discussed below.

Oxygen Supplies: Most of the errors are due to insufficient documentation to support the medical necessity for the home oxygen equipment. These oxygen supplies are generally provided on a monthly basis, given the nature of these supplies it is critical that the patient be closely monitored by the physician to ensure appropriate care and support the continued medical necessity of the oxygen supplies. The critical documentation required but **missing** from the medical records includes:

- Most recent Certificate of Medical Necessity (CMN) to document patient's condition;
- Test results from the qualifying oximetry or arterial blood gas test as required by the CMN;
- Documentation showing that the patient was seen by a physician 30 days prior to the initial certification date documenting the diagnosis for which the oxygen is prescribed;
- Documentation showing that the patient was seen by a physician 90 days prior to the recertification date (if applicable); and
- For claims subsequent to the recertification date, physician visit note supporting continued medical monitoring of oxygen use and needs.

Glucose Monitoring Supplies: Medicare pays for glucose monitors, test strips and lancets for all Medicare beneficiaries with diabetes. A prescription from an ordering doctor is

required for Medicare coverage of all diabetic supplies. The prescription must state the number of times per day a beneficiary should test his or her blood sugar. Medicare requires that an ordering physician must review the prescription every 6 months. Medicare does not pay for automatic shipment of glucose supplies; the beneficiary or beneficiary's caregiver must directly submit a request for a refill of all diabetic supplies.

Many improper payment errors for glucose monitoring supplies resulted from the fact that the ordering physician did not submit required documentation to support the need for the glucose supplies. These glucose supplies are generally provided on a monthly basis, given the nature of these supplies it is critical that the patient be closely monitored by the physician to ensure appropriate care and support the continued medical necessity of the glucose supplies. The critical documentation required but missing from the medical records includes:

- Physician's original order for the glucose supplies;
- Documentation from the physician regarding the patient's condition and the continued use or support of testing frequency for which Medicare was billed; and
- Documentation supporting the physician's 6-month review of the original order.

Improper payment errors for diabetic supplies were also attributed to medically unnecessary services. For example, in some cases, medical necessity errors for diabetic supplies were assigned because the beneficiary exceeded allowable utilization of their diabetic supplies by receiving diabetic supplies concurrently from multiple DME suppliers during over-lapping periods of time.

Power Wheelchairs: Medicare pays for power wheelchairs or scooters only when specific statutory requirements are met. These requirements are listed below.

- There must be an in-person visit with a physician specifically addressing the beneficiary's mobility needs.
- There must be a history and physical examination by the physician or other medical professional focusing on an assessment of the beneficiary's mobility limitation and needs. The results of this evaluation must be recorded in the beneficiary's medical record.
- A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements.
- The prescription and medical records documenting the in-person visit and evaluation must be sent to the DME supplier within 45 days after the completion of the evaluation.

If any of the requirements listed above are not documented by the DME supplier and ordering physician CERT denies the DME item as insufficiently documented.

In addition, the in-person visit and mobility evaluation together are often referred to as the “Face-to-Face examination.” The complete history and physical examination of the beneficiary’s mobility limitation(s) and needs, typically includes the following components:

- A history of the present condition(s) and past medical history that is relevant to the beneficiary’s mobility needs in the home;
- Evaluation of symptoms that limit ambulation;
- Diagnoses that is responsible for these symptoms;
- Prescribing medications or other treatment for these symptoms;
- Assessment of the progression of ambulation difficulty over time;
- Determination of other diagnoses that may relate to ambulatory problems;
- Assessment of how far the beneficiary can walk without stopping; including the assistive device, (such as a cane or walker) that may be necessary;
- Assessment of the pace of ambulation;
- A history of falls, including frequency, circumstances leading to falls; and
- Assessment of whether a walker (or other mobility assistive device) is sufficient to meet the mobility of the beneficiary.

If the medical review by CERT shows that the physician’s physical and history examination did not fully support the need for a power wheelchair, CERT denied the service as not medically necessary.

Errors Due to Services Provided in an Inappropriate Setting

Medicare pays for an acute inpatient hospital stay only if the beneficiary demonstrates signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians are expected to use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

There are situations where a patient was admitted as an inpatient but the clinical care and procedures should have been provided in an outpatient or other non-hospital based setting. Under Medicare statute these claims must be denied in full, even if the claim would be potentially payable in another setting. By law, CMS cannot partially deny the claim or allow the provider to re-bill using a different setting.

Based on a review of the claims in error, CMS determined that there were 2,453 inpatient hospital claims in the CERT sample totaling \$25.1 million in actual overpayments where the claim was denied in full because the services provided were not medically necessary as an inpatient service and should have been provided as an outpatient service. These inpatient hospital errors project to \$5.1 billion of improper payments in the Medicare universe. The projected net difference between what was called an error and what may have been payable had the service been billed in the appropriate outpatient setting was \$3.2 B, or a difference in the error rate of -1.5 percent; 9.0 percent rather than 10.5 percent.

Corrective Actions

CMS strives to prevent and eliminate improper payments in the Medicare program to sustain the Medicare trust funds and protect beneficiaries. To better account for and identify improper payments, CMS refined the CERT process in 2009 by requiring a strict adherence to our policies. CMS continues to improve the error rate measurement process and has redesigned the CERT sampling methodology to provide additional error information on high risk areas, in accordance with the President's Executive Order 13520 "Reducing Improper Payments"⁶ issued in November 2009.

