# Improper Medicare Fee-For-Service Payments Report - November 2005 Long Report

# EXECUTIVE SUMMARY

## Background

CMS established two programs to monitor the accuracy of payments made in the Medicare Fee-for-Service (FFS) program: The Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The national paid claims error rate is a combination of error rates calculated by the CERT program and HPMP; the CERT program represents about 60% of the payments upon which the error rate is calculated while the HPMP represents the remaining 40%. The CERT program calculates the error rates for Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs). HPMP calculates the error rate for the Quality Improvement Organizations (QIOs). More information on the differences between Carriers/DMERCs/FIs/QIOs may be found in later sections of this report.

Strong outcome-oriented performance measures are a good way to assess the degree to which a government program is accomplishing its mission and to identify improvement opportunities. This November 2005 Report describes the performance measurement process for Carriers/DMERCs/FIs/QIOs.

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates from 1996 to 2002. The OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Carriers/DMERCs/FIs/QIOs erroneously allowed to be paid). To better measure the performance of the Carriers/DMERCs/FIs/QIOs and to gain insight about the causes of errors, CMS decided to calculate a number of additional rates. The additional rates include provider compliance error rates (which measure how well providers prepared claims for submission) and paid claims error rates (which measure how accurately Carriers/DMERCs/FIs made coverage, coding, and other claims payment decisions) for specific contractors, service types, and provider types. CMS began producing error rates and estimates of improper payments in November 2003.

CMS calculated the Medicare FFS error rate and improper payment estimate for Carriers/DMERCs/FIs/QIOs for this November 2005 Report using a methodology approved by the OIG. This methodology includes:

- CERT randomly selecting a sample of 143,263 claims submitted to Carriers/DMERCs/FIs during the reporting period.
- HPMP randomly selecting a sample of:
  - 38,448 prospective payment system (PPS) short term acute care inpatient hospital discharges,
  - 1,383 PPS long term acute care inpatient hospital discharges, and
  - 1,140 denied PPS short term inpatient hospital and PPS long term inpatient hospital claims during the reporting period.
- Requesting medical records from the health care providers that submitted the claims in the sample.

- Where medical records were submitted by the provider, reviewing the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules, and, if not, assigning errors to the claims.
- Where medical records were not submitted by the provider, classifying the case as a no documentation claim and counting it as an error.
- Sending providers overpayment letters/notices or making adjustments for claims that were overpaid or underpaid.

# Reporting Periods

CMS calculated error rates in this report by reviewing claims that providers submitted during specific *reporting periods*. Two upcoming changes are of particular note: first, is the the planned release of a midyear report beginning in May of 2006 and second, is the acceleration of the CERT reporting period by 3 months beginning with the November 2006 report. CMS believes that a decrease in time between report periods and report publications will increase the value of the report. CMS expects that a shorter report cycle will be of particular benefit to Carriers/DMERCs/FIs as well as anyone interested in using the data to lower improper payments.

It is difficult to substantially accelerate the HPMP reporting period without compromising the accuracy of the error estimate for acute care inpatient claims. Providers have over 2 years to submit inpatient acute care claims and adjustments. There are further statutory and regulatory time requirements related to supplying documentation in the case review process.
The following table outlines the reporting periods to date for improper payment reports as well as the changes planned for upcoming reports.

| Report | CERT (Carriers/DMERCs/FIs) | HPMP (QIOs) |
|---|---|---|
| **November 2003** | Claims submitted in the 12 month period ending December 31, 2002 | Discharges that occurred between April 1, 2001 and March 31, 2002 |
| **November 2004** | Claims submitted in the 12 month period ending December 31, 2003 | Discharges that occurred between July 1, 2002 and June 30, 2003 |
| **November 2005** | Claims submitted in the 12 month period ending December 31, 2004 | Short-Term Acute Care: Discharges that occurred July 1, 2003 through June 30, 2004. Long-Term Acute Care and Denied Claims: Claims processed between January 1, 2004 and December 31, 2004. |
| **May 2006 (planned)** | Claims submitted in the 12 month period ending September 30, 2005 | Discharges that occurred between October 1, 2003 and September 30, 2004 |
| **November 2006 (planned)** | Claims submitted in the 12 month period ending March 31, 2006 | Discharges that occur between September 1, 2004 and August 31, 2005 |

# Impact of Improper Payments Information Act (IPIA)

To promote consistency in improper payment reporting across federal agencies, the IPIA requires agencies to follow a number of methodological requirements when calculating error rates and improper payment estimates. The IPIA mandates that agencies use gross figures when reporting improper payment amounts and rates. A gross improper payment amount is calculated

by **adding** underpayments to overpayments. All figures in this report are gross figures; therefore, historical figures that were originally reported as net number have been converted for consistency.

An additional IPIA requirement is the inclusion of denied claims in the sample. Accordingly, the CERT program began including denied claims in last year's sample and the HPMP began including denied claims in this year's sample.

# Summary of Findings

### National Error Rate

This report shows that, for the November 2005 reporting period, 5.2% of the dollars paid nationally did not comply with one or more of Medicare coverage, coding, billing, and payment rules. Projected overpayments were $11.2 B and the underpayments were $0.9 B. Thus, gross improper payments were projected as $12.1 B (i.e., $11.2 B **plus** $0.9 B).

### Contractor Type Error Rates

The following chart displays the error rates and improper payment amounts for the Medicare FFS Program for the November 2005 reporting period.

| Type of Contractor | Total Dollars Paid | Overpayments | | Underpayments | | (Overpayments + Underpayments) | |
|---|---|---|---|---|---|---|---|
| | | Payment | Rate | Payment | Rate | Improper Payments | Error Rates |
| Carrier | $67.6B | $4.2B | 6.2% | $0.1B | 0.2% | $4.3B | 6.4% |
| DMERC | $9.1B | $0.8B | 8.6% | $0B | 0.0% | $0.8B | 8.6% |
| FI | $63.7B | $2.1B | 3.3% | $0.1B | 0.1% | $2.2B | 3.4% |
| QIOs | $93.7B | $4.2B | 4.5% | $0.7B | 0.7% | $4.8B | 5.2% |
| **All Medicare FFS** | **$234.1B** | **$11.2B** | **4.8%** | **$0.9B** | **0.4%** | **$12.1B** | **5.2%** |

On average, Carriers lowered their paid claim error rate from 11.4% in 2004 to 6.4% in 2005. The DMERCs paid claim error rate dropped from 11.1% in 2004 to 8.6% in 2005. The FIs saw a decline in their paid claim error rate from 16.4% in 2004 to 3.4% in 2005. The QIO paid claim error rate increased from 4.8% in 2004 to 5.2% in 2005.

### Other Error Rates

This report also describes the other error rates in order to provide the most specific information available to target problem areas. Other error rates include error rates by specific contractor, error rates by service type, and error rates by provider type.

When comparing contractors, services, or provider types, it is important to note that the highest error rate does not necessarily have the highest projected improper payments. For example, the reported error rate is higher for chiropractic services than for E&M services, but the projected

improper payments associated with claims submitted for E&M are higher than those for chiropractic services. Therefore, efforts focused on reducing improper payments may focus on E&M services despite the higher error rate in chiropractic services.

| Report Section | Highest Paid Claims Error Rates | | | Highest Projected Improper Payments | | |
|---|---|---|---|---|---|---|
| | Entity | Paid Claim Error Rate | Projected Improper Payments | Entity | Projected Improper Payments | Paid Claim Error Rate |
| Error Rates by Specific Contractors | Triple S, Inc. PR/VI | 15.7% | $96.3 M | First Coast Service Options FL, Carrier | $831.0 M | 11.9% |
| Error Rates by Service Type | Surgical Dressings | 67.8% | $85.7 M | OPPS/Laboratory/Ambulatory | $861.9 M | 4.3% |
| Error Rates by Provider Type | Unknown Supplier/Provider | 69.1% | $68.6 M | | | |

The contractor with the highest error rate was Triple S, Inc. PR/VI; however, they did not have the highest projected improper payments. The table shows that First Coast Service Options FL, Carrier was the contractor with the highest projected improper payments in the November 2005 report. The service type with the highest error rate is Surgical Dressings. Despite not having the highest error rate, OPPS/Laboratory/Ambulatory was the service type with the highest projected improper payments. Similarly, the provider type with the highest error rate was Unknown Supplier/Provider and, while OPPS/Laboratory/Ambulatory has an error rate of only 4.3%, it is also the provider type with the highest projected improper payments at $861.9 M.

## Goals

One of the performance goals for CMS is the reduction of improper payments made under the FFS program to 7.9% or less by the November 2005 reporting period, 6.9% or less by the November 2006 reporting period, 5.4% or less by the November 2007 reporting period and 4.7% by the 2008 reporting period. The findings in this November 2005 Report indicate that CMS exceeded the November 2005 goal and is well on the way toward meeting the November 2008 goal.

## Corrective Actions Taken to Date

CMS is working with the **QIOs** to implement the following efforts to lower the paid claims error rate:

1. Using the First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) that generates state-specific hospital billing reports to help QIOs analyze administrative claims data and target interventions with hospitals,
2. Increasing and refining one-on-one educational contacts with providers found to be billing in error,

3. Developing projects with the QIOs addressing state-specific admissions necessity, coding concerns, and billing, as well as, conducting surveillance and monitoring of inpatient payment error trends by error type,
4. Distributing FATHOM generated hospital-specific reports to hospitals,
5. Providing targeted education to hospitals with high numbers of medically unnecessary admissions,
6. Developing and distributing QIO-specific payment error cause analyses, and
7. Conducting national training on the use of FATHOM reports in compliance efforts.

CMS is working with each **Carrier/DMERC/FI** to develop a plan that addresses the cause of the contractor's errors, the steps the contractor will take to fix the problems, and other recommendations that will ultimately lower the error rate.

CMS is working with the **CERT contractors** to:

1. Reduce the lag time between the end of a reporting period and the production of the CERT report for that period, thereby providing Carriers/DMERCs/FIs with more timely error rates. CMS plans to decrease this time lag from 11 months to 8 months for the November 2006 Report.
2. Produce error rate reports more frequently; thus, allowing contractors to make corrections to their error rate reduction activities between November reports. Beginning in 2006, CMS will produce two Improper Payment Reports: one in May and one in November.
3. Perform a small area variation analysis to produce maps of the United States that display CERT error rates and improper payment amounts geographically (available at www.CMS.HHS.gov/cert).
4. Reduce the no documentation errors by:
    - Having CERT contractors make direct contact with every provider that has not provided a medical record or other requested information.
    - Developing a monthly newsletter to explain the importance of CERT and how the CERT program operates.
    - Sending the monthly newsletter to all Carriers/DMERCs/FIs for redistribution to their providers.
    - Providing a website (http://www.certprovider.org/) to help providers understand the importance of providing an address from which CERT can obtain the provider's medical records.
    - Encouraging providers to use http://www.certprovider.org/ to correct address errors in CERT records.
5. Decrease the insufficient documentation errors by:
    - Improving the processes of requesting and receiving medical records. For example, the CERT Documentation Contractor uses fax servers to capture images of incoming faxes. In addition, they manually image all hardcopy medical records they receive.
    - Modifying the medical record request letters to clarify the components of the record needed for CERT review and to encourage the billing provider to forward the request to the appropriate location. A partial impact of this change will be

seen in the November 2006 report and the full impact of this change will be seen in the November 2007 report.

- Encouraging Carriers/DMERCs/FIs to educate providers about the importance of submitting thorough and complete documentation, including signing all plans of care, etc.

# OVERVIEW

## Background

The Social Security Act established the Medicare program in 1965. Medicare currently covers health care needs of people aged 65 and over, the disabled, people with End Stage Renal Disease (ESRD), and certain others that elect to purchase Medicare coverage. Both Medicare costs and the number of Medicare beneficiaries has increased dramatically since 1965. In fiscal year (FY) 2004, more than 42 million beneficiaries were enrolled in the Medicare program, and the total Medicare benefit outlays (both Medicare Fee-for-Service (FFS) and managed care payments) was estimated at about $301.1 B.[1] The Medicare budget represents over 11% of the total federal budget.

CMS uses several types of contractors to prevent improper payments from being made for Medicare claims and admissions including Carriers, Durable Medical Equipment Regional Carriers (DMERCs), Fiscal Intermediaries (FIs), and Quality Improvement Organizations (QIOs).

The primary goal of each Carrier/DMERC/FI is to "Pay it Right" – that is, to pay the right amount to the right provider for covered and correctly coded services. Budget constraints limit the number of claim reviews these contractors can conduct; thus, they must choose carefully which claims to review. To improve provider compliance, Carriers/DMERCs/FIs must also determine how best to educate providers about the Medicare rules and implement the most effective methods for accurately answering coverage and coding questions. As part of its Improper Payments Information Act (IPIA) compliance efforts, and to help all Medicare FFS contractors better focus review and education, CMS has established the Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program (HPMP) to randomly sample and review claims submitted to Medicare.

## History of Error Rate Production

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) estimated the Medicare FFS error rate from 1996 through 2002. The OIG designed their 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. The confidence interval for the national paid claims error rates during these years was +/- 2.5%. Following recommendations from the OIG, CMS increased the sample size for the CERT program when production began on the Medicare FFS error rate for the November 2003 Report. The sample size for error rates concerning Carriers/DMERCs/FIs for the November 2005 reporting period was 143,263 paid and denied claims. The sample size for error rates concerning QIOs for the November 2005 reporting period was 38,448 discharges for prospective payment system (PPS) short term acute care inpatient hospital discharges, 1,383 discharges for PPS long term acute care inpatient

[1] 2005 CMS Statistics: U.S. Department of Health and Human Services, CMS pub. No 03455, September 2005

hospital discharges, and 1,140 denied claims. The standard error for the national error rate for the November 2005 report was calculated as .3%.

# Types of Error Rates Produced

To better measure the performance of the Carriers/DMERCs/FI and to gain insight into the causes of errors, CMS decided to calculate not only a national Medicare FFS paid claims error rate but also a provider compliance error rate.

### Paid Claims Error Rate

This rate is based on dollars paid after the Medicare contractor made its payment decision on the claim. Beginning with the November 2004 Report, this rate includes fully denied claims for Carriers/DMERCs/FIs. Beginning with the November 2005 Report, this rate includes fully denied claims for QIOs as well. 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 influence the trust fund. CMS calculated the gross rate by adding underpayments to overpayments and dividing that sum by total dollars paid. This error rate is quantified in dollars.

### Provider Compliance Error Rate

This rate is based on how the claims looked when they first arrived at the Carrier/DMERC – before the Carrier/DMERC applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the Carrier/DMERC is educating the provider community since it measures how well providers prepared claims for submission. This error rate is quantified in dollars. CMS does not collect covered charge data from FIs; therefore, current FI data is insufficient for calculating a provider compliance error rate. CMS anticipates that it will be able to generate FI provider compliance error rates for the November 2007 Report. This rate is not generated for QIOs.

### Previously Produced Rates

In previous reports CMS produced a Services Processed Error Rate that measured the number of services (rather than dollars) improperly processed. The Services Processed Error Rate included: claims improperly paid, claims improperly denied, and claims the contractor could not find. Many readers of the report found the Services Processed Error Rate to be confusing so CMS discontinued providing the Services Processed Error Rate. To see the claims improperly paid and denied (combined) measured in dollars, readers should focus on the paid claims error rates throughout this report. To see how many claims a contractor could not find, readers should see the No Resolution Rate data in Appendix C.

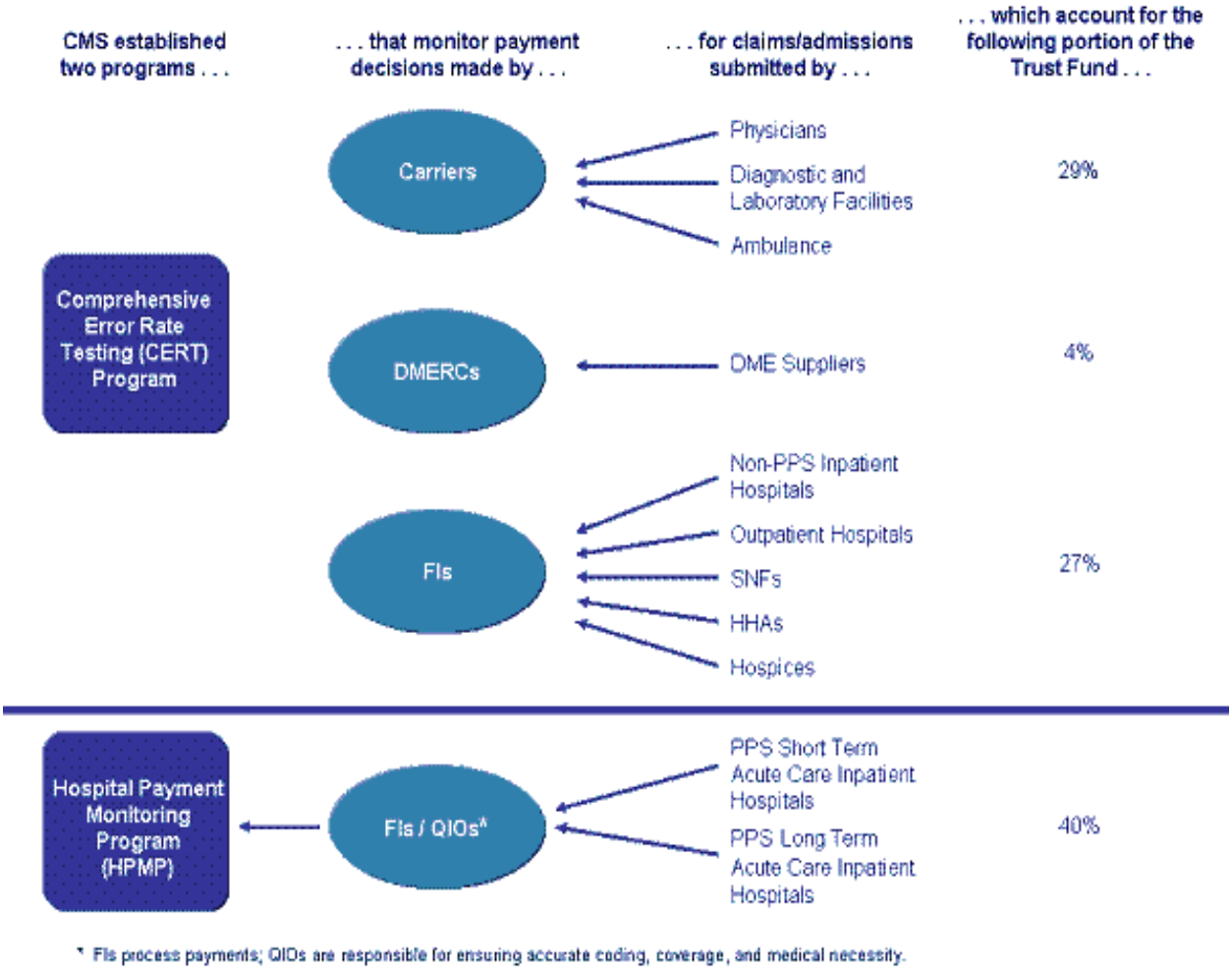
# Two Measurement Programs: CERT and HPMP

CMS established two programs to monitor the accuracy of the Medicare FFS Program: the CERT program and HPMP. The main objective of these programs is to measure the degree to

which CMS and its contractors are meeting the goal of *Paying it Right*. The HPMP monitors PPS short-term acute care inpatient hospital admissions. Beginning with the November 2005 reporting period, HPMP will also monitor PPS long-term acute care inpatient hospital admissions. The CERT program monitors all other claims.

The following figure (Figure 3) depicts the types of claims/admissions involved in each monitoring program.