CMS continues to analyze the improper payment data garnered from the CERT program and make changes in areas that show programmatic weakness. CMS also uses the results of the CERT program as feedback to the Medicare contractors to inform and enhance their medical review efforts, as well as improve their overall operations in a comprehensive manner that includes their education and outreach efforts. CMS has several corrective actions in place or under development to reduce documentation errors and medical necessity errors. Additionally, CMS plans to make several programmatic changes that are expected to decrease improper payments and ensure the authenticity of the services billed for by providers and suppliers. The following provides additional details about some of the corrective actions CMS is taking to reduce improper payments in the future.

Documentation Errors- CMS implemented improvements to the Medicare FFS error rate measurement program to ensure that providers and suppliers submit the required documentation, as follows.

⁶ The White House, Office of the Press Secretary, Executive Order-- Reducing Improper Payments and Eliminating Waste in Federal Programs, November 23, 2009 (<http://www.whitehouse.gov/the-press-office/executive-order-reducing-improper-payments>)

- CMS commenced a DME and A/B MAC provider outreach and education task forces in 2010. These task forces consist of contractor medical review professionals who meet regularly to develop strategies to address for provider education in error prone areas. The task force held several open door forums to discuss documentation requirements and answer providers/suppliers questions. The task force also issued several informational articles that have been distributed on an as-needed basis to promote education among providers. The articles are maintained on the Medicare Learning Network (MLN) and can be accessed at any time.
- CMS contacts the provider who ordered the DME at the same time a supplier is contacted for documentation to advise them of their responsibility to provide medical documentation in support of the supplier's DME claim.
- CMS revises the medical record request letters as needed to clarify for the provider/supplier the components of the medical record that are required for a CERT review. The letter services as a checklist for the provider/supplier to ensure that their record submission is complete. CMS also revised follow up medical record request letters to include information about the documentation that is missing to ensure the provider/supplier fully understands what documentation needs to be submitted.
- CMS contacts third party providers to request documentation when the billing provider indicated that a portion of the medical record is possessed by a third party. For example, such a third party provider may be a physician who orders a power wheelchair that is dispensed by the supplier that submits the claim.
- CMS staff regularly contacts providers to make additional attempts at collecting medical documentation to ensure insufficient documentation errors are accurate.
- CMS conducts ongoing education to inform providers about the importance of submitting thorough and complete documentation. This involves national training sessions, individual meetings with providers with high error rates, presentations at industry association meetings, and the dissemination of educational materials.
- CMS implementation of the Electronic Submission of Medical Documentation (esMD) into the CERT review process will create greater program efficiencies, allow a quicker response time to documentation requests, and provide better communication between the provider, the CERT contractors, and CMS. The first phase of esMD went live on September 15, 2011. Initially, CMS anticipates limited provider participation but as more Health Information Handlers (HIHs) begin to offer gateway services to providers and CMS and HIH provider outreach efforts take hold, CMS expects provider participation to increase.

Medical Necessity Errors- CMS is dedicated to reducing medical necessity errors and is conducting the following corrective actions.

- CMS implemented a National Fraud Prevention System (FPS) on June 30, 2011, as required by the Small Business Jobs Act of 2010. The FPS is an innovative risk scoring technology that applies proven predictive models to nationwide Medicare Fee-For-Service claims on a pre-payment basis. The risk-scores

- identify highly suspect claims, and help target resources to the areas of Medicare's greatest risk.
- CMS is in the process of implementing enhanced medical review policies including a Face-to-Face requirement for DME in accordance with Section 6407 of the Affordable Care Act (Affordable Care Act) (Pub. L. 111-148). CMS published a final rule that implemented the Face-to-Face encounter requirements for Medicare home health on November 17, 2010 as required by Section 6407 of the Affordable Care Act.
 - CMS developed Comparative Billing Reports (CBRs) to help Medicare non-hospital providers analyze administrative claims data. CBRs compare a provider's billing pattern for various procedures or services to their peers on a state and national level. CMS also uses the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER allows Medicare inpatient hospital providers to also analyze their billing patterns through a comparison to other providers in their state and in the nation.
 - CMS is developing a Program Vulnerability Tracking System (PVTS) that will track vulnerabilities identified by internal and external sources; including the National Fraud Prevention program, the Recovery Auditors, and the Office of the Inspector General. CMS will use the PVTS to inventory and prioritize vulnerabilities, and track corrective actions.
 - CMS is conducting a competition to procure private sector edits for implementation within the Medicare program. As part of this effort CMS will: 1) evaluate the accuracy of commercial products, 2) determine whether these products are feasible in the Medicare FFS environment, and 3) determine whether they can prevent errors and reduce improper payments in the Medicare FFS program.
 - CMS requires Carriers, FIs, and MACs to develop Error Rate Reduction Plans that identify the specific causes of the improper payments in their jurisdiction and outlines corrective actions for the errors.
 - CMS requires the Carriers, FIs, and MACs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce medical necessity and incorrect coding errors.
 - CMS developed and installed new correct coding edits in the claims processing systems.
 - CMS issued the first Medicare Quarterly Provider Compliance Newsletter in October 2010 to physicians, providers and suppliers to educate them on common errors found in the Medicare program and actions providers can take to prevent them from occurring in the future.
 - CMS developed medically unlikely auto-deny edits in the claims processing systems to catch those services where the level billed exceeds acceptable clinical limits. These edits are updated quarterly.
 - CMS approved additional areas for Medicare FFS Recovery Auditors review including inpatient hospital stays and DME. CMS also increased medical record request limits for Recovery Auditors. Information about the results of the

Recovery Audit Program provides valuable information to providers about areas where improvements are needed.

- CMS continually updates Medicare FFS manuals to clarify requirements for the review of documentation to promote uniform application of our policies across all medical reviews performed by Medicare contractors.

Ensuring the Authenticity of Providers and Suppliers- CMS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments, including the following.

- CMS is undertaking numerous aggressive actions to tighten the provider enrollment process, provide more rigorous oversight and monitoring once a provider/supplier enrolls in the program, and to strengthen the provider revocation process. CMS implemented a DME Accreditation program to ensure the legitimacy of the DME suppliers that bill Medicare and to ensure those suppliers meet all the requirements for participation in the Medicare program.
- CMS established a surety bond requirement for most suppliers of durable medical equipment, prosthetics and orthotics.
- CMS issued a request for proposals for an automated screening solution in July 2011 that will support the revalidation of 1.5 million providers, as required by the Affordable Care Act. The award is targeted for September 2011. The enrollment screening solution will automate the multiple database checks that are currently manual, increasing the accuracy of results and decreasing application processing time.
- CMS, in collaboration with California provider groups, law enforcement and the Senior Medicare Patrol, hosted a series of events across the state to educate physicians on medical identify theft and other fraud related topics and how to protect their professional and medical identity from fraud in September 2011.
 - CMS published a final rule with comment titled, “Medicare, Medicaid and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” on February 2, 2011. This final rule implemented many of the program integrity provisions in the Affordable Care Act, including the requirement that State Medicaid programs terminate a provider or supplier who has been terminated from another State Medicaid program or from Medicare.
 - CMS published a final rule titled, “Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards (CMS-6036-F) in the Federal Register on August 27, 2010. This final rule clarified and expanded on the existing enrollment requirements

that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.

- CMS has initiated the realignment of the Program Safeguard Contractors (PSC) with the MACs. When the realignment is completed, there will be seven zones to address fraud “hot spots” in the United States, thereby concentrating on areas of high fraud occurrence. The name for this entity is being changed from PSCs to Zone Program Integrity Contractor (ZPIC). Five of the seven ZPIC awards have been made.
- CMS has taken steps to fight DMEPOS fraud in the “high risk” states of Florida, California, Texas, Illinois, Michigan, North Carolina and New York. These efforts include more stringent reviews of new suppliers’ applications; unannounced site visits; extensive pre- and post-payment review of claims; interviews with high volume ordering/referring physicians; and visits to high risk beneficiaries to ensure they are appropriately receiving items and services for which Medicare is being billed.
- CMS implemented the first phase of the DME competitive bidding program which will have a gradual impact on the DME error rate.

Appendix

Paid Claims Error Rate by Error Type

The national Medicare improper payment rate was higher in 2009 and 2010 than in previous years. These increases are due primarily to CMS' changes to medical review criteria. Documentation requirements became more stringent and conditions for medical necessity had to be met precisely. Table 4 shows the national error rates by year and error category. The greatest increases in the error rates are due to insufficient documentation and medically unnecessary errors. These types of errors are most impacted by the revised review criteria.

Table 4: Summary of Error Rate by Year and by Category

Year and Category		No Documentation Errors	Insufficient Documentation Errors	Medically Unnecessary Errors	Incorrect Coding Errors	Other Errors	Improper Payments	Correct Payments
1996	Net ¹	1.9%	4.5%	5.1%	1.2%	1.1%	13.8%	86.2%
1997	Net	2.1%	2.9%	4.2%	1.7%	0.5%	11.4%	88.6%
1998	Net	0.4%	0.8%	3.9%	1.3%	0.7%	7.1%	92.9%
1999	Net	0.6%	2.6%	2.6%	1.3%	0.9%	8%	92%
2000	Net	1.2%	1.3%	2.9%	1%	0.4%	6.8%	93.2%
2001	Net	0.8%	1.9%	2.7%	1.1%	-0.2%	6.3%	93.7%
2002	Net	0.5%	1.3%	3.6%	0.9%	0%	6.3%	93.7%
2003	Net	5.4%	2.5%	1.1%	0.7%	0.1%	9.8%	90.2%
2004	Gross ²	3.1%	4.1%	1.6%	1.2%	0.2%	10.1%	89.9%
2005	Gross	0.7%	1.1%	1.6%	1.5%	0.2%	5.2%	94.8%
2006	Gross	0.6%	0.6%	1.4%	1.6%	0.2%	4.4%	95.6%
2007	Gross	0.6%	0.4%	1.3%	1.5%	0.2%	3.9%	96.1%
2008	Gross	0.2%	0.6%	1.4%	1.3%	0.1%	3.6%	96.4%
2009	Gross	0.2%	4.3%	6.3%	1.5%	0.1%	12.4%	87.6%
2010	Gross	0.1%	4.6%	4.2%	1.6%	0.1%	10.5%	89.5%

¹FY 1996-2003 Improper payments were calculated Overpayments – Underpayments

²FY 2004-2010 Improper payments were calculated Overpayments + absolute value of Underpayments

Table 5 summarizes the percent of total dollars improperly paid by error category and claim type.