**Figure 1: Types of Claims/Admissions Reviewed By CERT and HPMP**



The following table (Table 1) summarizes the data that is presented in this report.

**Table 1: Error Rates Available in this Report**

| Monitoring Program | Type of Error Rate(s) Produced | Paid Claims Error Rate | Provider Compliance Error Rate |
|---|---|---|---|
| **CERT+HPMP** | Medicare FFS | ✓ | Not Available |
| **CERT** | Carrier/DMERC/FI | ✓ | ✓ |
| | Carrier-Specific | ✓ | ✓ |
| | DMERC-Specific | ✓ | ✓ |
| | FI-Specific | ✓ | Available November 2007 |
| | Type of Service | ✓ | ✓ |
| | Type of Provider | ✓ | ✓ |
| **HPMP** | QIO Specific | ✓ | Not Produced |
| | Type of Service | ✓ | Not Produced |
| | Type of Provider | ✓ | Not Produced |

There will be one update to this November 2005 Report on October 15, 2006. The October Update will display error rates for the same time period covered by this original November 2005 Report but will include updated rates based on claims where late documentation has been received by the CERT program and claims that were fully or partially overturned in the provider appeals process. Rates calculated by the HPMP for the November 2005 report include all provider appeals allowed under the QIO appeals timeframes.

# The CERT Program

CMS established the CERT program to monitor the accuracy of Medicare FFS payments made by Carriers/DMERCs/FIs. The main objective of the CERT program is to measure the degree to which CMS and Carriers/DMERCs/FIs are meeting the goal of "Paying it Right". See Appendix H for additional details about the sample used for this report.

### Sampling and Medical Record Requests

For this report, the CERT Contractor randomly sampled 143,263 claims from Carriers/DMERCs/FIs. The CERT Contractor randomly selected about 193 claims each month from each Carrier/DMERC/FI. CERT designed this process to pull a blind, electronic sample of claims each day from all of the claims providers submitted that day.

The CERT Contractor requested the medical record associated with the sampled claim from the provider that submitted the claim. The CERT Contractor sent the initial request for medical records via letter. If the provider failed to respond to the initial request after 19 days, the CERT Contractor sent three subsequent letters and made up to three phone calls to the provider.

In cases where the CERT Contractor received no documentation from the provider once 90 days had passed since the initial request, the CERT Contractor considered the case to be a no

documentation claim and counted it as an error. The CERT Contractor considered any documentation received after the 90th day "late documentation." If the CERT Contractor received late documentation prior to the documentation cut-off date for this report, they reviewed the records and, if justified, revised the error in each rate throughout the report. If the CERT Contractor received late documentation after the cut-off date for this report, they continued to count the case as a no documentation error.

**Review of Claims**

Upon receipt of medical records, the CERT Contractor's clinicians conducted a review of the claims and submitted documentation to identify any improper payments. They checked the Common Working File to see if the person receiving the services was an eligible Medicare beneficiary, to see if the claim was a *duplicate* and to make sure that no other insurer was responsible for paying the claim. When performing these reviews, the CERT contractor followed Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective Carrier/DMERC/FI Local Coverage Determinations (LCDs), and articles.

**Appeal of Claims**

In the November 2003 reporting period, the CERT Contractor did not remove an error from the error rate if a provider appeal (using the normal appeals process) of a CERT initiated denial resulted in a reverse decision. However, in the November 2004 Report, the CERT Contractor implemented an appeals tracking system and began to back out overturned CERT initiated denials from the error rate; however, some contractors did not enter all the appeals information into the new tracking system before the cut-off date for the report. Therefore, CERT only backed out some of the determination reversals from the error rate in the November 2004 Report. All Carriers/DMERCs/FIs had opportunity to ensure that they entered all overturned appeals into the appeals tracking system in sufficient time for production of the November 2005 error rates.

**Variation from the General Methodology**

Due to a change in the FI shared system, the system did not correctly identify payments for non-PPS Hospital Inpatient claims for April through December of 2004. To correct for this problem, CMS used data for January 2004 through March 2004 as a basis to extrapolate improper payment and error rate estimates for non-PPS Hospital Inpatient claims in this report.

**Naming Conventions**

From time to time, a Carrier/DMERC/FI will choose to leave the Medicare program. When this occurs, CMS selects a replacement contractor to take over claims processing, error rate reduction efforts, etc. The *cutover date* is the term used to describe the date that the incoming contractor begins to receive and process claims while the outgoing contractor ceases operations. When preparing these improper payment reports, CMS has adopted a policy of listing the name of the contractor who processed claims from that jurisdiction for more than 6 months of the reporting period.

# HPMP

The CMS established the HPMP to measure, monitor, and reduce the incidence of improper PPS acute care inpatient Medicare payments. FIs process these payments; QIOs are responsible for ensuring accurate coding, admission necessity, and coverage. HPMP operates through the QIO program as QIOs have responsibility for ascertaining the accuracy of these payments through the physician peer review process. QIOs work with acute care hospitals to identify and prevent payment errors.

## Sampling

Each month a CMS contractor selected a random sample of paid short-term acute care inpatient claims for each state from a clinical data warehouse that mirrors the National Claims History (NCH) database. To allow time for hospital claims submission, HPMP sampled claims after the completion of three months from the month of discharge; claims are 97.5% complete at this time. Beginning with the November 2005 report, HPMP also sampled paid long-term acute care and FI-denied claims (both short-term and long-term). For long term acute care claims, a national random sample not stratified by state was selected monthly. Claims that had been denied at the FI were selected as a single, national random sample. The HPMP sampled a total of 38,448 claims from 52 states and jurisdictions (all 50 states plus Puerto Rico and Washington, D.C.) for short-term acute care inpatient hospital discharges, 1,383 claims for PPS long-term acute care hospital discharges, and 1,140 denied claims.

## Review of Claims

The CMS contractor that performed the sampling of PPS short-term acute care sample claims provided the sampled claims to the Clinical Data Abstraction Centers (CDACs) for screening. The CDACs validated Diagnosis Related Groups (DRGs), performing independent recoding and admission necessity screening based upon the information provided in the submitted record. Qualified coding specialists performed DRG coding validation. CDAC nurse reviewers performed admission necessity screening. Admission screening involved a detailed examination of each medical record using specific modules of the InterQual admission appropriateness criteria set. In addition, Maryland records were screened for length of stay (Maryland is the only waivered non-PPS state); Maryland length of stay errors are included under medically unnecessary services.

The CDACs did not follow-up with providers; the CDAC referred records that failed screening as well as those that were not received in a timely manner to the responsible QIO for case review. Under the case review process, records are again validated for coding and screened for admission necessity. Those records failing admission necessity screening are sent to peer physician review under which hospitals have further opportunity to supply documentation.

The long-term acute care sample was sent directly to QIOs and was not screened by the CDAC. Denied claims were handled only by the CDAC and were not sent to the QIOs.

## Weighting and Determining the Final Results

The CERT program weighted the error rates so that each Carrier/DMERC/FI/QIO contribution to the error rate was in proportion to its size (as measured by the percent of allowed charges for which they were responsible). The confidence interval is an expression of the numeric range of values for which CMS is 95% 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% confidence interval for the national error rate calculation.

All national improper payment estimates from 1996 to present EXCLUDE coinsurance, deductibles and reductions to recover previous overpayments. When CMS began calculating the additional error rates for contractor-specific, service-type and provider-type in the November 2003 and November 2004 reports, these types INCLUDED coinsurance, deductibles and reductions. The CERT program was unable to exclude them from the improper payment amounts due to system limitations. CMS has since implemented new systems and revised methodology that has allowed for the EXCLUSION of coinsurance, deductibles and reductions from all improper payment amounts beginning with the November 2005 reporting period. As a result, the improper payment estimates from the November 2005 report and forward can not be compared to previously published estimates for contractor-specific, service-type, or provider-type calculations. However, since error rate estimates are unaffected, they can be compared across all reports.

**Table 2: Summary of Inclusion vs. Exclusion**

| | **National Rate** | **Contractor Specific** | **Service Type** | **Provider Type** |
|---|---|---|---|---|
| 1996 - 2002 | **EXCLUDES** coinsurance, deductibles, and reductions | N/A | N/A | N/A |
| Nov 2003 | **EXCLUDES** coinsurance, deductibles, and reductions | Carrier/DMERC/FI improper payment estimates **INCLUDE** coinsurance, deductibles, and reductions. QIO contractor-specific improper payment estimates **EXCLUDE** coinsurance, deductibles, and reductions. | | |
| Nov 2004 | **EXCLUDES** coinsurance, deductibles, and reductions | Carrier/DMERC/FI improper payment estimates **INCLUDE** coinsurance, deductibles, and reductions. QIO contractor-specific improper payment estimates **EXCLUDE** coinsurance, deductibles, and reductions. | | |
| From Nov 2005 Forward | **EXCLUDES** coinsurance, deductibles, and reductions | Carrier/DMERC/FI/QIO improper payment estimates **EXCLUDE** coinsurance, deductibles, and reductions. | | |

## Outcome of Sampled Claims

When the CERT Contractor detected an overpayment, they notified the Carrier/DMERC/FI that made the overpayment. If a provider did not submit requested documentation, the CERT program considered any payments the Carrier/DMERC/FI made for the claim as overpayments.

When the CERT Contractor detected an underpayment (i.e., the provider billed a lower code than what was documented in the medical records and needed by the beneficiary, or the Carrier/DMERC/FI made an incorrect full or partial denial), they notified the Carrier/DMERC/FI. CMS will instruct the Carriers/DMERCs/FIs to make payments to providers in underpayment cases identified for the November 2006 and later reports. For more information about underpayments, see Appendix G.

For all overpayment and underpayment errors found in HPMP, the QIO notified the appropriate FI that an adjustment was necessary. When a QIO discerned a DRG coding change, the FI was informed of the appropriate DRG. The FI was also informed when: a stay was found to be inappropriate, the requested medical records were not supplied, or insufficient documentation was provided. In each case, the stay was denied and was considered an overpayment. FIs are responsible for determining payment adjustments for claims found to be in error. The QIOs neither determine adjustment amounts nor implement payment adjustments.

Providers can appeal denials (including no documentation denials) following the normal appeal processes by submitting documentation supporting their claims. For the November 2003 Report, the CERT program did not consider the outcome of appeal determinations. However, beginning with the claims in the November 2004 Report, the CERT program considered the outcome of any appeal determinations that reversed the CERT program's decision when computing the error rates. The CERT program deducted $1.0 B in appeals reversals from the error rates contained in the November 2005 Report. Under the QIO case review process, hospitals have multiple opportunities to appeal a QIO decision. Cases are not included as payment errors for all HPMP calculations until all hospital case review appeals are complete.

During the November 2005 reporting period, the CERT program identified $1.6 M in actual overpayments. As of the final cut-off date for this report Carriers/DMERCs/FIs had collected $1.0 M of those actual overpayments. During the November 2005 reporting period, the HPMP identified $10.2 M in overpayments, and, as of the final cutoff date for this report, the FIs had processed $9.4 M in HPMP adjustments. CMS and its contractors will never collect a small proportion of the identified overpayments because:

- The responsible provider appealed the overpayment and the outcome of the appeal overturned the CERT decision.
- The provider has gone out of business.

However, for all other situations, the Carrier/DMERC/FI will continue their attempts to collect the overpayments.

# GPRA Goals

CMS aims to accomplish three error rate goals under the Government Performance and Results Act (GPRA).

**1. Reduce the National Medicare FFS Paid Claims Error Rate.**

- By November 2005, reduce the percent of improper payments under Medicare FFS to 7.9%.

  **STATUS: <u>This goal was met</u>. The national paid claims error rate for the November 2005 reporting period was 5.2%. Because of this dramatic improvement, CMS will revise this GPRA goal for 2006 and beyond.**

**2. Reduce the Contractor-Specific Paid Claim Error Rate**

- By 2005, 25% of Medicare claims will be processed by contractors with an error rate less than or equal to the national error rate for FY 2004: 10.1%.

  **STATUS: <u>This goal was met.</u> During the November 2005 reporting period, 89.6% of the Medicare claims were processed by Carriers/DMERCs/FIs with a paid claim error rate less than or equal to the national error rate for November 2004 (10.1%).**
- By November 2006, 50% of Medicare claims will be processed by contractors with an error rate less than or equal to the national error rate for November 2005.
- By November 2007, 75% of Medicare claims will be processed by contractors with an error rate less than or equal to the national error rate for November 2006.
- By November 2008, every Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for November 2007.

**3. Decrease the Provider Compliance Error Rate**

- In November 2005, CMS will set the baseline for FIs and will decrease the Carrier and DMERC Provider Compliance Error Rate 20% over the 2004 level.

  **STATUS: <u>This goal was partially met</u>. Due to system limitations, CMS did not collect covered charge data from FIs during this reporting period. CMS was therefore unable to produced this rate for FIs during the November 2005 reporting period. Thus, the first part of this goal was NOT met. For Carriers, the provider compliance error rate decreased by 31% from 25.2% in November 2004 to 17.8% in November 2005. For DMERCs, the provider compliance error rate decreased by 8% (from 19.7% in November 2004 to 18.1% in November 2005. Thus the second part of this goal WAS met for Carriers but not DMERCs.**
- In November 2006, decrease the Provider Compliance Error Rate 20% over the November 2005 level.
- In November 2007, decrease the Provider Compliance Error Rate 20% over the November 2006 level.
- In November 2008, decrease the Provider Compliance Error Rate 20% over the November 2007 level.

## How Error Rates Will be Used

CMS will use the error rate findings described in this report to determine underlying reasons for claim errors and to adjust its action plans to improve compliance in payment, documentation, and provider billing practices. The tracking and reporting of error rates also helps CMS identify emerging trends and implement corrective actions designed to accurately manage all Medicare FFS contractors' performance. In addition, the error rates will provide all Medicare FFS contractors with the guidance necessary to direct claim review activities, provider education efforts, and data analysis. Carriers/DMERCs/FIs also use the error rate findings to adjust their Error Rate Reduction Plans. Lastly, CMS evaluates QIOs under their contract on payment error rates.

# FINDINGS

## National Medicare FFS Error Rate

The national paid claims error rate in the Medicare FFS program for the November 2005 reporting period is 5.2% (which equates to $12.1 B). The 95% confidence interval for Medicare FFS program paid claims error rate for the November 2005 reporting period was 4.7% - 5.7%. The 90% confidence interval (required to be reported by IPIA) was 4.8% - 5.6%.

The significant reduction in the Medicare FFS error rate from 2004 to 2005 can be attributed to marked improvement in the no documentation and the insufficient documentation error rates. Since the inception of the CERT program, CMS and the Medicare contractors focused a large part of their efforts on educating providers about CERT and its value to the Medicare program. The increased awareness of CERT has dramatically reduced the number of no documentation claims the program receives. Provider education also aided in the reduction of the insufficient documentation error rate; however, the most dramatic improvement came from a program change. During the November 2005 report time period providers were given an opportunity to submit additional documentation if the CERT review contractor concluded that the provider's first submission was insufficient to make a determination. This new policy had a dramatic impact on the national insufficient documentation error rate. For more information on corrective actions aimed at reducing the Medicare FFS error rate, see the Corrective Actions section.

Table 3a summarizes the overpayments and underpayments, improper payments and error rates by year.

**Table 3a: National Error Rates by Year[2]**

| Year | Total Dollars Paid | Overpayments | | Underpayments | | Overpayments + Underpayments | |
|---|---|---|---|---|---|---|---|
| | | Payment | Rate | Payment | Rate | Improper Payments | Rate |
| **1996** | $168.1 B | $23.5B | 14.0% | $0.3 B | 0.2% | $23.8 B | 14.2% |
| **1997** | $177.9 B | $20.6B | 11.6% | $0.3 B | 0.2% | $20.9 B | 11.8% |
| **1998** | $177.0 B | $13.8B | 7.8% | $1.2 B | 0.6% | $14.9 B | 8.4% |
| **1999** | $168.9 B | $14.0B | 8.3% | $0.5 B | 0.3% | $14.5 B | 8.6% |
| **2000** | $174.6 B | $14.1B | 8.1% | $2.3 B | 1.3% | $16.4 B | 9.4% |
| **2001** | $191.3 B | $14.4B | 7.5% | $2.4 B | 1.3% | $16.8 B | 8.8% |
| **2002** | $212.8 B | $15.2B | 7.1% | $1.9 B | 0.9% | $17.1 B | 8.0% |
| **2003** | $199.1 B | $20.5B | 10.3% | $0.9 B | 0.5% | $12.7 B | 6.4% |
| **2004** | $213.5 B | $20.8B | 9.7% | $0.9 B | 0.4% | $21.7 B | 10.1% |
| **2005** | $234.1 B | $11.2 B | 4.8% | $0.9 B | 0.4% | $12.1 B | 5.2% |

Table 3b summarizes the overpayments, underpayments, improper payments, and error rates by contractor type.

[2] The 2003 entries represent the adjusted figures. Had the adjustment not been made, the national projected improper payments would have been $21.5B and the national paid claims error rate would have been 10.8%.

**Table 3b: Error Rates and Projected Improper Payments by Contractor Type for 2005**

| Type of Contractor | Total Dollars Paid | Overpayments | | Underpayments | | (Overpayments + Underpayments) | |
|---|---|---|---|---|---|---|---|
| | | Payment | Rate | Payment | Rate | Improper Payments | Error Rates |
| Carrier | $67.6B | $4.2B | 6.2% | $0.1B | 0.2% | $4.3B | 6.4% |
| DMERC | $9.1B | $0.8B | 8.6% | $0B | 0.0% | $0.8B | 8.6% |
| FI | $63.7B | $2.1B | 3.3% | $0.1B | 0.1% | $2.2B | 3.4% |
| QIOs | $93.7B | $4.2B | 4.5% | $0.7B | 0.7% | $4.8B | 5.2% |
| **All Medicare FFS** | **$234.1B** | **$11.2B** | **4.8%** | **$0.9B** | **0.4%** | **$12.1B** | **5.2%** |

# Paid Claims Error Rate by Error Type

Table 3c summarizes the percent of the total dollars improperly allowed by error category during November 2005 reporting period and prior November reporting periods.

**Table 3c: Summary of Error Rates by Category[3]**

| TYPE OF ERROR | 1996 Net | 1997 Net | 1998 Net | 1999 Net | 2000 Net | 2001 Net | 2002 Net | 2003 Net | 2004 Gross | 2005 Gross |
|---|---|---|---|---|---|---|---|---|---|---|
| No Documentation Errors | 1.9% | 2.1% | 0.4% | 0.6% | 1.2% | 0.8% | 0.5% | 5.4% | 3.1% | 0.7% |
| Insufficient Documentation Errors | 4.5% | 2.9% | 0.8% | 2.6% | 1.3% | 1.9% | 1.3% | 2.5% | 4.1% | 1.1% |
| Medically Unnecessary Errors | 5.1% | 4.2% | 3.9% | 2.6% | 2.9% | 2.7% | 3.6% | 1.1% | 1.6% | 1.6% |
| Incorrect Coding Errors | 1.2% | 1.7% | 1.3% | 1.3% | 1.0% | 1.1% | 0.9% | 0.7% | 1.2% | 1.5% |
| Other Errors | 1.1% | 0.5% | 0.7% | 0.9% | 0.4% | -0.2% | 0.0% | 0.1% | 0.2% | 0.2% |
| **IMPROPER PAYMENTS** | **13.8%** | **11.4%** | **7.1%** | **8.0%** | **6.8%** | **6.3%** | **6.3%** | **9.8%** | **10.1%** | **5.2%** |
| CORRECT PAYMENTS | 86.2% | 88.6% | 92.9% | 92.0% | 93.2% | 93.7% | 93.7% | 90.2% | 89.9% | 94.8% |

[3] The 2003 entries represent the adjusted figures. Had the adjustment not been made, the national projected improper payments would have been $21.5B and the national paid claims error rate would have been 10.8%.

Table 3d summarizes the percent of total dollars improperly allowed by error category and contractor type.

**Table 3d: Type of Error Comparison for 2004 and 2005**

| Type of Error | Nov 2004 Report | November 2005 Report | | | | |
|---|---|---|---|---|---|---|
| | Total | Total | Carrier | DMERC | FI | QIO |
| No Documentation Errors | 3.1% | 0.7% | 0.4% | 0.2% | 0.1% | 0.1% |
| Insufficient Documentation Errors | 4.1% | 1.1% | 0.6% | 0.0% | 0.5% | 0.0% |
| Medically Unnecessary Errors | 1.6% | 1.6% | 0.2% | 0.1% | 0.1% | 1.2% |
| Incorrect Coding Errors | 1.2% | 1.5% | 0.7% | 0.0% | 0.2% | 0.6% |
| Other Errors | 0.2% | 0.2% | 0.0% | 0.0% | 0.0% | 0.2% |
| **Improper Payments** | 10.1% | 5.2% | 1.8% | 0.3% | 0.9% | 2.1% |

# No Documentation Errors

*No documentation* means the provider did not submit any documentation to support the services provided.[4] No documentation errors accounted for 0.7% of the total dollars all Medicare FFS contractors allowed during the November 2005 reporting period. QIO data is categorized in a different manner than the data for Carriers/DMERCs/FIs; therefore, the QIO no documentation estimates include claims that are categorized as *insufficient documentation* for Carriers/DMERCs/FIs. This data breaks down by contractor type as follows:

| Carrier | DMERC | FI | QIO | Total |
|---|---|---|---|---|
| 0.4% | 0.2% | 0.1% | 0.1% | 0.7% |

Table 4a lists the services with the highest no documentation paid claims error rates for each contractor type for the November 2005 reporting period. The data shows that, although the service with the highest improper payments due to no documentation is an FI-billed service (hospital outpatient services), the majority of the services and dollars in error are for physician visits.

**Table 4a: Top 20 Services with No Documentation Errors: Carriers/DMERCs/FIs/QIOs**

| Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG) | No Documentation Errors | | |
|---|---|---|---|
| | Paid Claims Error Rate | Projected Improper Payments | 95% Confidence Interval |
| Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13) | 0.6% | $121,689,716 | 0.4% - 0.8% |
| SNF-inpatient (including Part A) (21) | 0.3% | $52,598,220 | ( 0.0%) - 0.7% |
| Subsequent hospital care (99232) | 2.0% | $42,891,657 | 1.3% - 2.8% |
| Office/outpatient visit, est (99213) | 1.0% | $42,397,823 | 0.7% - 1.3% |
| MAJ SMALL & LARGE BOWEL PROC W CC | 1.2% | $32,714,048 | ( 0.8%) - 3.2% |
| Oxygen concentrator (E1390) | 1.3% | $23,749,877 | 0.6% - 2.0% |
| OTH DIG SYS OR PROC W CC | 8.1% | $22,962,231 | ( 7.7%) - 23.9% |

[4] Due to the extremely low insufficient documentation error rate for QIOs, any insufficient documentation errors have been added to the no documentation rate rather than the insufficient documentation category.

| | | | |
|---|---|---|---|
| Powered pres-redu air mattrs (E0277) | 18.1% | $22,686,554 | ( 5.7%) - 42.0% |
| Subsequent hospital care (99233) | 2.1% | $21,807,283 | 0.5% - 3.6% |
| Office/outpatient visit, est (99214) | 0.5% | $17,298,956 | 0.2% - 0.8% |
| Hospital-other (Part B) (14) | 1.1% | $17,198,970 | 0.1% - 2.1% |
| Blood glucose/reagent strips (A4253) | 1.9% | $16,505,042 | 1.1% - 2.7% |
| MAJ JOINT & LIMB REATTACH PROC - LOW EXT | 0.3% | $15,609,813 | 0.1% - 0.5% |
| Clinic-hospital based or independent renal dialysis facility (72) | 0.2% | $14,745,102 | ( 0.0%) - 0.5% |
| Initial inpatient consult (99254) | 2.5% | $14,275,752 | 0.5% - 4.5% |
| Tissue exam by pathologist (88305) | 1.7% | $12,563,534 | ( 0.7%) - 4.2% |
| Nursing fac care, subseq (99312) | 2.8% | $11,899,626 | 1.4% - 4.2% |
| Emergency dept visit (99285) | 1.6% | $11,450,790 | ( 0.1%) - 3.2% |
| Subsequent hospital care (99231) | 2.4% | $11,250,889 | 0.8% - 4.0% |
| No HCPCS Label | 0.5% | $11,091,261 | 0.1% - 0.9% |
| **Overall** | **0.7%** | **$1,711,974,091** | **0.5% - 1.0%** |

The following are examples of No Documentation errors:

- A Carrier paid $91.89 for an office visit and services. After repeated attempts from the CERT Contractor to obtain the supporting medical records from the provider, the provider indicated that they could not locate the records. As a result, the CERT Contractor counted the entire payment as an error. See Appendix E for more information about no documentation errors.
- A hospital submitted and was paid for a short-term acute care inpatient claim totaling $7,188.63. However, when the substantiating medical record was requested, the hospital failed to provide the record. Thus, the entire amount was considered an error.

## Insufficient Documentation Errors

*Insufficient documentation* means that the provider did not include pertinent patient facts (e.g., the patient's overall condition, diagnosis, and extent of services performed) in the medical record documentation submitted.[5]

Insufficient documentation errors accounted for 1.1% of the total dollars allowed during the November 2005 reporting period. This data breaks down as follows:

| Carrier | DMERC | FI | QIO | Total |
|---|---|---|---|---|
| 0.6% | 0.0% | 0.5% | 0.0% | 1.1% |

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 were incomplete. While these errant claims did not meet Medicare reimbursement rules regarding documentation, CMS could not conclude that the services were not provided.

[5] Due to the extremely low insufficient documentation error rate for QIOs, any insufficient documentation errors have been added to the no documentation rate rather than the insufficient documentation category.

In some instances, components of the medical documentation were located and 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 failed to contact the third party or the third party failed to submit the documentation to the CERT Contractor, CMS counted the claim as a full or partial insufficient documentation error.

Table 4b is a combined list of the services with the highest insufficient documentation paid claims error rates for Carriers/DMERCs/FIs during the November 2005 reporting period. This table does not include QIOs.

**Table 4b: Top 20 Services with Insufficient Documentation: Carriers/DMERCs/FIs**

| Carriers (HCPCS), DMERCs (HCPCS), and FIs (Type of Bill) | Insufficient Documentation Errors | | |
|---|---|---|---|
| | Paid Claims Error Rate | Projected Improper Payments | 95% Confidence Interval |
| Hospital-outpatient (13) | 2.8% | $529,767,557 | 2.1% - 3.5% |
| SNF-inpatient (including Part A) (21) | 1.7% | $265,545,644 | 0.8% - 2.6% |
| Subsequent hospital care (99232) | 9.8% | $208,507,464 | 7.6% - 12.1% |
| SNF-inpatient or home health visits (Part B only) (22) | 6.2% | $70,517,391 | 2.9% - 9.5% |
| Subsequent hospital care (99233) | 6.5% | $68,654,550 | 4.1% - 8.8% |
| Clinic-hospital based or independent renal dialysis facility (72) | 1.2% | $68,228,338 | 0.5% - 1.8% |
| Subsequent hospital care (99231) | 11.5% | $54,185,920 | 8.4% - 14.6% |
| HHA-inpatient or home health visits (Part B only) (32) | 1.1% | $52,970,277 | 0.4% - 1.8% |
| No HCPCS Label | 2.2% | $48,725,272 | 0.9% - 3.5% |
| Drugs unclassified injection (J3490) | 35.5% | $45,435,743 | ( 8.3%) - 79.2% |
| Critical care, first hour (99291) | 9.5% | $39,290,235 | ( 3.3%) - 22.3% |
| Therapeutic exercises (97110) | 6.0% | $36,506,291 | 3.9% - 8.2% |
| HHA-outpatient (HHA-A also) (33) | 0.8% | $31,806,102 | 0.1% - 1.5% |
| Office/outpatient visit, est (99214) | 0.9% | $30,646,473 | 0.6% - 1.3% |
| Initial hospital care (99223) | 4.5% | $30,321,620 | 2.1% - 6.9% |
| Office/outpatient visit, est (99213) | 0.7% | $29,437,424 | 0.5% - 0.9% |
| Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74) | 4.0% | $23,447,105 | 1.9% - 6.1% |
| Hospital-other (Part B) (14) | 1.5% | $22,963,484 | 0.8% - 2.1% |
| Special facility or ASC surgery-hospice (non-hospital based) (81) | 0.5% | $22,255,743 | ( 0.1%) - 1.0% |
| Initial inpatient consult (99254) | 3.5% | $20,236,730 | 1.6% - 5.5% |
| All Other Codes | 1.4% | $969,789,273 | 1.2% - 1.6% |
| **Overall Carriers/DMERCs/FIs** | **1.9%** | **$2,669,238,636** | **1.7% - 2.1%** |

The following is an example of an insufficient documentation error:

An FI paid an outpatient hospital $96.00 for a clinic visit. The documentation did not include a doctor's order, a medical history, or notes to support the diagnosis listed on the claim form. As a result, the CERT Contractor counted the entire payment as an error.

# Medically Unnecessary Services

*Medically Unnecessary Services* includes situations where the CERT or HPMP claim review staff identifies enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary. In the case of inpatient claims, determinations are also made with regard to the level of care; for example, in some instances another setting besides inpatient care may have been more appropriate. If a QIO determines that a hospital admission was unnecessary due to not meeting an acute level of care, the entire payment for the admission is denied.

Medically Unnecessary Service errors accounted for 1.6% of the total dollars allowed during the November 2005 reporting period. Just as in November 2004, the majority of the improper payments due to medically unnecessary services were for claims for which the QIOs were responsible. This data breaks down as follows:

| Carrier | DMERC | FI | QIO | Total |
|---|---|---|---|---|
| 0.2% | 0.1% | 0.1% | 1.2% | 1.6% |

Table 4c lists the top twenty medically unnecessary services for Carriers/DMERCs/FIs.

**Table 4c: Top 20 Medically Unnecessary Service: Carriers/DMERCs/FIs/QIOs**

| Service Billed to Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG) | Medically Unnecessary Errors | | |
|---|---|---|---|
| | Paid Claims Error Rate | Projected Improper Payments | 95% Confidence Interval |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W CC | 11.3% | $141,400,595 | 8.4% - 14.3% |
| CHEST PAIN | 16.3% | $102,271,819 | 12.2% - 20.3% |
| OTH PERMANENT CAR PACER IMPLANT | 5.9% | $98,349,238 | 2.1% - 9.7% |
| Blood glucose/reagent strips (A4253) | 11.2% | $96,108,224 | 8.8% - 13.6% |
| NUT & MISC METAB DISOR AGE >17 W CC | 7.7% | $89,704,237 | 5.2% - 10.3% |
| MEDICAL BACK PROB | 23.3% | $89,467,334 | 16.6% - 30.0% |
| CIRC DISOR EXC AMI,W CARD CATH W/O COMPLEX DX | 15.1% | $80,704,220 | 8.9% - 21.3% |
| HEART FAILURE & SHOCK | 1.9% | $69,347,992 | 0.9% - 2.8% |
| Therapeutic exercises (97110) | 11.4% | $68,935,530 | 8.1% - 14.7% |
| Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13) | 0.3% | $53,219,024 | 0.2% - 0.4% |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W/O CC | 22.4% | $52,473,888 | 13.1% - 31.7% |
| PERCU CAR-VAS PROC W DRUG-ELUT STENT W/O AMI | 2.0% | $51,021,544 | 0.2% - 3.9% |
| G.I. HEMOR W CC | 3.5% | $50,222,075 | 1.8% - 5.2% |
| SNF-inpatient or home health visits (Part B only) (22) | 4.4% | $49,754,236 | 3.0% - 5.8% |

| | | | |
|---|---|---|---|
| Special facility or ASC surgery-hospice (non-hospital based) (81) | 1.1% | $48,396,419 | ( 0.1%) - 2.2% |
| DIABETES AGE >35 | 11.1% | $45,760,294 | 5.2% - 17.1% |
| OTH -VAS PROC W CC | 2.7% | $45,253,206 | 0.3% - 5.1% |
| DEGEN NRV SYS DISOR | 16.4% | $43,866,929 | 9.1% - 23.7% |
| TRANSIENT ISCHEMIA | 9.8% | $43,111,939 | 5.0% - 14.5% |
| CIRC DISOR EXC AMI,W CARD CATH & COMPLEX DX | 4.2% | $40,193,027 | 0.7% - 7.7% |
| **Overall** | **1.6%** | **$3,798,813,791** | **1.5% - 1.7%** |

The following are examples of medically unnecessary services:

- An FI paid a Skilled Nursing Facility (SNF) $49.22 for 30 minutes of therapeutic procedures; however, the physician certification for the services did not cover the dates for which the services were billed. As a result, the reviewer determined that the services were not medically necessary and counted the claim as an error.
- A short-term acute care inpatient claim for $13,412.00 was submitted and paid. The patient was admitted for an elective percutaneous transluminal coronary angioplasty (PTCA). Upon review, it was discovered that the patient was stable and underwent the procedure without preoperative or postoperative complications; therefore, the patient should have been treated in an outpatient hospital observation setting. The entire claim amount was considered an error.

# Incorrect Coding

Providers use standard coding systems to bill Medicare. For most of the coding errors, the medical reviewers determined that providers submitted documentation that supported a lower code than the code submitted (in these cases, providers are said to have *overcoded* claims). However, for some of the coding errors, the medical reviewers determined that the documentation supported a higher code than the code the provider submitted (in these cases, the providers are said to have *undercoded* claims).

Incorrect Coding errors accounted for 1.5% percentage of the total dollars allowed during the November 2005 reporting period. This data breaks down as follows:

| Carrier | DMERC | FI | QIO | Total |
|---|---|---|---|---|
| 0.7% | 0.0% | 0.2% | 0.6% | 1.5% |

A common error involved overcoding or undercoding by one level on a scale of five code levels. Published studies suggest that under certain circumstances, experienced reviewers may disagree on the most appropriate code to describe a particular service. This may explain some of the incorrect coding errors in this report. CMS is investigating procedures to minimize the occurrence of this type of error in the future.

Table 4d provides information on the impact of 1 level disagreement between Carriers and providers when coding evaluation and management codes. The table is sorted in descending order by projected improper payments.

**Table 4d: Impact of One Level E&M (Top 20)**

| Final E&M Code | Incorrect Coding Errors | | |
|---|---|---|---|
| | Paid Claims Error Rate | Projected Improper Payments | 95% Confidence Interval |
| Office/outpatient visit, est (99214) | 4.7% | $155,504,863 | 4.2% - 5.2% |
| Subsequent hospital care (99233) | 10.5% | $112,099,711 | 8.7% - 12.4% |
| Subsequent hospital care (99232) | 2.6% | $54,828,648 | 1.9% - 3.3% |
| Office/outpatient visit, est (99215) | 8.6% | $50,427,584 | 7.1% - 10.2% |
| Initial inpatient consult (99254) | 8.6% | $49,312,958 | 6.9% - 10.3% |
| Office/outpatient visit, est (99213) | 0.9% | $40,313,404 | 0.8% - 1.1% |
| Office consultation (99244) | 4.7% | $37,704,935 | 3.5% - 5.9% |
| Initial hospital care (99222) | 12.0% | $35,307,720 | 9.2% - 14.8% |
| Office/outpatient visit, new (99204) | 7.3% | $22,078,440 | 5.1% - 9.4% |
| Emergency dept visit (99285) | 2.5% | $18,206,636 | 1.4% - 3.5% |
| Office/outpatient visit, est (99212) | 2.4% | $17,066,786 | 1.9% - 2.9% |
| Office/outpatient visit, new (99203) | 5.0% | $15,924,974 | 3.4% - 6.6% |
| Office consultation (99243) | 2.6% | $11,325,761 | 1.6% - 3.6% |
| Nursing fac care, subseq (99312) | 2.3% | $9,712,836 | 1.5% - 3.1% |
| Nursing fac care, subseq (99313) | 5.1% | $9,214,752 | 3.3% - 7.0% |
| Office consultation (99245) | 2.8% | $8,182,195 | 1.1% - 4.5% |
| Initial inpatient consult (99253) | 3.0% | $7,089,172 | 1.7% - 4.2% |
| Nursing facility care (99303) | 6.2% | $6,271,997 | 3.9% - 8.6% |
| Initial hospital care (99223) | 0.9% | $5,907,218 | 0.3% - 1.5% |
| Emergency dept visit (99283) | 2.3% | $5,309,202 | 0.9% - 3.8% |
| All Other Codes | 0.1% | $49,035,937 | 0.1% - 0.1% |
| **Overall Carriers** | **1.1%** | **$720,825,729** | **1.0% - 1.1%** |

Table 4e lists the services with paid claims error rates that include incorrectly coded claims for Carriers/DMERCs/FIs in the November 2005 reporting period.

Among the Top 20 services, the highest calculated incorrect coding error rates are for three level one E&M codes: Level 1 Office/outpatient visits (6.4%, $11M), Level 1 Office consultations (18.2%, $3M), and Level 1 Follow-up inpatient consults (17.2%, $2M). All three incorrect coding error rates are up from last year when they were 5.9%, 16.9% and 3.1%, respectively.

**Table 4e: Top 20 Services with Incorrect Coding Underpayment Errors: Carriers/DMERCs/FIs**

| Carriers (HCPCS), DMERCs (HCPCS), and FIs (Type of Bill) | Incorrect Coding Underpayment Errors | | |
|---|---|---|---|
| | Paid Claims Error Rate | Projected Improper Payments (Underpayments) | 95% Confidence Interval |
| Hospital-outpatient (13) | 0.2% | $33,931,306 | 0.1% - 0.3% |
| Office/outpatient visit, est (99212) | 2.9% | $20,613,287 | 2.2% - 3.5% |
| Office/outpatient visit, est (99213) | 0.4% | $16,809,789 | 0.3% - 0.5% |
| SNF-inpatient (including Part A) (21) | 0.1% | $13,220,861 | ( 0.0%) - 0.2% |
| Office/outpatient visit, est (99211) | 6.4% | $11,059,880 | 3.8% - 9.0% |
| Clinic-hospital based or independent renal dialysis facility (72) | 0.2% | $10,430,019 | ( 0.0%) - 0.4% |
| HHA-inpatient or home health visits (Part B only) (32) | 0.2% | $9,435,387 | ( 0.1%) - 0.5% |
| HHA-outpatient (HHA-A also) (33) | 0.2% | $7,054,078 | 0.0% - 0.3% |
| Subsequent hospital care (99231) | 1.1% | $5,201,265 | ( 0.1%) - 2.3% |
| Tissue exam by pathologist (88305) | 0.4% | $2,970,676 | ( 0.4%) - 1.2% |
| Emergency dept visit (99283) | 1.1% | $2,601,746 | 0.1% - 2.1% |
| Office consultation (99241) | 18.2% | $2,550,973 | 11.7% - 24.8% |
| Nursing fac care, subseq (99311) | 1.6% | $2,238,124 | 0.5% - 2.7% |
| Subsequent hospital care (99232) | 0.1% | $1,886,866 | ( 0.0%) - 0.2% |
| Ct abdomen w/dye (74160) | 1.2% | $1,850,222 | ( 0.4%) - 2.9% |
| Subsequent hospital care (99233) | 0.2% | $1,806,477 | ( 0.0%) - 0.4% |
| Follow-up inpatient consult (99261) | 17.2% | $1,613,876 | ( 4.0%) - 38.4% |
| Office/outpatient visit, est (99214) | 0.0% | $1,495,159 | ( 0.0%) - 0.1% |
| Follow-up inpatient consult (99262) | 2.3% | $1,271,487 | 0.3% - 4.3% |
| Chiropractic manipulation (98940) | 1.0% | $1,173,305 | ( 0.1%) - 2.0% |
| All Other Codes | 0.1% | $45,879,623 | 0.0% - 0.1% |
| **Overall Carriers/DMERCs/FIs** | **0.1%** | **$195,094,405** | **0.1% - 0.2%** |

For more data pertaining to incorrect coding errors, see Appendix G.