Table 5: Type of Error Comparison for 2009 and 2010⁷

Type of Error	2009 Report	2010 Report				
	Total	Total	Part A excl. Acute Inpatient Hospital	Part A Acute Inpatient Hospital	Part B	DME
No documentation	0.2%	0.1%	0.1%	0.0%	0.2%	0.7%
Insufficient Documentation	4.3%	4.6%	2.5%	0.9%	8.0%	45.3%
Medically Unnecessary	6.3%	4.2%	1.2%	6.8%	1.7%	27.3%
Incorrect Coding	1.5%	1.6%	0.4%	1.7%	3.0%	0.1%
Other	0.1%	0.1%	0.1%	0.0%	0.1%	0.3%
All Type of Error	12.4%	10.5%	4.2%	9.5%	12.9%	73.8%

Table 6 summarizes the overall improper payments, overpayments, underpayments and error rates by claim type.

Table 6: Error Rate and Projected Improper Payment by Claim Type and Over/Under Payments (Dollars in Billions)⁸

Claim Type	Total Paid Amount	Overall Improper Payment			Overpayment		Underpayment	
		Improper Payment	Paid Claim Error Rate	95% Confidence Interval	Improper Payment	Paid Claim Error Rate	Improper Payment	Paid Claim Error Rate
Part A (total)	\$232.0	\$16.1	6.9%	6.0% - 7.9%	\$15.2	6.6%	\$0.8	0.4%
Part A (Excluding Acute Inpatient Hospital)	\$112.6	\$4.7	4.2%	3.7% - 4.7%	\$4.6	4.1%	\$0.1	0.1%
Part A (Acute Inpatient Hospital)	\$119.4	\$11.3	9.5%	7.8% - 11.2%	\$10.6	8.9%	\$0.7	0.6%
Part B	\$84.5	\$10.9	12.9%	12.1% - 13.8%	\$10.7	12.7%	\$0.2	0.3%
DME	\$9.8	\$7.3	73.8%	71.5% - 76.1%	\$7.3	73.8%	\$0.0	0.0%
Overall	\$326.4	\$34.3	10.5%	9.8% - 11.2%	\$33.2	10.2%	\$1.1	0.3%

⁷ Some columns and/or rows may not sum correctly due to rounding.

⁸ Some columns and/or rows may not sum correctly due to rounding.

Summary of Error Rate Categories

(1) No Documentation Errors

Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medial records in support of the claim or the provider responded that they do not have the requested records.

No documentation errors accounted for 0.1 percent of the total dollars all Medicare FFS contractors allowed during the reporting period. The data breaks down by claim type as follows.

Part A (excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DME	Overall
0.0%	0.0%	0.1%	0.0%	0.1% ⁹

The following is an example of a no documentation error.

- An FI paid \$172.00 to a hospital for an outpatient clinic visit. After multiple attempts to obtain the record, the CERT contractor received a letter which stated “Medical information you are requesting does not exist in the patient’s medical record. No information available.” The FI recouped the entire amount.

(2) Insufficient Documentation Errors

Claims are placed into this category when the medical documentation submitted is inconclusive to support the rendered service (medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or medically necessary).

Insufficient documentation errors accounted for 4.6 percent of the total dollars allowed during the reporting period. The data breaks down as follows.

⁹ Some columns and/or rows may not sum correctly due to rounding.

Part A (excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DME	Overall
0.9%	0.3%	2.1%	1.4%	4.6% ¹⁰

The following is an example of an insufficient documentation error.

- An FI paid \$2,766.87 to a provider for an inpatient hospital stay. After multiple attempts to obtain the documentation, we received an initial history and physical and a brief discharge summary only. The CERT reviewer determined there was insufficient documentation to support the services billed. The FI recouped the entire payment.

See the section entitled *Types of Errors by Clinical Setting* for further information about insufficient documentation errors. Refer to page 25.

(3) Medically Unnecessary Services Errors

Claims are placed into this category when claim review staff receives enough documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies.

Medically unnecessary service errors accounted for 4.2 percent of the total dollars allowed during the reporting period. This data breaks down in the following manner.

Part A (excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DME	Overall
0.4%	2.5%	0.4%	0.8%	4.2% ¹¹

For inpatient hospital claims, medically unnecessary services errors are often related to hospital stays of short duration where services could have been rendered at a lower level of care. A smaller, but persistent amount of medically unnecessary payment errors are for inpatient hospital stays of three to five days, many of which resulted in a transfer to a skilled nursing facility (SNF). Some of these patients may have been admitted solely to satisfy the requirement for a minimum of three days as an inpatient in order to qualify for a SNF stay.

A portion of medical necessity errors for inpatient claims is related to denying an invasive procedure that affected the DRG payment. If an invasive procedure did not

¹⁰ Some columns and/or rows may not sum correctly due to rounding.