The following are examples of coding errors:

- A Carrier paid a physician $135.42 for the evaluation and management of an established patient. This procedure requires at least two of three key components: a detailed history, a detailed examination, and/or medical decision-making of moderate complexity. The medical reviewer determined that the services did not meet the minimum criteria for the key components since a licensed nurse rendered the services rather than physician. Instead, the medical record met the criteria for a lower level service that would have paid $91.59. The CERT reviewer determined that the service should have been billed at a lower E&M code and counted $43.83 as paid in error.
- A hospital billed a procedure without documenting that the procedure was performed. The removal of the procedure code from the billing resulted in an adjustment to a lower DRG, which, in turn, resulted in a reduced payment. In this case, $9,863.77 was determined to be in error.

The OIG and CMS have noted problems with certain procedure codes for the past several years. These problematic codes include Current Procedural Terminology (CPT) codes 99214 (office or other outpatient visit), 99232 (subsequent hospital care level 2) and 99233 (subsequent hospital care level 3). See Appendix F for more information on problematic codes.

# Other Errors

Under CERT, *other errors* include instances when provider claims did not meet benefit category requirements or other billing requirements. Errors for services that did not meet the benefit category requirements were more common among claims submitted to DMERCs than among claims submitted to Carriers and FIs. The absence of a valid physician's order made some DME items non-covered because an order or Certificate of Medical Necessity (CMN) was required to meet the benefit category requirements for the DME item.

Under HPMP, other errors include quality of care and billing errors. Billing errors include payments for claims where the stay was billed as non-exempt unit but was exempt, outpatient billed as inpatient, and HMO bills paid under FFS. Most other errors occur on claims for which QIOs are responsible.

Other errors accounted for 0.2% of the total dollars allowed during the November 2005 reporting period. This data breaks down as follows:

| Carrier | DMERC | FI | QIO | Total |
|---|---|---|---|---|
| 0.0% | 0.0% | 0.0% | 0.2% | 0.2% |

Table 4f lists the services with other errors and their paid claims error rate for the November 2005 reporting period.

**Table 4f: Top 20 Other Errors: Carriers/DMERCs/FIs/QIOs**

| Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG) | Other Errors | | |
|---|---|---|---|
| | Paid Claims Error Rate | Projected Improper Payments (Underpayments) | 95% Confidence Interval |
| No HCPCS Label | 0.8% | $17,407,343 | ( 0.7%) - 2.3% |
| SNF-inpatient (including Part A) (21) | 0.1% | $15,645,883 | ( 0.1%) - 0.3% |
| OTH -VAS PROC W CC | 0.9% | $14,599,451 | ( 0.2%) - 1.9% |
| NON-EXT OR PROC UNRELATEDPRIN DX | 5.1% | $14,581,333 | ( 2.4%) - 12.5% |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W CC | 1.1% | $13,233,523 | 0.0% - 2.1% |
| OTH KID & URINARY TRACT OR PROC | 2.5% | $12,146,545 | ( 0.2%) - 5.3% |
| MAJ CAR-VAS PROC W CC | 0.9% | $11,948,786 | ( 0.9%) - 2.7% |
| BIOPSIESMUS-SKEL SYS & CON TIS | 4.7% | $10,308,094 | ( 1.2%) - 10.7% |
| CHEST PAIN | 1.4% | $8,858,901 | 0.4% - 2.5% |
| NUT & MISC METAB DISOR AGE >17 W CC | 0.8% | $8,851,019 | 0.4% - 1.1% |
| MAJ JOINT & LIMB REATTACH PROC - LOW EXT | 0.2% | $8,036,257 | ( 0.0%) - 0.3% |
| Hospital-outpatient (HHA-A also)(under OPPS | 0.0% | $7,708,389 | 0.0% - 0.1% |

| | | | |
|---|---|---|---|
| 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13) | | | |
| RESP INFECTS & INFLAM AGE >17 W CC | 0.5% | $7,378,842 | ( 0.2%) - 1.2% |
| OTH PERMANENT CAR PACER IMPLANT | 0.4% | $7,224,041 | ( 0.4%) - 1.3% |
| HEART FAILURE & SHOCK | 0.2% | $6,789,664 | 0.0% - 0.3% |
| HEPATOBILIARY SYS/PANCREAS | 3.1% | $6,762,182 | ( 3.0%) - 9.2% |
| CHOLE EXC BY LAP W/O C.D.E. W CC | 2.5% | $6,408,814 | ( 2.3%) - 7.2% |
| SIMPLE PNEU & PLEURISY AGE >17 W CC | 0.2% | $5,797,061 | 0.0% - 0.4% |
| OTH OR PROC-INJURIES W CC | 2.0% | $5,456,423 | ( 1.9%) - 5.9% |
| PERCU CAR-VAS PROC W NON-DRUG ELUT STENT W/O AMI | 0.5% | $5,330,742 | ( 0.2%) - 1.2% |
| **Overall** | **0.2%** | **$510,026,630** | **0.2% - 0.3%** |

The following are examples of other errors:

- A Carrier paid $76.64 for routine foot care. Routine foot care is statutorily excluded. Therefore, the CERT Contractor counted the full payment as an error.
- A hospital billed for a short-term acute care inpatient stay when the orders indicated that it should have been billed as an observation stay. The dollars paid in error were $5,778.71.

## Paid Claims Error Rate by Contractor Type

Figures 3 and 4 summarize the paid claims error rate and projected improper payments during November 2005 reporting period for each type of contractor. This data breaks down by contractor type as follows:

| Carrier | DMERC | FI | QIO | Total |
|---|---|---|---|---|
| 1.8% | 0.3% | 0.9% | 2.1% | 5.2% |

The following figures (Figures 3 and 4) detail the paid claim error rates and projected improper payments by contractor type. They show that the estimated paid claim error rates for the November 2005 reporting period was 6.4% for Carriers (down from 11.4% last year), 8.6% for DMERCs (down from 11.1%), 3.4% for FIs (down from 16.4%) and 5.2% for QIOs (up from 4.8%).

**Figure 3: Paid Claims Error Rates by Contractor Type**

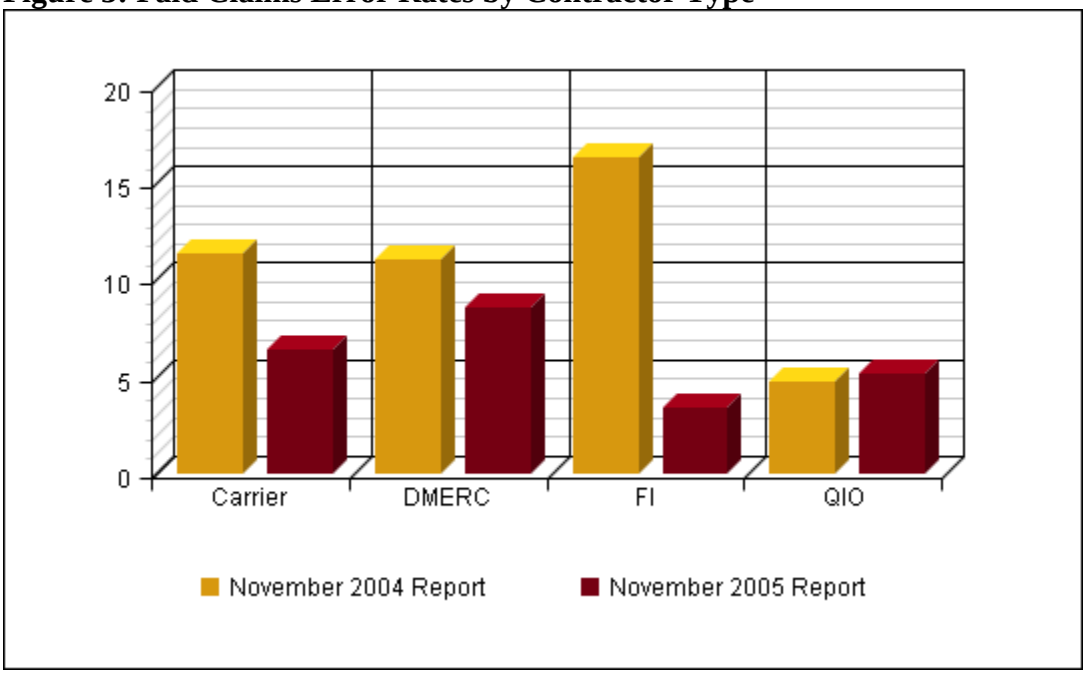
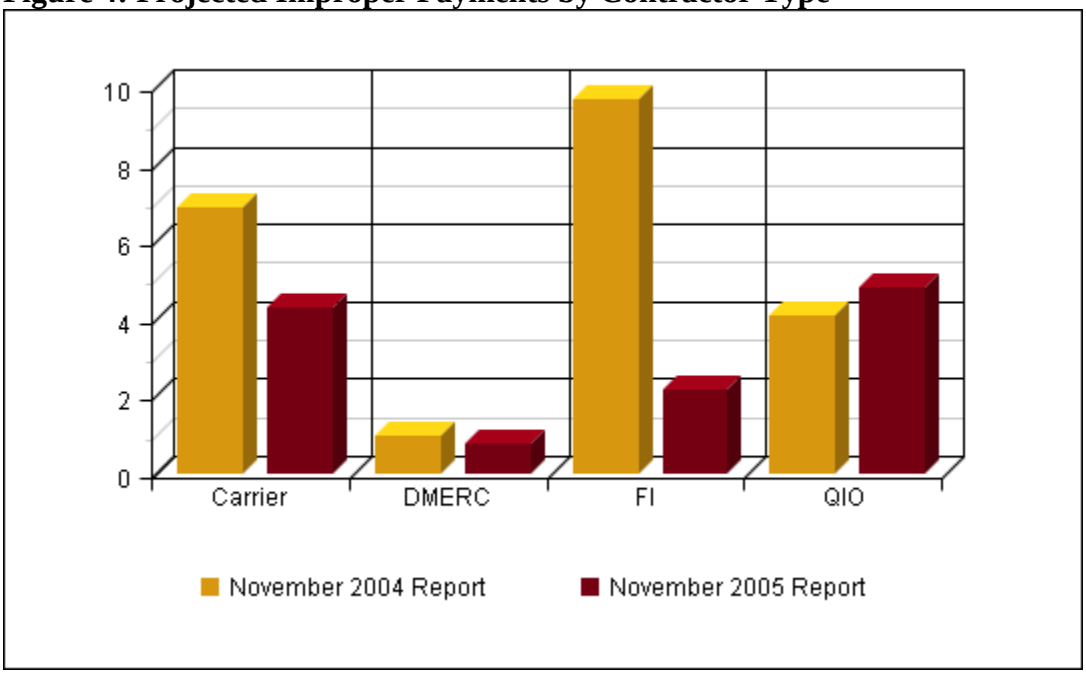



**Figure 4: Projected Improper Payments by Contractor Type**



# Contractor-Specific Error Rates

### Carrier-Specific Error Rates

Table 5 contains error rates and improper payment amounts for Carriers. Most Carriers lowered their paid claims error rate from the 2004 report to the 2005 report. For example, in 2004, the carriers with the highest error rates were Triple S PR/VI (18.7%), GHI NY (16.0%), and Trailblazer TX (14.8%). By 2005, these carriers had achieved error rates of 15.7%, 10.6% and 4.4%. The calculated paid claim error rate increased from 2004 to 2005 for only one Carrier: First Coast Service Options, FL.

The increase was primarily due to a single claim with multiple services that totaled $10,414. This claim was paid by First Coast in order to avoid compromising an on-going fraud investigation. When the CERT Contractor requested the medical record from the provider, the provider did not respond despite numerous follow-up requests; thus, the claim was scored as a No Documentation error. If this claim had not been scored as an error, the calculated error rate for First Coast would have been 7.9% rather than the reported number of 11.9%.

**Table 5: Error Rates and Improper Payments: Carriers**

| Carrier | Paid Claims Error Rate | | | | | Provider Compliance Error Rate | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Triple S, Inc. PR/VI 00973/00974 | 15.7% | $96,273,363 | 3.7% | 8.5% - 22.9% | 14.7% | 24.4% | 23.6% |
| First Coast Service Options FL 00590 | 11.9% | $831,028,166 | 3.9% | 4.2% - 19.6% | 6.5% | 20.0% | 15.8% |
| GHI NY 14330 | 10.6% | $35,950,914 | 1.0% | 8.8% - 12.5% | 9.6% | 26.4% | 25.7% |
| Empire NY 00803 | 9.7% | $343,119,055 | 0.9% | 7.9% - 11.4% | 8.9% | 20.4% | 19.8% |
| BCBS AR RI 00524 | 8.4% | $16,455,197 | 1.0% | 6.3% - 10.4% | 7.2% | 22.7% | 21.9% |
| BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528 | 7.2% | $264,618,233 | 3.5% | 0.5% - 14.0% | 6.5% | 20.1% | 19.5% |
| BCBS UT 00910 | 7.1% | $22,307,606 | 0.8% | 5.5% - 8.7% | 6.5% | 21.8% | 21.4% |
| CIGNA TN 05440 | 6.8% | $107,032,155 | 0.8% | 5.2% - 8.3% | 6.0% | 17.1% | 16.5% |
| Palmetto GBA OH/WV 00883/00884 | 6.7% | $205,505,628 | 0.7% | 5.3% - 8.0% | 5.3% | 16.0% | 14.9% |
| **Average=** | **6.4%** | | | | | | |
| Empire NJ 00805 | 6.3% | $181,849,570 | 0.7% | 4.9% - 7.8% | 5.9% | 19.5% | 19.2% |
| First Coast Service Options CT 00591 | 5.8% | $60,161,032 | 0.6% | 4.6% - 7.1% | 4.5% | 17.3% | 16.3% |
| NHIC CA 31140/31146 | 5.4% | $339,261,900 | 1.2% | 3.1% - 7.8% | 4.5% | 20.1% | 19.4% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Noridian AK/AZ/AS/CNMI/GU/HI/NV/OR/ WA0831/00832/00833/00834/00835 /00836 | 5.4% | $180,887,807 | 1.2% | 3.0% - 7.9% | 4.5% | 15.9% | 15.2% |
| HGSA PA 00865 | 5.3% | $159,110,610 | 0.7% | 4.0% - 6.6% | 4.9% | 15.7% | 15.5% |
| Palmetto GBA SC 00880 | 5.3% | $53,133,892 | 0.8% | 3.8% - 6.8% | 4.3% | 16.1% | 15.4% |
| Trailblazer MD/DE/DC/VA 00901/00902/00903/00904 | 5.1% | $164,682,989 | 1.4% | 2.5% - 7.8% | 4.5% | 19.3% | 18.9% |
| WPS WI/IL/MI/MN 00951/00952/00953/00954 | 5.1% | $369,199,174 | 1.5% | 2.1% - 8.1% | 4.4% | 15.8% | 15.3% |
| CIGNA NC 05535 | 5.0% | $101,175,981 | 0.7% | 3.7% - 6.3% | 4.6% | 15.9% | 15.6% |
| Cahaba GBA AL/GA/MS 00510/00511/00512 | 5.0% | $185,348,351 | 1.8% | 1.5% - 8.5% | 4.7% | 16.5% | 16.3% |
| BCBS KS KS/NE/ W MO 00650/00655/00651 | 4.6% | $60,009,876 | 1.7% | 1.2% - 8.0% | 3.8% | 12.6% | 12.0% |
| AdminaStar IN/KY 00630/00660 | 4.6% | $112,708,541 | 1.2% | 2.3% - 6.9% | 3.9% | 16.3% | 15.8% |
| HealthNow NY 00801 | 4.5% | $53,949,543 | 0.6% | 3.3% - 5.6% | 3.9% | 14.5% | 14.1% |
| Trailblazer TX 00900 | 4.4% | $212,745,519 | 0.5% | 3.4% - 5.4% | 4.1% | 19.7% | 19.4% |
| NHIC ME/MA/NH/VT 31142/31143/31144/31145 | 4.4% | $91,842,130 | 0.4% | 3.5% - 5.3% | 4.1% | 12.0% | 11.8% |
| Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889 | 4.3% | $66,195,615 | 1.5% | 1.4% - 7.2% | 3.4% | 14.6% | 13.9% |
| BCBS MT 00751 | 2.8% | $5,147,227 | 0.5% | 1.9% - 3.7% | 2.4% | 12.1% | 11.8% |
| CIGNA ID 05130 | 2.8% | $5,262,686 | 0.5% | 1.9% - 3.7% | 2.7% | 15.9% | 15.8% |
| **Combined** | **6.4%** | **$4,324,962,761** | **0.4%** | **5.5% - 7.2%** | **5.2%** | **17.8%** | **17.0%** |

For paid claim error rates, provider compliance error rates and no resolution rates by contractor and provider type, see Appendix D.

## DMERC-Specific Error Rates

Table 6 contains DMERC specific error rates and improper payment amounts. The paid claims error rate for three of the four DMERC decreased from 2004 to 2005 while one rate, Tricenturion Region A, remained the same. In addition, while three of the four DMERCs' projected improper payments are around $100 M, Palmetto Region C has a projected improper payment amount 4 times higher than the others.

See Appendix D for more information on paid claims and provider compliance error rates by contractor or provider type.

**Table 6: Error Rates and Improper Payments: DMERCs**

| DMERCs | Paid Claims Error Rate | | | | | Provider Compliance Error Rate | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Palmetto GBA Region C 00885 | 11.5% | $474,929,530 | 1.9% | 7.8% - 15.2% | 5.1% | 22.0% | 15.9% |
| **Average=** | **8.6%** | | | | | | |
| Tricenturion Region A 77011 | 7.3% | $95,733,277 | 1.1% | 5.1% - 9.5% | 4.3% | 12.7% | 10.1% |
| CIGNA Region D 05655 | 5.8% | $98,896,933 | 1.0% | 3.9% - 7.7% | 5.0% | 14.7% | 14.0% |
| AdminaStar FederalRegion B 00635 | 5.6% | $110,259,808 | 0.7% | 4.3% - 6.9% | 4.7% | 16.4% | 15.7% |
| **Combined** | **8.6%** | **$779,819,548** | **0.9%** | **6.8% - 10.3%** | **4.9%** | **18.1%** | **14.7%** |

# FI-Specific Error Rates

Table 7 contains error rates and improper payment amounts for FIs. This table shows that every FI dramatically lowered their error rates from 2004 to 2005. During the 2004 reporting period, most FIs experienced a high number of providers who submitted insufficient documentation to the CERT program. Corrective actions in the CERT program, as well as actions taken by FIs, have caused this significant improvement. For example, corrective actions taken by CMS included sending second chance letters in each instance of insufficient documentation while FI corrective actions included increased provider education with regard to CERT requests.

See Appendix D for paid claims error rates and provider compliance error rates.