¹¹ Some columns and/or rows may not sum correctly due to rounding.

meet the requirements of an LCD or NCD and the invasive procedure affected the DRG payment, the invasive procedure was denied. In these cases, the DRG was reclassified after removing the medical unnecessary invasive procedure and the improper payment is attributed to medically unnecessary services.

The following is an example of a medically unnecessary services error.

- A DME MAC paid \$140.46 for the monthly rental of a semi-electric hospital bed. Per the DME MAC’s LCD, semi-electric hospital beds are covered by Medicare if the patient’s medical condition requires one or more of the following: positioning of the body in ways not feasible with an ordinary bed; elevation of the head more than 30 degrees most of the time; traction equipment; or frequent changes in body position. The reviewer requested additional documentation from the supplier and ordering physician. The medical records received from the ordering physician failed to support the need for the hospital bed per the DMAC’s LCD and Medicare requirements. The entire amount was recouped.

(4) Incorrect Coding Errors

Claims are placed into this category when providers submit medical documentation that supports a different code than the code billed, the number of units submitted was incorrect, the service was done by someone other than the billing provider, the billed service was unbundled, or a beneficiary was discharged to a site other than the one coded on a claim).

Incorrect coding errors accounted for 1.6 percent of the total dollars allowed during the reporting period.

Part A (excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DME	Overall
0.1%	0.6%	0.8%	0.0%	1.6% ¹²

The following is an example of an incorrect coding error.

- An FI paid a provider \$136.48 for the drug Remicade; HCPCS code J1745, 10 mg per unit. The beneficiary received 500 mg or 50 units, but the hospital billed only 10 units. After CERT review, the underpayment of \$343.56 was paid to the hospital.

¹² Some columns and/or rows may not sum correctly due to rounding.

(5) Other Errors

This category includes claims that do not fit into any of the other categories (e.g., duplicate payment error, non covered or unallowable service).

Other errors accounted for 0.1 percent of the total dollars allowed during the reporting period. This data breaks down as follows.

Part A (excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DME	Overall
0.0%	0.0%	0.0%	0.0%	0.1% ¹³

The following is an example of an ‘other’ error.

- A Carrier paid \$152.95 for anesthesia used during the routine extraction of dental caries. Since services associated with a non-covered service (dental extraction) are not allowed, the entire amount was recouped.

Types of Errors by Clinical Setting

Examining the types of medical review errors and their impact on improper payments is a crucial step toward reducing improper payments in Medicare FFS. Table 7 shows that projected improper payments are driven by insufficient documentation errors, medically unnecessary errors, and to a lesser extent, incorrect coding errors. When the errors are analyzed by clinical setting, the data show that the most improper payments due to medically unnecessary errors are for inpatient hospitals and DME. Substantial improper payments are attributable to physicians and inpatient hospitals due to insufficient documentation and incorrect coding errors.

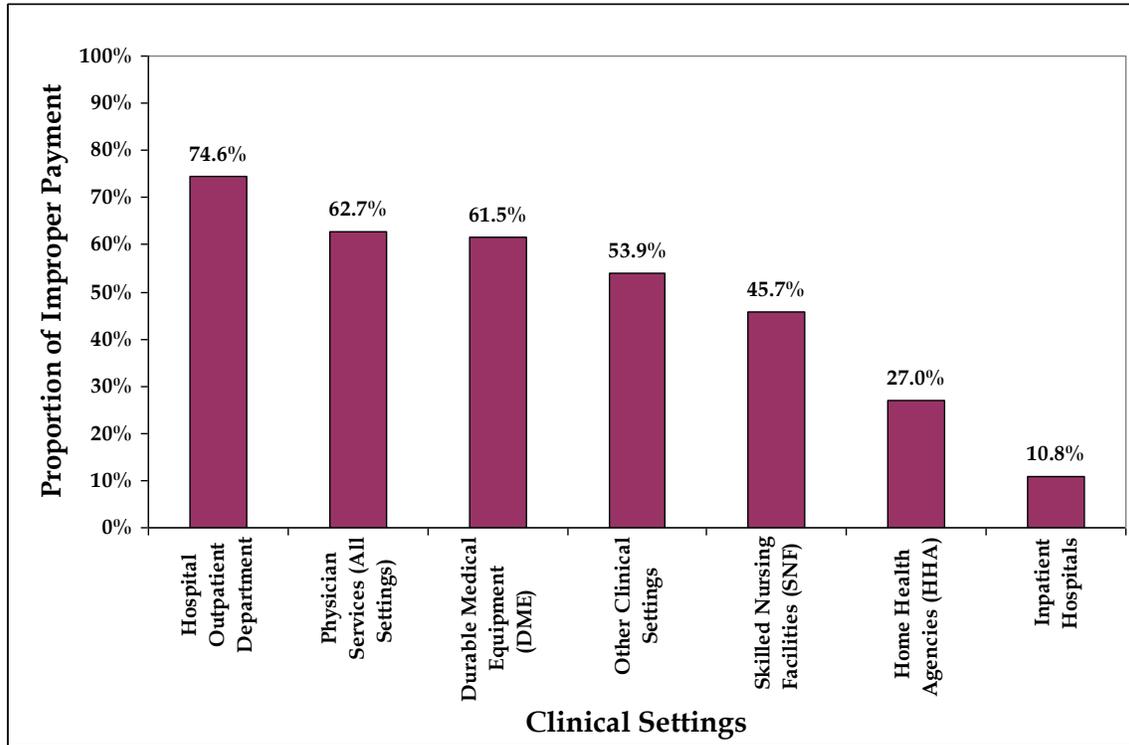
¹³ Some columns and/or rows may not sum correctly due to rounding.