**Table 7: Error Rates and Improper Payments: FIs**

| FIs | Paid Claims Error Rate | | | | |
|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| COSVI PR/VI 57400 | 8.6% | $8,269,584 | 1.6% | 5.5% - 11.8% | 6.1% |
| BCBS WY 00460 | 7.4% | $3,931,533 | 2.2% | 3.1% - 11.7% | 6.9% |
| BCBS KS 00150 | 5.9% | $23,624,838 | 2.3% | 1.4% - 10.3% | 3.9% |
| Riverbend NJ/TN 00390 | 5.7% | $147,423,720 | 1.4% | 3.0% - 8.4% | 5.5% |
| Palmetto GBA NC 00382 | 5.7% | $66,782,386 | 1.5% | 2.7% - 8.6% | 5.6% |
| First Coast Service Options FL 00090 | 5.4% | $108,046,203 | 1.0% | 3.4% - 7.3% | 4.5% |
| Medicare Northwest ID/OR/UT 00350 | 5.2% | $40,289,151 | 1.5% | 2.3% - 8.2% | 3.8% |

| | | | | | |
|---|---|---|---|---|---|
| Mutual of Omaha (all states) 52280 | 4.9% | $363,218,483 | 1.0% | 3.0% - 6.8% | 3.9% |
| BCBS AR AR 00020 | 4.8% | $17,607,810 | 1.3% | 2.2% - 7.4% | 4.4% |
| Cahaba GBA AL 00010 | 4.8% | $59,671,288 | 2.4% | 0.1% - 9.4% | 4.6% |
| UGS AS/CA/GU/HI/NV/NMI 00454 | 4.2% | $186,871,283 | 1.1% | 2.0% - 6.3% | 3.8% |
| Carefirst DC/MD 00190 | 3.7% | $116,393,936 | 0.7% | 2.2% - 5.1% | 3.5% |
| Veritus PA 00363 | 3.6% | $64,111,963 | 1.0% | 1.6% - 5.7% | 3.2% |
| BCBS AR RI 00021 | 3.6% | $4,648,265 | 0.9% | 1.8% - 5.4% | 3.4% |
| **Average=** | **3.4%** | | | | |
| Noridian AK/WA 00322 | 3.3% | $16,773,352 | 0.8% | 1.7% - 4.9% | 2.6% |
| BCBS AZ 00030 | 3.2% | $9,449,337 | 1.1% | 1.1% - 5.3% | 3.1% |
| AdminaStar IN/IL/KY/OH 00130/00131/00160/00332 | 3.2% | $187,012,576 | 3.2% | ( 3.0%) - 9.4% | 3.0% |
| Chisholm OK 00340 | 3.1% | $10,213,512 | 1.3% | 0.5% - 5.6% | 3.0% |
| Trailblazer CO/NM/TX 00400 | 3.0% | $98,261,460 | 0.6% | 1.8% - 4.3% | 2.6% |
| BCBS GA 00101 | 2.8% | $46,641,372 | 0.6% | 1.6% - 4.0% | 2.5% |
| Palmetto GBA SC 00380 | 2.7% | $222,063,876 | 0.5% | 1.7% - 3.7% | 2.6% |
| UGS VA/WV 00453 | 2.5% | $28,945,475 | 0.6% | 1.3% - 3.8% | 2.3% |
| UGS WI/MI 00450/00452 | 2.3% | $124,815,832 | 1.5% | ( 0.6%) - 5.2% | 2.1% |
| Trispan LA/MO/MS 00230 | 2.3% | $31,219,088 | 0.6% | 1.0% - 3.5% | 2.1% |
| Anthem ME/MA 00180/00181 | 2.2% | $41,479,224 | 1.1% | 0.1% - 4.3% | 2.1% |
| Cahaba GBA IA/SD 00011 | 2.2% | $54,394,603 | 0.6% | 1.0% - 3.4% | 2.1% |
| Empire CT/DE/NY 00308 | 2.0% | $78,650,521 | 0.4% | 1.1% - 2.8% | 1.7% |
| BCBS MT 00250 | 1.3% | $2,181,055 | 0.5% | 0.3% - 2.3% | 1.2% |
| Noridian MN/ND 00320/00321 | 1.3% | $11,534,979 | 2.0% | ( 2.5%) - 5.1% | 1.2% |
| Anthem NH/VT 00270 | 1.2% | $3,717,028 | 0.3% | 0.5% - 1.9% | 1.2% |
| BCBS NE 00260 | 1.0% | $1,986,218 | 0.6% | ( 0.2%) - 2.1% | 0.9% |
| **Combined** | **3.4%** | **$2,180,229,950** | **0.2%** | **3.0% - 3.8%** | **3.1%** |

For error rates and improper payment amounts for individual contractors, paid claims error rates by cluster and type of error, and improper payment amounts for clusters, see Appendix C.

# QIO-Specific Error Rates

Table 8a contains QIO specific short-term PPS acute care hospital error rates and improper payment amounts, total short-term PPS acute care hospital error rates and improper payment amounts, total PPS long term acute care hospital error rates and improper payment amounts, and total error rates and improper payment amounts for all types of facilities for which QIOs are responsible.

**Table 8: Error Rates and Improper Payments: QIOs[6]**

| QIOs | Paid Claims Error Rate | | | | | Provider Compliance Error Rate | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Alaska | 3.3% | $3,690,282 | 0.4% | 2.6% - 4.1% | 3.1% | N/A | N/A |
| Alabama | 4.8% | $81,595,031 | 0.7% | 3.4% - 6.3% | 4.6% | N/A | N/A |
| Arkansas | 5.4% | $50,277,769 | 0.6% | 4.2% - 6.6% | 5.4% | N/A | N/A |
| Arizona | 5.1% | $62,922,529 | 0.7% | 3.7% - 6.5% | 4.2% | N/A | N/A |
| California | 4.8% | $352,704,536 | 0.7% | 3.5% - 6.0% | 4.7% | N/A | N/A |
| Colorado | 4.9% | $38,231,498 | 1.0% | 2.8% - 7.0% | 4.3% | N/A | N/A |
| Connecticut | 2.4% | $32,961,295 | 0.4% | 1.6% - 3.2% | 2.4% | N/A | N/A |
| District of Columbia | 3.0% | $12,694,702 | 0.5% | 2.1% - 4.0% | 2.8% | N/A | N/A |
| Delaware | 3.9% | $11,670,733 | 0.4% | 3.0% - 4.8% | 3.7% | N/A | N/A |
| Florida | 5.4% | $325,866,865 | 0.7% | 3.9% - 6.8% | 5.2% | N/A | N/A |
| Georgia | 4.4% | $104,036,152 | 1.0% | 2.5% - 6.4% | 4.0% | N/A | N/A |
| Hawaii | 1.9% | $4,297,969 | 0.3% | 1.3% - 2.5% | 1.9% | N/A | N/A |
| Iowa | 4.0% | $33,606,422 | 0.6% | 2.8% - 5.2% | 3.7% | N/A | N/A |
| Idaho | 6.3% | $15,672,163 | 0.8% | 4.7% - 7.9% | 6.3% | N/A | N/A |
| Illinois | 6.8% | $280,522,959 | 0.9% | 5.1% - 8.6% | 6.8% | N/A | N/A |
| Indiana | 3.4% | $65,285,745 | 0.5% | 2.3% - 4.4% | 3.4% | N/A | N/A |
| Kansas | 3.1% | $23,981,674 | 0.5% | 2.2% - 3.9% | 3.1% | N/A | N/A |
| Kentucky | 4.9% | $76,148,365 | 0.8% | 3.4% - 6.4% | 4.4% | N/A | N/A |
| Louisiana | 7.1% | $100,931,722 | 0.9% | 5.4% - 8.8% | 5.7% | N/A | N/A |
| Massachusetts | 5.0% | $116,024,855 | 0.6% | 3.8% - 6.2% | 4.8% | N/A | N/A |
| Maryland | 2.2% | $51,821,605 | 0.3% | 1.6% - 2.8% | 2.1% | N/A | N/A |
| Maine | 5.7% | $25,738,491 | 0.8% | 4.2% - 7.3% | 5.7% | N/A | N/A |
| Michigan | 5.8% | $216,692,999 | 0.8% | 4.3% - 7.3% | 5.8% | N/A | N/A |
| Minnesota | 5.1% | $75,847,099 | 0.6% | 3.8% - 6.3% | 5.0% | N/A | N/A |
| Missouri | 1.0% | $19,850,027 | 0.2% | 0.5% - 1.4% | 1.0% | N/A | N/A |
| Mississippi | 5.6% | $55,126,869 | 0.8% | 4.1% - 7.1% | 5.3% | N/A | N/A |
| Montana | 1.3% | $3,302,813 | 0.4% | 0.5% - 2.0% | 1.1% | N/A | N/A |
| North Carolina | 5.6% | $164,474,174 | 0.8% | 4.0% - 7.3% | 5.5% | N/A | N/A |
| North Dakota | 2.3% | $5,365,830 | 0.3% | 1.7% - 2.9% | 2.2% | N/A | N/A |
| Nebraska | 1.2% | $6,244,194 | 0.5% | 0.2% - 2.1% | 1.1% | N/A | N/A |
| New Hampshire | 2.9% | $9,890,654 | 0.5% | 1.9% - 3.8% | 2.9% | N/A | N/A |
| New Jersey | 4.8% | $156,585,575 | 0.7% | 3.5% - 6.1% | 4.5% | N/A | N/A |
| New Mexico | 9.4% | $31,531,124 | 1.0% | 7.4% - 11.4% | 8.8% | N/A | N/A |
| Nevada | 5.6% | $24,708,865 | 0.6% | 4.4% - 6.8% | 5.0% | N/A | N/A |
| New York | 5.7% | $391,777,893 | 0.9% | 4.0% - 7.4% | 4.3% | N/A | N/A |
| Ohio | 2.9% | $112,010,116 | 0.5% | 2.0% - 3.9% | 2.9% | N/A | N/A |
| Oklahoma | 4.2% | $45,465,761 | 0.6% | 2.9% - 5.5% | 4.2% | N/A | N/A |

[6] Due to the extremely low insufficient documentation error rate for QIOs, any insufficient documentation errors have been added to the no documentation rate rather than the insufficient documentation category.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Oregon | 4.2% | $32,261,643 | 0.6% | 3.1% - 5.4% | 4.2% | N/A | N/A |
| Pennsylvania | 5.8% | $252,585,179 | 0.8% | 4.1% - 7.4% | 5.5% | N/A | N/A |
| Puerto Rico | 8.0% | $30,661,853 | 1.0% | 6.0% - 9.9% | 8.0% | N/A | N/A |
| Rhode Island | 4.3% | $12,400,450 | 0.6% | 3.1% - 5.5% | 4.3% | N/A | N/A |
| South Carolina | 5.6% | $81,062,030 | 0.7% | 4.2% - 7.1% | 5.3% | N/A | N/A |
| South Dakota | 5.0% | $12,481,331 | 0.9% | 3.3% - 6.7% | 4.9% | N/A | N/A |
| Tennessee | 4.1% | $91,479,131 | 0.7% | 2.7% - 5.5% | 4.1% | N/A | N/A |
| Texas | 8.7% | $517,090,072 | 1.0% | 6.7% - 10.6% | 8.4% | N/A | N/A |
| Utah | 5.2% | $22,367,160 | 0.6% | 4.0% - 6.4% | 4.5% | N/A | N/A |
| Virginia | 5.7% | $115,405,753 | 1.1% | 3.5% - 7.9% | 5.3% | N/A | N/A |
| Vermont | 4.2% | $6,828,170 | 0.7% | 2.7% - 5.6% | 4.2% | N/A | N/A |
| Washington | 4.2% | $56,350,852 | 0.7% | 2.9% - 5.6% | 4.2% | N/A | N/A |
| Wisconsin | 2.5% | $41,327,413 | 0.4% | 1.6% - 3.4% | 2.5% | N/A | N/A |
| West Virginia | 2.2% | $16,922,255 | 0.4% | 1.3% - 3.0% | 1.6% | N/A | N/A |
| Wyoming | 1.3% | $1,329,656 | 0.2% | 0.8% - 1.8% | 1.3% | N/A | N/A |
| **Short-term Acute Paid Claims** | **5.0%** | **$4,480,110,299** | **0.2%** | **4.7%-5.4%** | **4.7%** | **N/A** | **N/A** |
| **Long-term Acute Paid Claims** | **6.9%** | **$289,300,051** | **0.6%** | **5.7%-8.1%** | **6.5%** | **N/A** | **N/A** |
| **Denied Claims** | **N/A** | **$76,358,973** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Total** | **5.2%** | **$4,845,769,323** | **0.2%** | **4.9%-5.6%** | **N/A** | **N/A** | **N/A** |

For paid claims error rates by contractor and type of error and improper payment amounts for contractors, see Appendix C.

## Error Rates by Type of Service

Table 9 displays the paid claims error rates for each type of service by type of error. All estimates in this table are based on a minimum of 30 lines in the sample.

**Table 9a: Top 20 Service Types with Highest Improper Payments: Carriers**

| Service Type Billed to Carriers (BETOS codes) | Projected Improper Payment | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | Type of Error | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| Hospital visit - subsequent | $697.3M | 16.4% | 14.7% - 18.0% | 13.0% | 52.0% | 0.2% | 34.6% | 0.2% |
| All Other Codes | $578.2M | 2.1% | 1.8% - 2.4% | 25.6% | 51.3% | 4.9% | 14.2% | 3.9% |
| Office visits - established | $550.9M | 6.0% | 5.6% - 6.4% | 13.0% | 16.4% | 1.5% | 68.9% | 0.2% |
| Consultations | $511.0M | 16.4% | 15.0% - 17.9% | 8.1% | 15.3% | 0.6% | 75.6% | 0.4% |
| Other drugs | $393.5M | 10.8% | ( 2.7%) - 24.3% | 74.6% | 17.6% | 3.5% | 4.3% | 0.0% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Minor procedures - other (Medicare fee schedule) | $352.0M | 15.4% | 13.0% - 17.8% | 10.4% | 36.5% | 46.1% | 6.0% | 0.9% |
| Hospital visit - initial | $213.3M | 20.4% | 17.6% - 23.1% | 6.0% | 22.7% | 0.0% | 70.1% | 1.2% |
| Ambulance | $156.7M | 5.1% | 2.9% - 7.2% | 9.6% | 18.9% | 65.2% | 6.3% | 0.0% |
| Office visits - new | $139.6M | 15.2% | 13.0% - 17.5% | 9.1% | 8.4% | 0.0% | 82.5% | 0.0% |
| Nursing home visit | $123.6M | 13.0% | 11.0% - 14.9% | 23.1% | 33.1% | 1.9% | 41.3% | 0.5% |
| Emergency room visit | $89.9M | 6.6% | 5.0% - 8.3% | 24.8% | 28.2% | 0.0% | 47.0% | 0.0% |
| Other tests - other | $76.1M | 7.6% | 3.6% - 11.7% | 31.2% | 39.5% | 18.8% | 9.2% | 1.3% |
| Hospital visit - critical care | $75.1M | 16.2% | 4.6% - 27.7% | 3.6% | 63.6% | 3.7% | 29.2% | 0.0% |
| No Service Code | $69.6M | 4.1% | 2.1% - 6.1% | 13.9% | 72.5% | 0.4% | 13.2% | 0.0% |
| Lab tests - other (non-Medicare fee schedule) | $56.4M | 3.6% | 2.3% - 4.9% | 38.6% | 43.6% | 15.7% | 1.6% | 0.7% |
| Oncology - radiation therapy | $43.6M | 4.6% | 1.7% - 7.4% | 18.3% | 52.1% | 27.6% | 2.0% | 0.0% |
| Standard imaging - nuclear medicine | $41.9M | 3.2% | ( 1.3%) - 7.7% | 11.6% | 83.3% | 5.2% | 0.0% | 0.0% |
| Chiropractic | $41.9M | 8.8% | 6.3% - 11.4% | 6.3% | 38.6% | 31.1% | 24.1% | 0.0% |
| Chemotherapy | $39.6M | 1.8% | 0.1% - 3.6% | 1.1% | 80.8% | 0.0% | 18.2% | 0.0% |
| Specialist - other | $37.6M | 17.3% | 7.6% - 27.0% | 9.1% | 45.1% | 17.7% | 0.2% | 28.0 % |
| Major procedure - Other | $37.3M | 5.2% | ( 2.2%) - 12.6% | 14.6% | 79.4% | 0.0% | 6.0% | 0.0% |
| **All Type of Services (Incl. Codes Not Listed)** | **$4,325.0M** | **6.4%** | **5.5% - 7.2%** | **19.8%** | **34.4%** | **8.8%** | **36.0%** | **1.1%** |

**Table 9b: Top 20 Service Types with Highest Improper Payments: DMERCs**

| Service Type Billed to DMERCs (SADMERC Policy Group) | Projected Improper Payment | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | Type of Error | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| Glucose Monitor | $145.5M | 14.3% | 11.7% - 16.8% | 14.8% | 3.7% | 76.0% | 5.1% | 0.4% |
| Lower Limb Prostheses | $88.4M | 16.4% | ( 3.2%) - 36.1% | 99.6% | 0.0% | 0.0% | 0.4% | 0.0% |
| Surgical Dressings | $85.7M | 67.8% | 46.8% - 88.8% | 76.1% | 8.0% | 15.7% | 0.1% | 0.1% |
| All Other Codes | $75.2M | 5.3% | 0.1% - 10.6% | 62.2% | 0.4% | 13.1% | 1.1% | 23.1% |
| Ostomy Supplies | $66.1M | 45.9% | 27.0% - 64.7% | 59.1% | 1.8% | 35.5% | 3.5% | 0.2% |
| Nebulizers & Related Drugs | $63.2M | 5.3% | 3.2% - 7.3% | 8.9% | 10.1% | 64.4% | 16.5% | 0.1% |
| Oxygen Supplies/ Equipment | $59.8M | 2.7% | 1.8% - 3.7% | 48.3% | 18.5% | 31.0% | 1.7% | 0.6% |
| Enteral Nutrition | $45.0M | 8.2% | 3.0% - 13.4% | 11.5% | 4.3% | 63.8% | 20.4% | 0.0% |
| Support Surfaces | $34.0M | 22.2% | 2.3% - 42.0% | 66.7% | 0.0% | 33.3% | 0.0% | 0.0% |
| Immunosuppressive Drugs | $31.7M | 11.9% | 2.7% - 21.2% | 33.5% | 0.0% | 66.5% | 0.0% | 0.0% |
| CPAP | $23.0M | 9.1% | 4.7% - 13.4% | 16.1% | 4.8% | 79.1% | 0.0% | 0.0% |
| Lower Limb Orthoses | $17.3M | 13.3% | 1.1% - 25.6% | 17.9% | 24.7% | 48.6% | 8.9% | 0.0% |
| Diabetic Shoes | $9.8M | 5.6% | 0.7% - 10.6% | 0.0% | 20.4% | 79.6% | 0.0% | 0.0% |
| Wheelchairs Manual | $7.6M | 2.9% | 0.4% - 5.3% | 38.6% | 7.9% | 45.8% | 7.7% | 0.0% |
| Lenses | $5.5M | 6.2% | 2.1% - 10.3% | 37.4% | 11.7% | 39.2% | 11.7% | 0.0% |
| Hospital Beds/ Accessories | $5.2M | 1.6% | ( 0.2%) - 3.4% | 64.6% | 0.0% | 35.4% | 0.0% | 0.0% |
| Urological Supplies | $4.1M | 8.7% | 0.3% - 17.1% | 9.9% | 30.2% | 10.5% | 21.6% | 27.8% |
| Upper Limb Orthoses | $3.5M | 9.7% | ( 0.5%) - 19.9% | 73.1% | 12.8% | 0.0% | 0.0% | 14.1% |
| Walkers | $3.3M | 3.8% | 0.4% - 7.3% | 15.8% | 0.0% | 73.8% | 0.0% | 10.4% |
| Breast Prostheses | $3.0M | 7.5% | ( 1.2%) - 16.2% | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% |
| Commodes/ Bed Pans/Urinals | $3.0M | 5.9% | ( 0.7%) - 12.6% | 39.0% | 0.0% | 61.0% | 0.0% | 0.0% |
| **All Type of Services (Incl. Codes Not Listed)** | **$779.8M** | **8.6%** | **6.8% - 10.3%** | **45.3%** | **5.6%** | **41.9%** | **4.5%** | **2.6%** |

**Table 9c: Top 20 Service Types with Highest Improper Payments: FIs**

| Service Type Billed to FIs (Type of Bill) | Projected Improper Payment | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | Type of Error | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| OPPS, Laboratory (an FI), Ambulatory (Billing an FI) | $861.9M | 4.3% | 3.5% - 5.0% | 15.6% | 62.9% | 6.2% | 14.1% | 1.2% |
| SNF | $742.1M | 4.5% | 3.3% - 5.6% | 7.4% | 46.7% | 12.9% | 30.8% | 2.2% |
| ESRD | $165.8M | 2.8% | 1.8% - 3.8% | 8.9% | 41.2% | 2.8% | 47.1% | 0.1% |
| HHA | $146.1M | 1.7% | 1.1% - 2.3% | 0.2% | 58.0% | 22.3% | 15.2% | 4.2% |
| Hospice | $112.7M | 2.1% | 0.7% - 3.5% | 4.4% | 27.5% | 49.9% | 18.1% | 0.0% |
| Other FI Service Types | $83.6M | 4.1% | 3.0% - 5.2% | 15.4% | 51.1% | 21.2% | 11.8% | 0.5% |
| Non-PPS Hospital In-patient | $50.7M | 1.2% | 0.3% - 2.1% | 25.3% | 34.3% | 3.4% | 36.8% | 0.3% |
| FQHC | $7.6M | 3.0% | 1.5% - 4.4% | 54.1% | 45.9% | 0.0% | 0.0% | 0.0% |
| RHCs | $7.1M | 1.8% | 1.2% - 2.4% | 42.5% | 52.8% | 3.2% | 0.8% | 0.7% |
| Free Standing Ambulatory Surgery | $2.8M | 1.2% | ( 0.5%) - 2.9% | 44.5% | 0.0% | 1.9% | 53.7% | 0.0% |
| **All Type of Services (Incl. Codes Not Listed)** | **$2,180.2M** | **3.4%** | **3.0% - 3.8%** | **11.2%** | **52.3%** | **12.1%** | **23.0%** | **1.5%** |

**Table 9d: Top 20 Service Types with Highest Improper Payments: QIOs**

| Service Types for Which QIOs are Responsible (DRG) | Projected Improper Payment | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | Type of Error | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| ESOPH,GASTROENT & MISC DIG DISORAGE >17 W CC | $173.7M | 13.9% | 10.8% - 17.1% | 1.0% | 0.0% | 81.4% | 10.0% | 7.6% |
| CHEST PAIN | $120.9M | 19.2% | 14.8% - 23.7% | 0.4% | 0.0% | 84.6% | 7.7% | 7.3% |
| NUT & MISC METAB DISORAGE >17 W CC | $113.7M | 9.8% | 7.0% - 12.5% | 2.2% | 0.0% | 78.9% | 11.1% | 7.8% |
| OTH PERMANENT CAR PACER IMPLANT | $106.7M | 6.4% | 2.5% - 10.2% | 0.0% | 0.0% | 92.2% | 1.0% | 6.8% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| CIRC DISOR EXC AMI,W CARD CATH W/O COMPLEX DX | $95.6M | 17.9% | 11.1% - 24.7% | 9.5% | 0.0% | 84.4% | 6.1% | (0.0%) |
| MEDICAL BACK PROB | $93.3M | 24.3% | 17.6% - 31.1% | 0.5% | 0.0% | 95.9% | 1.5% | 2.1% |
| HEART FAILURE & SHOCK | $91.8M | 2.5% | 1.5% - 3.4% | 0.9% | 0.0% | 75.6% | 16.1% | 7.4% |
| OTH -VAS PROC W CC | $90.3M | 5.5% | 2.5% - 8.4% | 11.0% | 0.0% | 50.1% | 22.7% | 16.2% |
| PERCU CAR-VAS PROC W DRUG-ELUT STENT W/O AMI | $64.8M | 2.6% | 0.7% - 4.5% | 4.4% | 0.0% | 78.8% | 11.0% | 5.8% |
| G.I. HEMOR W CC | $64.1M | 4.5% | 2.7% - 6.3% | 3.5% | 0.0% | 78.4% | 16.4% | 1.7% |
| MAJ SMALL & LARGE BOWEL PROC W CC | $58.9M | 2.2% | ( 0.0%) - 4.4% | 55.6% | 0.0% | 1.2% | 43.2% | 0.0% |
| MAJ JOINT & LIMB REATTACH PROC - LOW EXT | $58.5M | 1.1% | 0.3% - 1.9% | 26.7% | 0.0% | 51.6% | 8.0% | 13.7% |
| RENAL FAILURE | $58.5M | 4.7% | 2.3% - 7.1% | 0.0% | 0.0% | 65.1% | 32.5% | 2.5% |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W/O CC | $56.2M | 24.0% | 14.6% - 33.4% | 0.0% | 0.0% | 93.4% | 6.1% | 0.5% |
| EXT OR PROC UNRELATEDPRIN DX | $53.6M | 4.5% | 1.2% - 7.9% | 0.0% | 0.0% | 8.6% | 91.4% | 0.0% |
| DIABETES AGE >35 | $52.0M | 12.6% | 6.6% - 18.7% | 0.0% | 0.0% | 88.0% | 8.0% | 4.0% |
| OTH CIRC SYS OR PROC | $51.6M | 9.9% | 3.8% - 16.0% | 4.8% | 0.0% | 32.9% | 57.3% | 5.0% |
| TRANSIENT ISCHEMIA | $51.5M | 11.7% | 6.7% - 16.6% | 0.0% | 0.0% | 83.6% | 9.4% | 7.0% |
| OTH KID & URINARY TRACT OR PROC | $51.4M | 10.6% | 4.6% - 16.6% | 0.0% | 0.0% | 38.5% | 37.9% | 23.6% |
| CIRC DISOR EXC AMI,W CARD CATH & COMPLEX DX | $51.1M | 5.4% | 1.8% - 8.9% | 0.0% | 0.0% | 78.6% | 12.9% | 8.4% |
| **Overall** | **$4,845.8M** | **5.2%** | **4.9% - 5.5%** | **5.4%** | **0.0%** | **58.4%** | **27.8%** | **8.5%** |

# Paid Claim Error Rates by Provider Type

The table 10 series presents error rates by provider type. The tables include the top provider types based on improper payments for providers that bill each type of contractor. All estimates are based on a minimum of 30 lines in the sample.

The CERT program was unable to calculate provider compliance error rates for FIs due to systems limitations. CMS plans to resolve these issues and produce provider compliance error rates for FIs in the November 2007 Report.

**Table 10a: Error Rates and Improper Payments by Provider Type: Carriers**

| Provider Types Billing to Carriers | Paid Claims Error Rate | | | | | Provider Compliance Error Rate | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payment Amount Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Internal Medicine | 9.8% | $775,369,891 | 0.5% | 8.8% - 10.8% | 8.6% | 19.2% | 18.2% |
| Pulmonary Disease | 27.7% | $410,141,742 | 14.2% | ( 0.2%) - 55.6% | 8.4% | 32.8% | 19.1% |
| Cardiology | 6.7% | $379,553,992 | 0.7% | 5.2% - 8.1% | 6.1% | 17.1% | 16.7% |
| Family Practice | 9.1% | $332,507,361 | 1.0% | 7.1% - 11.1% | 7.7% | 20.2% | 19.2% |
| Physical Therapist in Private Practice | 20.5% | $172,889,004 | 2.2% | 16.1% - 24.8% | 20.0% | 32.9% | 32.6% |
| Nephrology | 12.3% | $158,945,925 | 1.7% | 9.0% - 15.6% | 11.1% | 21.9% | 21.0% |
| Ambulance Service Supplier (e.g., private ambulance companies, funeral homes) | 5.1% | $156,747,908 | 1.1% | 2.9% - 7.2% | 4.6% | 14.3% | 14.0% |
| General Practice | 16.0% | $150,521,507 | 4.5% | 7.3% - 24.8% | 14.8% | 38.4% | 37.8% |
| General Surgery | 7.2% | $116,982,738 | 1.9% | 3.4% - 11.0% | 6.6% | 22.8% | 22.5% |
| Hematology/Oncology | 3.1% | $110,279,681 | 0.7% | 1.7% - 4.5% | 2.9% | 12.1% | 12.0% |
| Orthopedic Surgery | 4.6% | $104,608,341 | 0.6% | 3.4% - 5.8% | 4.2% | 16.3% | 16.0% |
| Urology | 6.0% | $99,035,103 | 1.2% | 3.7% - 8.3% | 5.9% | 20.9% | 20.7% |
| Gastroenterology | 7.3% | $96,703,638 | 0.8% | 5.7% - 8.9% | 7.2% | 16.3% | 16.2% |
| Ophthalmology | 2.1% | $84,928,559 | 0.5% | 1.2% - 3.0% | 1.9% | 11.0% | 10.9% |
| Emergency Medicine | 5.9% | $84,119,865 | 0.8% | 4.3% - 7.4% | 4.4% | 15.7% | 14.6% |
| Diagnostic Radiology | 2.1% | $82,763,683 | 0.3% | 1.5% - 2.7% | 1.3% | 16.1% | 15.5% |
| Neurology | 9.2% | $79,718,685 | 1.4% | 6.5% - 11.9% | 7.3% | 19.8% | 18.3% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Physical Medicine and Rehabilitation | 13.8% | $75,627,464 | 1.9% | 10.2% - 17.5% | 11.4% | 25.3% | 23.4% |
| Clinical Laboratory (Billing Independently) | 3.3% | $70,498,144 | 0.7% | 2.0% - 4.7% | 1.7% | 14.7% | 13.4% |
| Otolaryngology | 7.6% | $54,826,580 | 1.3% | 5.1% - 10.2% | 6.8% | 21.5% | 20.9% |
| Podiatry | 4.8% | $54,416,004 | 0.9% | 3.1% - 6.6% | 3.9% | 18.2% | 17.8% |
| Obstetrics/Gynecology | 11.2% | $48,646,358 | 2.5% | 6.4% - 16.1% | 8.5% | 30.8% | 29.3% |
| Radiation Oncology | 4.6% | $47,466,763 | 1.4% | 1.9% - 7.3% | 3.8% | 13.8% | 13.2% |
| Psychiatry | 6.6% | $45,223,569 | 1.2% | 4.3% - 8.9% | 5.3% | 14.5% | 13.4% |
| Chiropractic | 8.9% | $42,098,243 | 1.3% | 6.4% - 11.5% | 8.4% | 30.8% | 30.6% |
| Dermatology | 2.5% | $40,894,056 | 0.5% | 1.5% - 3.4% | 2.2% | 8.8% | 8.5% |
| Nurse Practitioner | 9.2% | $36,126,547 | 1.6% | 6.0% - 12.4% | 4.6% | 22.3% | 19.1% |
| Endocrinology | 12.4% | $30,860,526 | 2.3% | 7.8% - 16.9% | 11.5% | 18.6% | 17.9% |
| Infectious Disease | 7.2% | $29,610,386 | 1.9% | 3.6% - 10.9% | 6.6% | 15.2% | 14.7% |
| Medical Oncology | 1.8% | $28,874,030 | 0.5% | 0.7% - 2.9% | 1.5% | 17.8% | 17.6% |
| Pathology | 4.3% | $27,844,932 | 1.1% | 2.1% - 6.6% | 3.4% | 17.9% | 17.3% |
| Anesthesiology | 2.1% | $26,356,823 | 0.5% | 1.1% - 3.1% | 1.9% | 15.3% | 15.1% |
| Physician Assistant | 7.2% | $25,469,553 | 1.8% | 3.7% - 10.7% | 6.4% | 15.3% | 14.6% |
| Rheumatology | 3.5% | $20,646,358 | 0.7% | 2.1% - 5.0% | 3.1% | 10.8% | 10.5% |
| Vascular Surgery | 4.6% | $18,781,400 | 1.4% | 1.9% - 7.4% | 4.4% | 18.9% | 18.7% |
| Clinical Psychologist | 5.6% | $17,910,519 | 3.3% | ( 0.9%) - 12.1% | 4.5% | 15.8% | 15.1% |
| Neurosurgery | 4.0% | $16,925,711 | 1.4% | 1.2% - 6.8% | 3.3% | 17.6% | 17.2% |
| Critical Care (Intensivists) | 9.7% | $15,493,988 | 4.0% | 1.9% - 17.4% | 7.5% | 18.0% | 16.3% |
| Optometry | 3.3% | $15,429,933 | 1.0% | 1.3% - 5.3% | 3.3% | 17.4% | 17.4% |
| Unknown Provider Type | 11.8% | $12,723,045 | 7.1% | ( 2.1%) - 25.7% | 10.8% | 24.5% | 23.9% |
| Occupational Therapist in Private Practice | 23.2% | $12,527,371 | 5.4% | 12.6% - 33.9% | 23.2% | 42.9% | 42.9% |
| Certified Registered Nurse Anesthetist (CRNA) | 2.9% | $11,629,631 | 0.9% | 1.1% - 4.7% | 2.4% | 13.0% | 12.6% |
| Hematology | 6.1% | $11,155,134 | 2.7% | 0.9% - 11.3% | 6.0% | 10.9% | 10.8% |
| Portable X-Ray Supplier (Billing Independently) | 5.9% | $11,032,804 | 2.2% | 1.6% - 10.1% | 2.6% | 17.0% | 14.6% |
| Geriatric Medicine | 10.6% | $10,082,233 | 2.9% | 4.9% - 16.2% | 10.1% | 18.3% | 17.9% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Thoracic Surgery | 3.5% | $8,740,817 | 1.4% | 0.7% - 6.2% | 2.8% | 34.1% | 33.8% |
| Osteopathic Manipulative Therapy | 24.6% | $8,586,843 | 11.0% | 3.0% - 46.1% | 24.6% | 33.4% | 33.4% |
| Pediatric Medicine | 13.9% | $8,202,460 | 5.6% | 2.9% - 25.0% | 10.5% | 24.7% | 22.0% |
| Cardiac Surgery | 1.5% | $6,400,301 | 1.1% | ( 0.6%) - 3.7% | 1.5% | 6.5% | 6.5% |
| Allergy /Immunology | 5.4% | $6,057,345 | 2.4% | 0.7% - 10.2% | 5.3% | 12.3% | 12.2% |
| All Provider Types With Less Than 30 Lines | 2.1% | $5,849,897 | 1.7% | ( 1.2%) - 5.3% | 1.2% | 47.1% | 46.4% |
| Plastic and Reconstructive Surgery | 1.6% | $4,483,763 | 0.8% | ( 0.1%) - 3.3% | 1.6% | 16.9% | 16.9% |
| Multispecialty Clinic or Group Practice | 4.1% | $3,472,461 | 1.9% | 0.4% - 7.9% | 4.1% | 22.8% | 22.8% |
| Interventional Pain Management | 8.1% | $3,028,156 | 7.3% | ( 6.2%) - 22.4% | 8.1% | 26.3% | 26.3% |
| Interventional Radiology | 1.4% | $2,940,169 | 0.8% | ( 0.2%) - 3.0% | 0.3% | 9.5% | 8.7% |
| Independent Diagnostic Testing Facility (IDTF) | 0.4% | $2,890,668 | 0.3% | ( 0.2%) - 0.9% | 0.1% | 20.9% | 20.7% |
| Gynecological/ Oncology | 5.4% | $2,332,296 | 2.0% | 1.4% - 9.3% | 5.4% | 16.8% | 16.8% |
| Colorectal Surgery (formerly proctology) | 4.3% | $2,202,304 | 1.3% | 1.7% - 6.8% | 4.3% | 30.9% | 30.9% |
| Clinical Social Worker | 1.6% | $2,084,924 | 0.8% | 0.0% - 3.1% | 1.0% | 8.4% | 7.8% |
| Hand Surgery | 1.4% | $1,048,876 | 1.1% | ( 0.8%) - 3.6% | 1.4% | 27.3% | 27.3% |
| Clinical Nurse Specialist | 4.2% | $823,683 | 2.4% | ( 0.5%) - 8.8% | 2.5% | 11.2% | 10.1% |
| Pain Management | 0.5% | $493,955 | 0.4% | ( 0.3%) - 1.3% | 0.5% | 27.3% | 27.3% |
| Preventive Medicine | 1.1% | $134,703 | 0.0% | 1.1% - 1.1% | 1.1% | 11.1% | 11.1% |
| Audiologist (Billing Independently) | 0.7% | $88,756 | 0.7% | ( 0.7%) - 2.1% | 0.7% | 29.5% | 29.5% |
| Nuclear Medicine | 0.1% | $83,520 | 0.1% | ( 0.1%) - 0.3% | 0.1% | 7.0% | 7.0% |
| Public Health or Welfare Agencies (Federal, State, and local) | 0.1% | $21,138 | 0.0% | ( 0.0%) - 0.1% | 0.0% | 10.6% | 10.4% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ambulatory Surgical Center | 0.0% | $0 | 0.0% | 0.0% - 0.0% | 0.0% | 10.5% | 10.5% |
| Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations) | 0.0% | $0 | 0.0% | 0.0% - 0.0% | 0.0% | 11.1% | 11.1% |
| **All Provider Types** | **6.4%** | **$4,324,962,761** | **0.4%** | **5.5% - 7.2%** | **5.2%** | **17.8%** | **17.0%** |