Table 7: Projected Improper Payments (in Billions of Dollars) by Type of Error and Clinical Setting¹⁴

Type of Error	Durable Medical Equipment (DME)	Home Health Agencies (HHA)	Hospital Outpatient Department	Acute Inpatient Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities (SNF)	Other Clinical Settings	Overall
No Documentation	\$0.07	\$0.03	\$0.03	\$0.02	\$0.14	\$0.00	\$0.02	\$0.32
Insufficient Documentation	\$4.46	\$0.27	\$1.97	\$1.24	\$6.22	\$0.42	\$0.55	\$15.12
Medically Unnecessary	\$2.69	\$0.60	\$0.53	\$8.14	\$1.08	\$0.19	\$0.37	\$13.58
Incorrect Coding	\$0.01	\$0.06	\$0.10	\$2.08	\$2.43	\$0.30	\$0.08	\$5.07
Other	\$0.03	\$0.03	\$0.01	\$0.03	\$0.05	\$0.01	\$0.00	\$0.17
All Types of Errors	\$7.25	\$1.00	\$2.64	\$11.52	\$9.92	\$0.92	\$1.02	\$34.27

Figure 2 provides an analysis of the clinical settings where most insufficient documentation errors are occurring.

Figure 2: Share of Error Due to Insufficient Documentation by Clinical Setting



¹⁴ Some columns and/or rows may not sum correctly due to rounding.

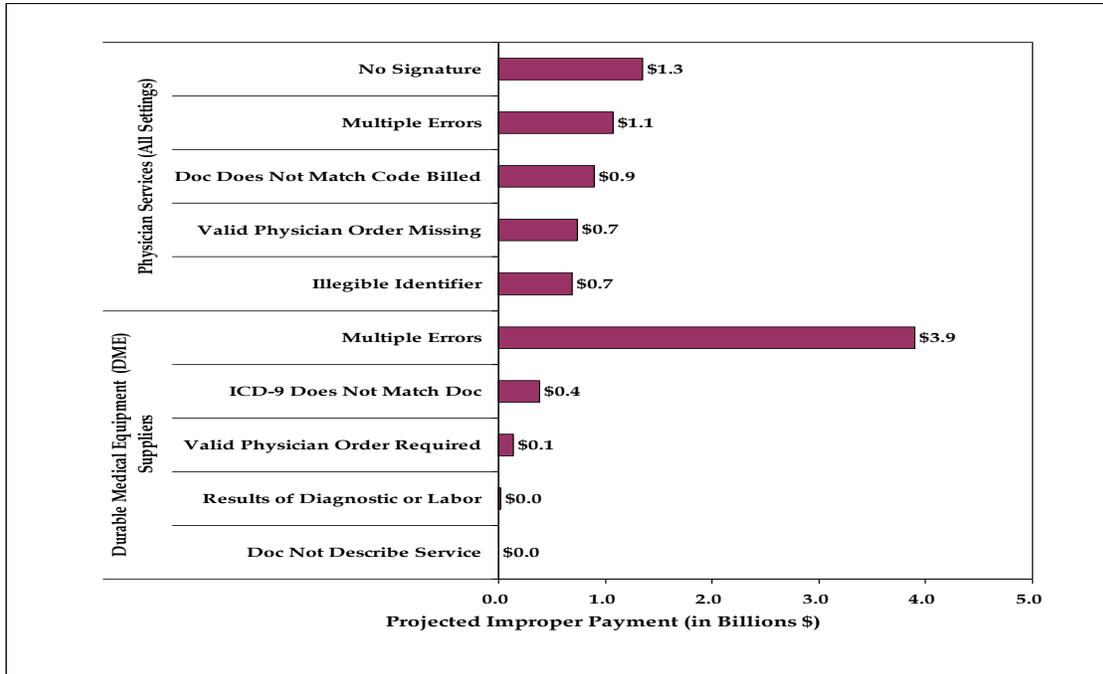
In several cases of insufficient documentation, it was clear that Medicare beneficiaries received services, but the physician's orders or documentation supporting the beneficiary's medical condition was incomplete. While CMS could not conclude that the services were not provided, these claims were counted as overpayments. In some instances, components of the medical documentation were maintained at a third party facility. For instance, although a lab may have billed for a blood test, the physician who ordered the lab test maintained the medical record. If the billing provider did not submit records maintained by a third party, the CERT contractor contacted the third party to request the missing documentation. If the third party failed to submit the documentation to the CERT contractor, CMS scored the inadequately documented items or services as insufficient documentation errors. If the medical documentation submitted for all items or services on a claim was inconclusive to support the billed item or service, the entire payment amount was considered improper. If the submitted medical documentation supported some, but not all, of the billed items or services, only those that were insufficiently documented were considered errors.