**Table 10b: Error Rates and Improper Payments by Provider Type: DMERCs**

| **Provider Types Billing to DMERCs** | **Paid Claims Error Rate** | | | | | **Provider Compliance Error Rate** | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payment Amount Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Pharmacy | 8.6% | $301,098,165 | 1.0% | 6.7% - 10.5% | 6.6% | 17.7% | 15.9% |
| Medical supply company not included in 51, 52, or 53 | 6.8% | $237,093,409 | 1.2% | 4.5% - 9.2% | 4.0% | 16.3% | 12.8% |
| Unknown Supplier/Provider | 69.1% | $68,613,190 | 14.1% | 41.4% - 96.8% | 7.7% | 78.0% | 58.4% |
| Medical Supply Company with Respiratory Therapist | 5.5% | $51,116,103 | 1.9% | 1.8% - 9.2% | 2.5% | 13.8% | 11.3% |
| Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization | 14.5% | $38,786,611 | 13.7% | ( 12.3%) - 41.3% | 0.2% | 15.9% | 2.3% |
| Individual orthotic personnel certified by an accrediting organization | 17.7% | $36,284,075 | 11.8% | ( 5.4%) - 40.7% | 6.3% | 41.1% | 35.5% |
| All Provider Types With Less Than 30 Lines | 19.1% | $21,585,077 | 12.4% | ( 5.2%) - 43.4% | 8.6% | 21.3% | 11.6% |
| Podiatry | 9.0% | $6,829,409 | 4.9% | ( 0.6%) - 18.5% | 9.0% | 33.7% | 33.7% |
| Orthopedic Surgery | 23.0% | $6,546,767 | 13.3% | ( 3.1%) - 49.1% | 21.2% | 31.2% | 29.8% |
| Individual prosthetic personnel certified by an accrediting organization | 1.9% | $3,676,731 | 2.2% | ( 2.3%) - 6.2% | 0.3% | 8.0% | 6.5% |
| Nursing Facility, Other | 13.8% | $3,311,609 | 11.8% | ( 9.3%) - 36.9% | 12.6% | 17.5% | 16.4% |
| Optician | 11.7% | $2,818,273 | 5.6% | 0.7% - 22.8% | 8.7% | 19.9% | 17.4% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ophthalmology | 3.8% | $1,122,055 | 2.7% | ( 1.5%) - 9.1% | 3.8% | 11.5% | 11.5% |
| Medical Supply Company with registered pharmacist | 2.4% | $513,087 | 2.5% | ( 2.4%) - 7.2% | 0.0% | 3.1% | 0.8% |
| Medical supply company with orthotic personnel certified by an accrediting organization | 1.0% | $424,986 | 0.9% | ( 0.6%) - 2.7% | 1.0% | 13.7% | 13.7% |
| Medical supply company with prosthetic personnel certified by an accrediting organization | 0.0% | $0 | 0.0% | 0.0% - 0.0% | 0.0% | 7.2% | 7.2% |
| Optometry | 0.0% | $0 | 0.0% | 0.0% - 0.0% | 0.0% | 17.1% | 17.1% |
| Skilled Nursing Facility | 0.0% | $0 | 0.0% | 0.0% - 0.0% | 0.0% | 2.6% | 2.6% |
| **All Provider Types** | **8.6%** | **$779,819,548** | **0.9%** | **6.8% - 10.3%** | **4.9%** | **18.1%** | **14.7%** |

**Table 10c: Error Rates and Improper Payments by Provider Type: FIs**

| **Provider Types Billing to FIs** | **Paid Claims Error Rate** | | | | |
|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| **Overall** | **3.4%** | **2,180,229,950** | **0.2%** | **3.0% - 3.8%** | **3.1%** |
| OPPS, Laboratory (an FI), Ambulatory (Billing an FI) | 4.3% | 861,895,367 | 0.4% | 3.5% - 5.0% | 3.7% |
| SNF | 4.5% | 742,066,217 | 0.6% | 3.3% - 5.6% | 4.1% |
| ESRD | 2.8% | 165,766,948 | 0.5% | 1.8% - 3.8% | 2.6% |
| HHA | 1.7% | 146,149,611 | 0.3% | 1.1% - 2.3% | 1.7% |
| Hospice | 2.1% | 112,713,377 | 0.7% | 0.7% - 3.5% | 2.0% |
| Other FI Service Types | 4.1% | 83,612,733 | 0.6% | 3.0% - 5.2% | 3.5% |
| Non-PPS Hospital In-patient | 1.2% | 50,658,301 | 0.4% | 0.3% - 2.1% | 0.9% |
| FQHC | 3.0% | 7,551,508 | 0.8% | 1.5% - 4.4% | 1.4% |
| RHCs | 1.8% | 7,058,272 | 0.3% | 1.2% - 2.4% | 1.1% |
| Free Standing Ambulatory Surgery | 1.2% | 2,757,616 | 0.9% | ( 0.5%) - 2.9% | 0.7% |

The CERT program was unable to calculate provider compliance error rates for FIs due to systems limitations. CMS plans to resolve these issues and produce provider compliance error rates for FIs beginning with the November 2007 report.

**Table 10d: Error Rates and Improper Payments by Provider Type: QIOs**

| Provider Types for Which QIOs are Responsible | Paid Claims Error Rate | | | | |
|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| Short-term Acute Paid Claims | 5.0% | $4,480,110,299 | 0.2% | 4.7%-5.4% | 4.7% |
| Long-term Acute Paid Claims | 6.9% | $289,300,051 | 0.6% | 5.7%-8.1% | 6.5% |
| Denied Claims | N/A | $76,358,973 | N/A | N/A | N/A |
| **Total** | **5.2%** | **$4,845,769,323** | **0.2%** | **4.9%-5.5%** | **N/A** |

# CORRECTIVE ACTIONS

CMS's goal is to reduce the percentage of improper payments made under the Medicare FFS program to 7.9% by November 2005 and to 4.7% by November 2008. The national error rate for the November 2005 reporting period was 5.2%. CMS is confident that implementation of the following corrective actions will help reduce the error rate.

**No Documentation**

CMS has made great progress in lowering the no documentation rate from 3.1% in November 2004 to only 0.7% in November 2005. The no documentation issue continues to be more pronounced in the CERT program than in HPMP. The difference is due to several factors: first, providers are more likely to respond to HPMP requests since the average claim value is much higher; second, the providers included in the HPMP were more familiar with that program; and third, HPMP pays PPS inpatient hospital providers separately for the cost of supplying medical records while CERT does not. The cost of supplying such medical records by non-PPS inpatient hospital providers is included in the fees they are paid for each service, and thus CERT is prohibited from paying the providers' cost of supplying medical records.
Reasons for no documentation errors include:

- The provider indicated that the beneficiary does not exist,
- The provider indicated that they submitted the claim for the wrong date of service,
- The provider responded but did not provide the medical record for some reason (such as fear of violating HIPAA or refusing to submit without separate payment for copying/mailing charges),
- The provider commented that they had gone out of business,
- The provider indicated that a third party is in possession of the needed medical record, or
- The provider did not respond at all.

CMS continued the following corrective actions in 2005 to address the no documentation problem:

1. CMS and the Carriers/DMERCs/FIs have been educating providers about the CERT program so that providers are not hesitant about supplying medical records.
2. The CERT contractor developed a Web-based mechanism to allow Carriers/DMERCs/FIs to see which providers respond to CERT documentation requests. CMS then encouraged Carriers/DMERCs/FIs to contact non-responding providers.
3. CMS revised the medical record request letters to emphasize that faxing is the most effective way to submit medical records.
4. CMS required the CERT Review Contractor to implement an appeals tracking system. The CERT Review Contractor used the appeals information to adjust the errors when the provider appealed a CERT decision and the appeals review concluded that the claim should have been paid. Since providers that initially failed to respond to CERT requests for medical records frequently appealed the denial, this change (adjusting the error rate to account for appeals decisions) lowered the percent of the error rate due to no documentation.

5. CMS published a monthly CERT provider newsletter that contained CERT news, helpful hints, and documentation submission reminders.
6. CMS is exploring the possibility of using a secure online system to submit electronic medical records (EMR). The pilots will help CMS test whether:
    - A Medicare Carrier/DMERC/FI can realize efficiencies in their medical review program and lower their error rate by accepting computerized and imaged medical records, and
    - It would be feasible for the CERT program to accept computerized or imaged medical records from providers via a secure Web system.
    -

CMS initiated several new corrective actions that will have an impact on the November 2006 report. A new contractor was hired to specialize in requesting and receiving medical records reviewed by the CERT program. This new contractor, known as the CERT Documentation Contractor, has implemented new policies such as:

1. Calling providers before sending correspondence in order to verify contact information,
2. Offering to fax request letters to providers who can receive faxes,
3. Developing a website that allows providers to customize the delivery address for CERT medical record request letters, and
4. Developing a clear policy and documentation process to deal with medical records that are lost or damaged due to disaster.

**Insufficient Documentation**

The insufficient documentation rate improved significantly, decreasing from 4.1% of the total payments in November 2004 to 1.1% in the November 2005 reporting period. The majority of improper payments due to insufficient documentation were for Carrier/DMERC/FI processed claims. The primary reason for the drop in insufficient documentation was due to a change in the medical record request process; unlike previous reporting periods, the CERT program was able to give all providers a second chance to submit additional documentation in support of a claim. In addition, Carriers/DMERCs/FIs educated providers on what types of documentation to submit in response to a CERT request.

The insufficient documentation problem was caused by multiple factors, including:

- Some providers remain confused about exactly what they needed to submit to the CERT contractor.
- Portions of the medical record were at a location within the billing provider organization other than the location to which the CERT contractor sent the request and the provider did not forward the request to the appropriate location (e.g., the request was sent to the home office but the record was located in a field office).
- Portions of the medical record were located at a third party and the provider did not contact the third party (e.g., the request was sent to the billing physician but the record was located at the hospital).
- Providers failed to properly document the billed service in the medical record (e.g., the plan of care lacked the required physician signature).

- Providers misplaced portions of the medical record.

CMS has already undertaken the following corrective actions aimed at reducing the insufficient documentation rate:

1. The CERT program now solicits improved addresses from Carriers/DMERC/FIs and providers themselves.
2. CMS modified the medical record request letters to clarify the components of the record needed for CERT review. The new letters also encourage the billing provider to forward the request to the appropriate location if the medical record is not on-site.
3. A new provider address customization website allows providers to supply the CERT program with alternate, third party addresses.
4. CMS now customizes the second chance letters to list the parts of the medical record that are needed to complete the review.
5. CMS encouraged Carriers/DMERCs/FIs to educate providers about the importance of submitting thorough and complete documentation.

**Medically Unnecessary Services**

Medically unnecessary services remained steady at 1.6% of the total dollars in error for the November 2005 reporting period. The QIOs were responsible for the largest portion of the improper payments due to medically unnecessary services.

CMS has already undertaken actions to correct this problem:

1. CMS has developed a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data.
2. CMS has developed projects with the QIOs that address problems identified in state-specific hospital billing reports.
3. CMS will provide hospitals with training on using comparative data reports to help them prioritize auditing and monitoring efforts with the goal of preventing payment errors.
4. CMS conducts an annual payment error cause analysis to discern sources of payment error. CMS will be developing and distributing QIO specific payment error cause analyses.
5. CMS is working to address possible issues with observation versus inpatient admission that could be contributing to inappropriate inpatient admissions.
6. CMS has completed and distributed an extensive workbook designed to be a resource for hospitals in their compliance efforts and activities.
7. CMS has tasked each Carrier/DMERC/FI with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.

**Incorrect Coding**

The percentage of sampled dollars found to be in error due to incorrect coding increased this year from 1.2% in November 2004 to 1.5% in the November 2005 reporting period.

CMS will continue the following corrective actions:

1. QIOs will continue to work with hospitals to reduce coding errors through educational efforts and the use of statewide and hospital specific reports from First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM). FATHOM is designed to identify emerging problem areas through data analysis. FATHOM includes reports on DRG-based target areas such as the ratio of the count of discharges with DRG 0079 (respiratory infections and inflammations age >17 with complications or comorbidity) to the count of discharges with DRGs 079, 080, 089, or 090 (lower paying pneumonia DRGs).
2. CMS is considering a resolution passed by the American Medical Association (AMA), the owner of the physician coding system, that recommends CMS defer to the billing physician's judgment in evaluation and management cases where a reviewer and the billing physician disagree by only one coding level.

**Delay in Producing Error Rate Reports**

Readers of this report should keep in mind that November 15, 2003 was the first time CMS produced detailed error rate statistics. CMS and the Medicare contractors analyzed the error rate data included in that report and developed corrective actions plans based on the identified problem areas. The majority of the impact from CMS and contractor error rate reduction efforts after November 2004 will not evident until the November 2006 Report.

The delays in the production of the error rate reports are inherent in the current structure of the CERT and HPMP processes. For example, prior to March 2005, the CERT program requested sampled claim information from the Carriers/DMERCs/FIs daily but requested re-pricing data from them only once a month. In HPMP, claims are sampled four months after discharge in order to allow for hospital clams submission times and the records that undergo QIO case review can go through multiple levels of physician review and appeals.

CMS has taken the following actions:

1. The CERT program now requests sampled claim information from the Carriers/DMERCs/FIs on a daily basis.
2. The CERT Documentation Contractor's medical record request letter asks the providers to respond in 30 days. However, claims are not marked as an error until day 90.
3. The CERT program now requests re-pricing data from the Carriers/DMERCs/FIs twice a month.
4. The CERT program plans to conduct a complete analysis of its procedures to identify any other areas where the program can be more time efficient. The CERT program will also advance the time period covered by each November report by three months to decrease the time lag between claim sampling and error reporting.
5. Due to issues related to claim submission and time to complete case review, it is difficult to decrease the lag time for HPMP without adversely affecting the accuracy of the estimate. However, by affecting when data is reported internally, HPMP will be able to decrease the lag time by two months to four months. Under their current contract, QIOs are investigating where efficiency in the case review process can be improved and this

potentially will eliminate unnecessary time lags in the case review process and further reduce the lag time. It should be noted that for HPMP, short-term acute care claims were sampled by discharge date. For the November 2005 reporting period, July 1, 2003 through June 30, 2004 discharges were sampled; these claims were submitted for processing from July 7, 2003 through September 22, 2004.

**Miscellaneous**

CMS continues to take the following general corrective actions:

1. CMS has directed Medicare contractors to develop local efforts to lower the error rate by submitting Error Rate Reduction Plans that address the cause of the errors, identify the steps they are taking to fix the problems, and provide recommendations to CMS. CMS closely monitors and evaluates the development and implementation of the Contractor Error Rate Reduction Plan for each each Carrier/DMERC/FI.
2. Contractors have implemented educational programs that entail both broad-based efforts and more focused communication with specific providers or provider groups concerning specific billing problems. The broad-based efforts include Websites that provide detailed information on Medicare payment policies, provider training sessions, open door forums, and written materials that explain payment policies in detail.
3. CMS has required its Carriers/DMERCs/FIs to develop annual medical review strategies to reduce the error rates. CMS ties contractor budgets to medical review strategies, evaluates contractor performance based on how well each contractor accomplishes the goals, and conforms to the procedures included in their strategies. CMS required its contractors to intensify their one-on-one educational programs to target known problems that contribute to error rates.
4. CMS will develop and install new Correct Coding Initiative edits to target identified problem areas.
5. CMS will use the Carrier/DMERC/FI-specific error rates in the contractor performance evaluation program.
6. CMS will encourage contractors to address provider billing/payment questions more consistently.
7. CMS is implementing a major initiative to determine if Recovery Audit Contractors (RACs) can lower the error rate by identifying and recovering Medicare overpayments. CMS has begun a three-year demonstration in the states of California, New York, and Florida as required by Section 306 of the Medicare Modernization Act. For more information about this demonstration, see www.cms.hhs.gov/researchers/demos/MMAdemolist.asp. CMS will closely monitor provider compliance error rates and paid claim error rates in these three states to see if providers in RAC states improve their provider compliance error rate faster than those in non-RAC states. During CY 2006, CMS will be looking to see if the Carriers/DMERCs/FIs in these states are able to lower their paid claim error rates more rapidly than other states by reducing post payment medical review and increasing provider education and prepayment medical review.
8. The CERT program completes a small area variation analysis of the Carrier/DMERC/FI error rates using data from the Improper Medicare Fee-for-Service report. This annual

special study produces maps that depict local error rate problem areas. This study facilitates a better understanding of how error rates vary geographically and where CMS and the Carriers/DMERCs/FIs should focus corrective actions.

9. The Medicare Modernization Act requires that CMS publish a list of over-utilized codes. The list provides service type error rates for each CERT cluster group. The CERT program develops and distributes the list annually via the CERT public website (www.cms.hhs.gov/CERT).
10. The HPMP is developing national and state-specific models for predicting payment errors. This study facilitates a better understanding of areas prone to payment error and where QIOs should focus corrective actions.
11. CMS will form a workgroup to address the high provider compliance error rate. This workgroup will examine causes of the errors and develop recommendations for corrective actions.

# SUPPLEMENTAL INFORMATION

The full copy of The Supplementary Appendices for the Improper Medicare Fee-for-Service Payments Report may be downloaded here. The full file is an Adobe PDF file of approximately 1.5 MB.

## Error Rates by Cluster by Type of Error

Appendix C provides error rates for each cluster by type of error.

## Alternate No Documentation Rate

Appendix E provides an alternate no documentation rate based on the ratio of medical records received to medical records requested. This additional information is provided in order to assist contractors with their efforts to lower the no documentation rate. The November 2005 Report provides data for the nation by Carrier/DMERC/FI. The appendix provides three no documentation rates for the following categories:

- All no documentation,
- No documentation rates that have a value of less than $100 in overpayments, and
- No documentation rates with a value of $100 or more in overpayments.

The alternate no documentation rates are different from the earlier error due to no documentation rates because the alternate rates are based on the number of records requested but not received rather than the dollars in error due to no documentation.

## No Documentation

Under CERT, no documentation errors fall into six sub-categories:

1) Beneficiary Issue - This category includes the following:
- The provider indicated that no such patient exists or,
- The provider indicated that although this patient exists, no such service was provided to the patient.

2) Wrong Date of Service – For this category, the provider indicated that they do not have a medical record for the date of service in the CERT request, but they do have a medical record for that service just a few days before or after the service in question. The claim in question may be a duplicate claim.

3) Medical Record Issue – This category includes instances where the provider responded to a CERT documentation request but did not provide a medical record to support payment of a claim. The category includes the following:
- The provider indicated that another department within the provider organization is responsible for fulfilling documentation requests,
- The provider indicated they have the medical record but refused to provide it without payment for copying/mailing charges,
- The provider indicated that it is a HIPAA violation to supply the record,

- The provider submitted a statement that the record was destroyed as a result of extenuating circumstances (e.g., fire, flood, explosion),
- The provider indicated in writing that they did not provide a service to the beneficiary on the date indicated on the claim, and
- The provider indicated they have the medical record but refuse to provide it for some other reason.

4) Billing Provider Issue - This category contains the following reasons for no documentation:

- The provider number has been deactivated,
- The provider has gone out of business, and
- The provider commented but failed to produce a record.

5) Third Party Record - This category contains the situations in which the provider indicated that a different provider - a third party - has the relevant medical record.

6) Did Not Respond – No response to any CERT documentation request.