Figure 3 displays projected improper payments due to insufficient documentation for physicians and DME by the specific reason for the error. These two clinical settings account for 71 percent of the improper payments due to insufficient documentation. Within each clinical setting the specific reasons are in descending order of improper payments.

Physicians have a multitude of specific reasons that contribute heavily to insufficient documentation errors. These include documentation not describing service, valid physician order required, and no signature when required.

For DME, insufficient documentation errors are mainly categorized as "Multiple Errors" because the majority of the cases involved more than one reason for errors.

Figure 3: Projected Improper Payments (in Billions of Dollars) for Top 5 Reasons for Insufficient Documentation Error for 2 Clinical Settings with Largest Errors



The following are the subcategory descriptions for the physician service and DME insufficient documentation errors in Figure 3.

Physician Services

Insufficient Documentation/Subcategory - No signature

- Medicare requires that services provided / ordered be authenticated by the author, either hand written or electronically signed.

Insufficient Documentation/Subcategory – Documentation does not match code billed

- The submitted information documents a service which is different from the service described by the billed procedure code.

Insufficient Documentation/Subcategory - A valid physician order as required by regulation, interpretive manual or LCD missing (includes physician signature or date)

- For most items and services, a signed and dated physician order is required for payment.

Insufficient Documentation/Subcategory - Illegible identifier

- Medicare requires that services provided / ordered be authenticated by the author, either hand written or electronically signed. When written, the signature must be legible or otherwise identifiable (e.g., signed over the physician's printed name or via signature log). If the signature is illegible or missing, CMS gives the provider an opportunity to attest to their signature. If the attestation is not returned, it is considered an insufficient documentation-illegible identifier error.

Durable Medical Equipment

Insufficient Documentation/Subcategory – Multiple Errors

- Represents claims that have more than one reason for error.

Insufficient Documentation/Subcategory - Though a valid International Classification of Diseases Clinical Modification Volume 9 (ICD-9) code was submitted, the ICD-9 code alone was insufficient information

- A valid ICD-9-CM code (per the relevant LCD) was submitted, but there was no documentation to otherwise support the medical necessity of the service.

Insufficient Documentation/Subcategory - A valid physician order as required by regulation, interpretive manual or LCD missing

- For DME items, the supplier must have a detailed written order from the treating physician prior to submitting a claim. For certain items (e.g., power wheelchairs) the detailed written order is required prior to delivery.

Insufficient Documentation/Subcategory – Results of Diagnostic or Lab Tests Missing

- The medical necessity for an item is based on the result of a diagnostic test (e.g., an arterial blood gas for home oxygen therapy), but the result is not included in the documentation.

Insufficient Documentation/Subcategory – Documentation Does Not Describe Service

- The submitted information documents a service which is different from the service described by the billed procedure code.

Geographic Trends

Improper payments vary greatly by geographic location. Identifying the most problematic areas and the differentiating characteristics of those geographic locations can be useful for targeting improper payment reduction efforts.

Figure 4 displays the error rates by state and Figure 5 displays the projected improper payments by state. The states with very high error rates and extremely large expenditures are New York, California, Texas, and Florida. These four states constitute X percent of overall Medicare FFS payments, but 40 percent of total improper payments. New York has the highest error rate of 14.2 percent with \$3.7 billion in improper payments. California has an 11.4 percent error rate and \$3.4 billion in improper payments. If the improper payment rates for New York, California, Texas, and Florida were reduced halfway between their current error rate and a target error rate of 5 percent, national improper payments would be reduced by \$8.2 billion, or 24 percent of total improper payments. Lowering improper payments in these states is critical to lowering the national error rate.

Figure 4: Improper Payment Error Rates by State

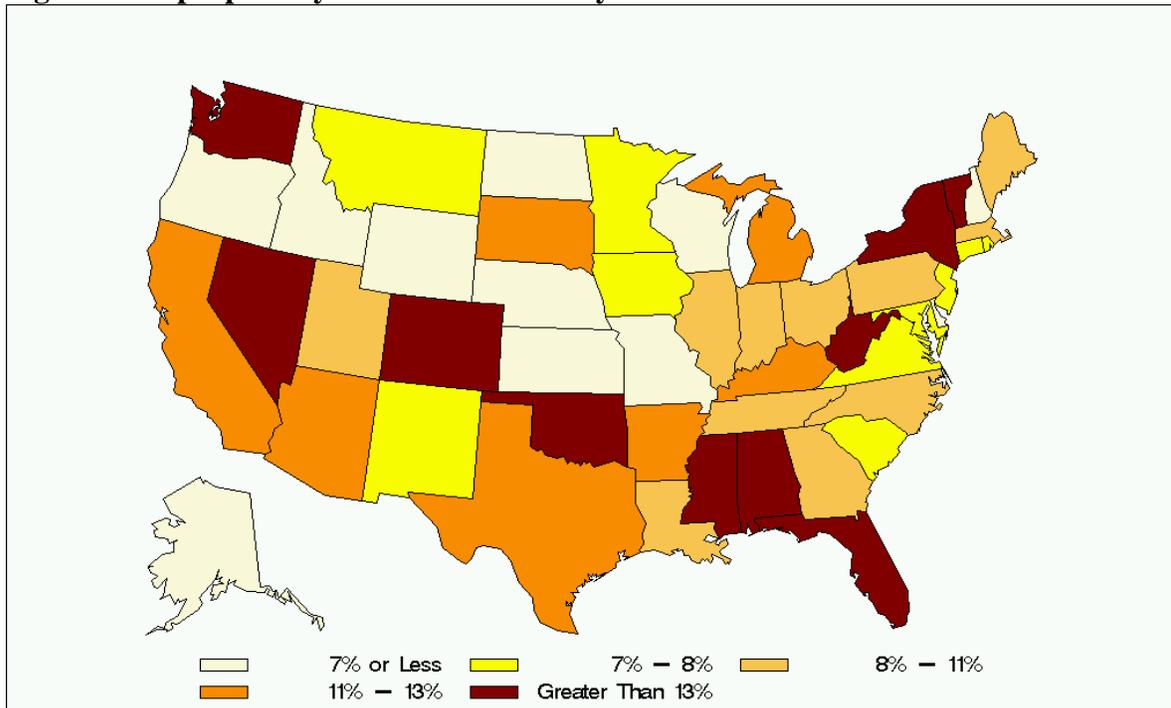


Figure 5: Improper Payments (in Millions of Dollars) by State

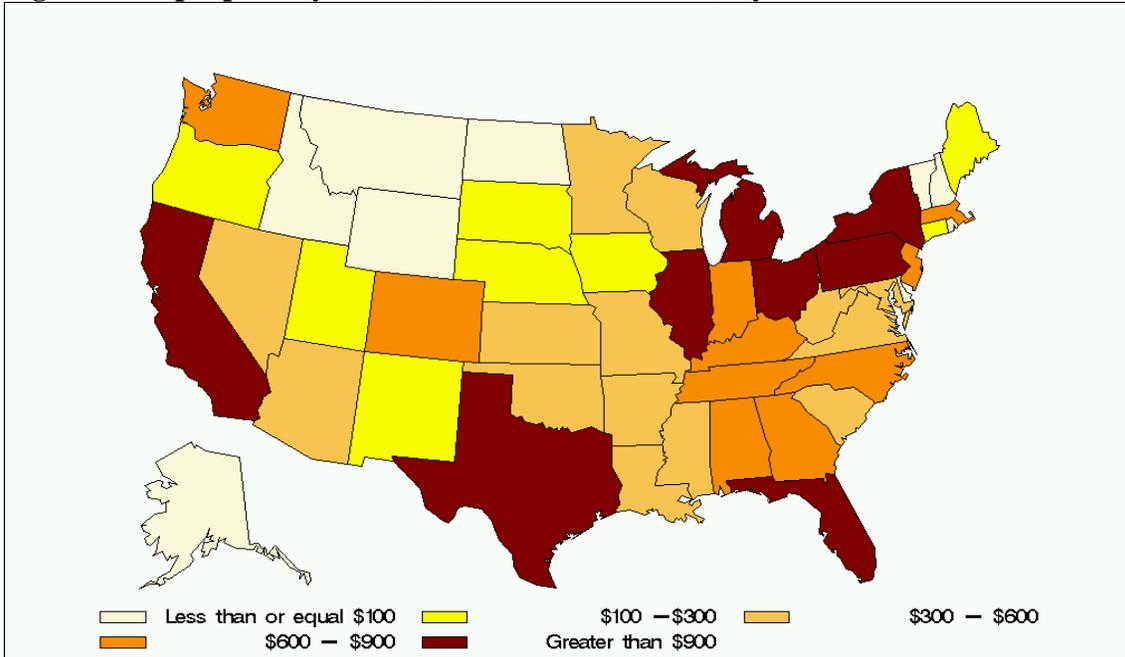


Table 8 displays the improper payments and error rates of the top 10 states for projected improper payments, as well as the breakdown by overpayments and underpayments. New York, California, Texas and Florida have very high overpayment error rates and extremely high overpayments.

Table 8: Projected Improper Payments, Overpayment and Underpayments by State (in Millions of Dollars)¹⁵

State	Overall		Overpayment		Underpayment	
	Improper Payment	Rate	Improper Payment	Rate	Improper Payment	Rate
Overall	\$34,268.7	10.5%	\$33,208.3	10.2%	\$1,060.4	0.3%
NY	\$3,668.7	14.2%	\$3,643.5	14.1%	\$25.2	0.1%
CA	\$3,443.1	11.4%	\$3,373.1	11.2%	\$70.0	0.2%
FL	\$3,350.8	13.4%	\$3,247.1	13.0%	\$103.7	0.4%
TX	\$3,175.5	11.8%	\$2,942.0	11.0%	\$233.4	0.9%
MI	\$1,320.5	12.7%	\$1,296.3	12.5%	\$24.2	0.2%
IL	\$1,266.1	9.0%	\$1,248.2	8.8%	\$18.0	0.1%
PA	\$1,245.6	8.8%	\$1,222.6	8.6%	\$23.0	0.2%
OH	\$1,078.9	8.9%	\$1,070.5	8.8%	\$8.4	0.1%
NJ	\$897.9	7.6%	\$815.9	6.9%	\$82.0	0.7%
NC	\$873.5	9.0%	\$851.7	8.8%	\$21.8	0.2%

¹⁵ Some columns and/or rows may not sum correctly due to rounding.

CMS Contact

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