# Error Rates by Type of Service

**Table 11a: Top 20 Service Type Error Rates: Carriers**

| Service Type Billed to Carriers (BETOS codes) | Type of Error | | | | | | |
|---|---|---|---|---|---|---|---|
| | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| Hospital visit - initial | 20.4% | 17.6% - 23.1% | 6.0% | 22.7% | 0.0% | 70.1% | 1.2% |
| Specialist - other | 17.3% | 7.6% - 27.0% | 9.1% | 45.1% | 17.7% | 0.2% | 28.0 % |
| Consultations | 16.4% | 15.0% - 17.9% | 8.1% | 15.3% | 0.6% | 75.6% | 0.4% |
| Hospital visit - subsequent | 16.4% | 14.7% - 18.0% | 13.0% | 52.0% | 0.2% | 34.6% | 0.2% |
| Hospital visit - critical care | 16.2% | 4.6% - 27.7% | 3.6% | 63.6% | 3.7% | 29.2% | 0.0% |
| Minor procedures - other (Medicare fee schedule) | 15.4% | 13.0% - 17.8% | 10.4% | 36.5% | 46.1% | 6.0% | 0.9% |
| Office visits - new | 15.2% | 13.0% - 17.5% | 9.1% | 8.4% | 0.0% | 82.5% | 0.0% |
| Nursing home visit | 13.0% | 11.0% - 14.9% | 23.1% | 33.1% | 1.9% | 41.3% | 0.5% |
| Other drugs | 10.8% | ( 2.7%) - 24.3% | 74.6% | 17.6% | 3.5% | 4.3% | 0.0% |
| Chiropractic | 8.8% | 6.3% - 11.4% | 6.3% | 38.6% | 31.1% | 24.1% | 0.0% |
| Other tests - other | 7.6% | 3.6% - 11.7% | 31.2% | 39.5% | 18.8% | 9.2% | 1.3% |
| Emergency room visit | 6.6% | 5.0% - 8.3% | 24.8% | 28.2% | 0.0% | 47.0% | 0.0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Office visits - established | 6.0% | 5.6% - 6.4% | 13.0% | 16.4% | 1.5% | 68.9% | 0.2% |
| Major procedure - Other | 5.2% | ( 2.2%) - 12.6% | 14.6% | 79.4% | 0.0% | 6.0% | 0.0% |
| Ambulance | 5.1% | 2.9% - 7.2% | 9.6% | 18.9% | 65.2% | 6.3% | 0.0% |
| Oncology - radiation therapy | 4.6% | 1.7% - 7.4% | 18.3% | 52.1% | 27.6% | 2.0% | 0.0% |
| No Service Code | 4.1% | 2.1% - 6.1% | 13.9% | 72.5% | 0.4% | 13.2% | 0.0% |
| Lab tests - other (non-Medicare fee schedule) | 3.6% | 2.3% - 4.9% | 38.6% | 43.6% | 15.7% | 1.6% | 0.7% |
| Standard imaging - nuclear medicine | 3.2% | ( 1.3%) - 7.7% | 11.6% | 83.3% | 5.2% | 0.0% | 0.0% |
| All Other Codes | 2.1% | 1.8% - 2.4% | 25.6% | 51.3% | 4.9% | 14.2% | 3.9% |
| Chemotherapy | 1.8% | 0.1% - 3.6% | 1.1% | 80.8% | 0.0% | 18.2% | 0.0% |
| **All Types of Services** | **6.4%** | **5.5% - 7.2%** | **19.8%** | **34.4%** | **8.8%** | **36.0%** | **1.1%** |

**Table 11b: Top 20 Service Type Error Rates: DMERCs**

| **Service Type Billed to DMERCs (SADMERC Policy Group)** | **Type of Error** | | | | | | |
|---|---|---|---|---|---|---|---|
| | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| Surgical Dressings | 67.8% | 46.8% - 88.8% | 76.1% | 8.0% | 15.7% | 0.1% | 0.1% |
| Ostomy Supplies | 45.9% | 27.0% - 64.7% | 59.1% | 1.8% | 35.5% | 3.5% | 0.2% |
| Support Surfaces | 22.2% | 2.3% - 42.0% | 66.7% | 0.0% | 33.3% | 0.0% | 0.0% |
| Lower Limb Prostheses | 16.4% | ( 3.2%) - 36.1% | 99.6% | 0.0% | 0.0% | 0.4% | 0.0% |
| Glucose Monitor | 14.3% | 11.7% - 16.8% | 14.8% | 3.7% | 76.0% | 5.1% | 0.4% |
| Lower Limb Orthoses | 13.3% | 1.1% - 25.6% | 17.9% | 24.7% | 48.6% | 8.9% | 0.0% |
| Immunosuppressive Drugs | 11.9% | 2.7% - 21.2% | 33.5% | 0.0% | 66.5% | 0.0% | 0.0% |
| Upper Limb Orthoses | 9.7% | ( 0.5%) - 19.9% | 73.1% | 12.8% | 0.0% | 0.0% | 14.1% |
| CPAP | 9.1% | 4.7% - 13.4% | 16.1% | 4.8% | 79.1% | 0.0% | 0.0% |
| Urological Supplies | 8.7% | 0.3% - 17.1% | 9.9% | 30.2% | 10.5% | 21.6% | 27.8% |
| Enteral Nutrition | 8.2% | 3.0% - 13.4% | 11.5% | 4.3% | 63.8% | 20.4% | 0.0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Breast Prostheses | 7.5% | ( 1.2%) - 16.2% | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% |
| Lenses | 6.2% | 2.1% - 10.3% | 37.4% | 11.7% | 39.2% | 11.7% | 0.0% |
| Commodes/Bed Pans/Urinals | 5.9% | ( 0.7%) - 12.6% | 39.0% | 0.0% | 61.0% | 0.0% | 0.0% |
| Diabetic Shoes | 5.6% | 0.7% - 10.6% | 0.0% | 20.4% | 79.6% | 0.0% | 0.0% |
| All Other Codes | 5.3% | 0.1% - 10.6% | 62.2% | 0.4% | 13.1% | 1.1% | 23.1% |
| Nebulizers & Related Drugs | 5.3% | 3.2% - 7.3% | 8.9% | 10.1% | 64.4% | 16.5% | 0.1% |
| Walkers | 3.8% | 0.4% - 7.3% | 15.8% | 0.0% | 73.8% | 0.0% | 10.4% |
| Wheelchairs Manual | 2.9% | 0.4% - 5.3% | 38.6% | 7.9% | 45.8% | 7.7% | 0.0% |
| Oxygen Supplies/ Equipment | 2.7% | 1.8% - 3.7% | 48.3% | 18.5% | 31.0% | 1.7% | 0.6% |
| Hospital Beds/Accessories | 1.6% | ( 0.2%) - 3.4% | 64.6% | 0.0% | 35.4% | 0.0% | 0.0% |
| **All Types of Services** | **8.6%** | **6.8% - 10.3%** | **45.3%** | **5.6%** | **41.9%** | **4.5%** | **2.6%** |

**Table 11c: Top 20 Service Type Error Rates: FIs**

| **Service Type Billed to FIs (Type of Bill)** | **Type of Error** | | | | | | |
|---|---|---|---|---|---|---|---|
| | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| SNF | 4.5% | 3.3% - 5.6% | 7.4% | 46.7% | 12.9% | 30.8% | 2.2% |
| OPPS, Laboratory (an FI), Ambulatory (Billing an FI) | 4.3% | 3.5% - 5.0% | 15.6% | 62.9% | 6.2% | 14.1% | 1.2% |
| Other FI Service Types | 4.1% | 3.0% - 5.2% | 15.4% | 51.1% | 21.2% | 11.8% | 0.5% |
| ESRD | 2.8% | 1.8% - 3.8% | 8.9% | 41.2% | 2.8% | 47.1% | 0.1% |
| FQHC | 2.8% | 1.3% - 4.2% | 50.8% | 49.2% | 0.0% | 0.0% | 0.0% |
| Hospice | 2.1% | 0.7% - 3.5% | 4.4% | 27.5% | 49.9% | 18.1% | 0.0% |
| RHCs | 1.8% | 1.2% - 2.4% | 42.5% | 52.8% | 3.2% | 0.8% | 0.7% |
| HHA | 1.7% | 1.1% - 2.3% | 0.2% | 58.0% | 22.3% | 15.2% | 4.2% |
| Non-PPS Hospital In-patient | 1.2% | 0.4% - 2.1% | 25.2% | 34.4% | 3.4% | 36.7% | 0.3% |
| Free Standing Ambulatory Surgery | 1.2% | ( 0.5%) - 2.9% | 44.5% | 0.0% | 1.9% | 53.7% | 0.0% |
| **All Types of Services** | **3.4%** | **3.0% - 3.8%** | **11.1%** | **52.3%** | **12.1%** | **23.0%** | **1.5%** |

**Table 11d: Top 20 Service Type Error Rates: QIOs**

| Service Types for Which QIOs are Responsible (DRG) | Type of Error | | | | | | |
|---|---|---|---|---|---|---|---|
| | Paid Claims Error Rate Including No Doc Claims | Confidence Interval | No Doc | Insufficient Doc | Medically Unnecessary Services | Incorrect Coding | Other |
| OTH DISORNRV SYS W/O CC | 50.2% | 1.2% - 99.2% | 45.0% | 0.0% | 46.0% | 8.9% | 0.0% |
| FX,SPRN,STRN&DIS L UPARM,LOWLEG EX FT AGE >17 W/O CC | 36.2% | 7.5% - 64.9% | 0.0% | 0.0% | 80.4% | 19.6% | 0.0% |
| RESP SIGNS & SYM W CC | 33.1% | 7.7% - 58.4% | 0.0% | 0.0% | 76.9% | 22.4% | 0.7% |
| SIGNS & SYMMUS-SKEL SYS & CON TISUE | 31.7% | 11.9% - 51.4% | 0.4% | 0.0% | 73.3% | 26.3% | 0.0% |
| ATHEROSCLEROSIS W/O CC | 30.3% | 4.3% - 56.4% | 18.8% | 0.0% | 42.3% | 38.9% | 0.0% |
| ANGINA PECTORIS | 26.0% | 8.2% - 43.7% | 20.4% | 0.0% | 64.0% | 15.6% | 0.0% |
| OTH DIG SYS DX AGE >17 W/O CC | 24.6% | 3.0% - 46.2% | 0.0% | 0.0% | 98.4% | 1.6% | 0.0% |
| MEDICAL BACK PROB | 24.3% | 17.6% - 31.1% | 0.5% | 0.0% | 95.9% | 1.5% | 2.1% |
| STOM,ESOPH & DUOD PROC AGE >17 W/O CC | 24.0% | ( 22.0%) - 70.0% | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W/O CC | 24.0% | 14.6% - 33.4% | 0.0% | 0.0% | 93.4% | 6.1% | 0.5% |
| SKIN ULCERS | 23.2% | 8.5% - 38.0% | 10.8% | 0.0% | 57.7% | 22.0% | 9.4% |
| ACUTE ADJUST REACT & PSYCHOSOC DYSFUNCT | 23.0% | 4.4% - 41.5% | 0.0% | 0.0% | 96.3% | 0.2% | 3.5% |
| SHLD,ELBOW/FORE ARM PROC,EXC MAJ JOINT PROC,W/O CC | 22.9% | 3.4% - 42.3% | 0.0% | 0.0% | 85.7% | 0.0% | 14.3% |
| DYSEQUILIBRIUM | 22.4% | 11.2% - 33.5% | 0.0% | 0.0% | 98.0% | 0.0% | 2.0% |
| LAPAROSCOPIC CHOLE W/O C.D.E. W/O CC | 21.4% | 3.6% - 39.3% | 0.0% | 0.0% | 84.5% | 0.0% | 15.5% |
| TRAUMSKIN,SUBCU TISS & BREAST AGE >17 W CC | 19.8% | 8.9% - 30.7% | 0.0% | 0.0% | 88.1% | 9.0% | 2.9% |
| SIGNS & SYM W CC | 19.7% | 10.7% - 28.8% | 0.0% | 0.0% | 65.6% | 34.2% | 0.2% |
| KID & URINARY TRACT INFECTS AGE >17 W/O CC | 19.3% | 7.0% - 31.7% | 0.0% | 0.0% | 28.6% | 49.1% | 22.4% |
| CHEST PAIN | 19.2% | 14.8% - 23.7% | 0.4% | 0.0% | 84.6% | 7.7% | 7.3% |
| SEIZURE & HEADACHE AGE >17 W/O CC | 18.2% | 2.3% - 34.1% | 0.0% | 0.0% | 95.3% | 0.0% | 4.7% |
| **Overall** | **5.2%** | **4.9% - 5.5%** | **5.4%** | **0.0%** | **58.4%** | **27.8%** | **8.5%** |

# Breakdown of Improper Payments

**Table 12a: Top 20 Service Type Error Rates: Carriers**

| Service Type Billed to Carriers (BETOS codes) | Paid Claims Error Rate Including No Doc Claims | Improper Payments | | |
|---|---|---|---|---|
| | | Projected Overpayment | Projected Underpayment | Projected Improper Payment |
| Hospital visit - subsequent | 16.4% | $688.4M | $8.9M | $697.3M |
| All Other Codes | 2.1% | $557.7M | $20.5M | $578.2M |
| Office visits - established | 6.0% | $500.2M | $50.7M | $550.9M |
| Consultations | 16.4% | $503.3M | $7.7M | $511.0M |
| Other drugs | 10.8% | $384.4M | $9.1M | $393.5M |
| Minor procedures - other (Medicare fee schedule) | 15.4% | $350.1M | $1.8M | $352.0M |
| Hospital visit - initial | 20.4% | $212.9M | $0.4M | $213.3M |
| Ambulance | 5.1% | $153.7M | $3.0M | $156.7M |
| Office visits - new | 15.2% | $138.7M | $0.9M | $139.6M |
| Nursing home visit | 13.0% | $119.9M | $3.8M | $123.6M |
| Emergency room visit | 6.6% | $86.3M | $3.6M | $89.9M |
| Other tests - other | 7.6% | $75.4M | $0.6M | $76.1M |
| Hospital visit - critical care | 16.2% | $75.1M | $0.0M | $75.1M |
| No Service Code | 4.1% | $69.3M | $0.3M | $69.6M |
| Lab tests - other (non-Medicare fee schedule) | 3.6% | $56.2M | $0.2M | $56.4M |
| Oncology - radiation therapy | 4.6% | $43.6M | $0.0M | $43.6M |
| Standard imaging - nuclear medicine | 3.2% | $41.9M | $0.0M | $41.9M |
| Chiropractic | 8.8% | $40.7M | $1.2M | $41.9M |
| Chemotherapy | 1.8% | $33.4M | $6.1M | $39.6M |
| Specialist - other | 17.3% | $37.6M | $0.0M | $37.6M |
| Major procedure - Other | 5.2% | $36.1M | $1.1M | $37.3M |
| **All Types of Services** | **6.4%** | **$4,204.9M** | **$120.1M** | **$4,325.0M** |

**Table 12b: Top 20 Service Types with Highest Improper Payments: DMERCs**

| Service Type Billed to DMERCs (SADMERC Policy Group) | Paid Claims Error Rate Including No Doc Claims | Improper Payments | | |
|---|---|---|---|---|
| | | Projected Overpayment | Projected Underpayment | Projected Improper Payment |
| Glucose Monitor | 14.3% | $144.4M | $1.1M | $145.5M |
| Lower Limb Prostheses | 16.4% | $88.4M | $0.0M | $88.4M |
| Surgical Dressings | 67.8% | $85.7M | $0.0M | $85.7M |
| All Other Codes | 5.3% | $75.0M | $0.2M | $75.2M |
| Ostomy Supplies | 45.9% | $66.1M | $0.0M | $66.1M |
| Nebulizers & Related Drugs | 5.3% | $63.2M | $0.0M | $63.2M |
| Oxygen Supplies/Equipment | 2.7% | $59.8M | $0.0M | $59.8M |

| | | | | |
|---|---|---|---|---|
| Enteral Nutrition | 8.2% | $45.0M | $0.0M | $45.0M |
| Support Surfaces | 22.2% | $34.0M | $0.0M | $34.0M |
| Immunosuppressive Drugs | 11.9% | $31.7M | $0.0M | $31.7M |
| CPAP | 9.1% | $22.8M | $0.2M | $23.0M |
| Lower Limb Orthoses | 13.3% | $17.3M | $0.0M | $17.3M |
| Diabetic Shoes | 5.6% | $9.8M | $0.0M | $9.8M |
| Wheelchairs Manual | 2.9% | $7.6M | $0.0M | $7.6M |
| Lenses | 6.2% | $5.5M | $0.0M | $5.5M |
| Hospital Beds/Accessories | 1.6% | $5.2M | $0.0M | $5.2M |
| Urological Supplies | 8.7% | $4.1M | $0.0M | $4.1M |
| Upper Limb Orthoses | 9.7% | $3.5M | $0.0M | $3.5M |
| Walkers | 3.8% | $3.3M | $0.0M | $3.3M |
| Breast Prostheses | 7.5% | $3.0M | $0.0M | $3.0M |
| Commodes/Bed Pans/Urinals | 5.9% | $3.0M | $0.0M | $3.0M |
| **All Types of Services** | **8.6%** | **$778.3M** | **$1.5M** | **$779.8M** |

**Table 12c: Top 20 Service Types with Highest Improper Payments: FIs**

| **Service Type Billed to FIs (Type of Bill)** | **Paid Claims Error Rate Including No Doc Claims** | **Improper Payments** | | |
|---|---|---|---|---|
| | | Projected Overpayment | Projected Underpayment | Projected Improper Payment |
| OPPS, Laboratory (an FI), Ambulatory (Billing an FI) | 4.3% | $810.1M | $51.8M | $861.9M |
| SNF | 4.5% | $728.6M | $13.4M | $742.1M |
| ESRD | 2.8% | $155.3M | $10.5M | $165.8M |
| HHA | 1.7% | $129.7M | $16.5M | $146.1M |
| Hospice | 2.1% | $112.7M | $0.1M | $112.7M |
| Other FI Service Types | 4.1% | $83.2M | $0.5M | $83.6M |
| Non-PPS Hospital In-patient | 1.2% | $49.1M | $1.6M | $50.7M |
| FQHC | 3.0% | $7.6M | $0.0M | $7.6M |
| RHCs | 1.8% | $7.0M | $0.1M | $7.1M |
| Free Standing Ambulatory Surgery | 1.2% | $2.8M | $0.0M | $2.8M |
| **All Types of Services** | **3.4%** | **$2,085.9M** | **$94.3M** | **$2,180.2M** |

**Table 12d: Top 20 Service Types with Highest Improper Payments: QIOs**

| **Service Types for Which QIOs are Responsible (DRG)** | **Paid Claims Error Rate Including No Doc Claims** | **Improper Payments** | | |
|---|---|---|---|---|
| | | Projected Overpayment | Projected Underpayment | Projected Improper Payment |
| **Overall** | **5.2%** | **$4,171.6M** | **$674.1M** | **$4,845.8M** |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W CC | 13.9% | $162.8M | $10.9M | $173.7M |
| CHEST PAIN | 19.2% | $111.7M | $9.2M | $120.9M |
| NUT & MISC METAB DISOR AGE >17 W CC | 9.8% | $104.1M | $9.5M | $113.7M |
| OTH PERMANENT CAR PACER | 6.4% | $105.6M | $1.1M | $106.7M |

| | | | | |
|---|---|---|---|---|
| IMPLANT | | | | |
| CIRC DISOR EXC AMI,W CARD CATH W/O COMPLEX DX | 17.9% | $90.0M | $5.7M | $95.6M |
| MEDICAL BACK PROB | 24.3% | $92.3M | $1.1M | $93.3M |
| HEART FAILURE & SHOCK | 2.5% | $84.1M | $7.7M | $91.8M |
| OTH -VAS PROC W CC | 5.5% | $89.0M | $1.3M | $90.3M |
| PERCU CAR-VAS PROC W DRUG-ELUT STENT W/O AMI | 2.6% | $62.1M | $2.7M | $64.8M |
| G.I. HEMOR W CC | 4.5% | $61.6M | $2.5M | $64.1M |
| MAJ SMALL & LARGE BOWEL PROC W CC | 2.2% | $58.9M | $0.0M | $58.9M |
| MAJ JOINT & LIMB REATTACH PROC - LOW EXT | 1.1% | $54.0M | $4.5M | $58.5M |
| RENAL FAILURE | 4.7% | $56.7M | $1.8M | $58.5M |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W/O CC | 24.0% | $52.9M | $3.3M | $56.2M |
| EXT OR PROC UNRELATEDPRIN DX | 4.5% | $53.6M | $0.0M | $53.6M |
| DIABETES AGE >35 | 12.6% | $48.1M | $3.9M | $52.0M |
| OTH CIRC SYS OR PROC | 9.9% | $37.7M | $13.9M | $51.6M |
| TRANSIENT ISCHEMIA | 11.7% | $46.8M | $4.8M | $51.5M |
| OTH KID & URINARY TRACT OR PROC | 10.6% | $41.8M | $9.6M | $51.4M |
| CIRC DISOR EXC AMI,W CARD CATH & COMPLEX DX | 5.4% | $49.2M | $2.0M | $51.1M |

# Paid Claims Error Rate by Service Type

Table 13 displays the paid claims error rate by service type for CY 2004 by contractor type. The table is sorted by projected improper payments from highest to lowest. All estimates in this table are based on a minimum of 30 claims in the sample.

**Table 13a: Paid Claims Error Rates by Service Type: Carriers**

| Service Types Billed to Carriers (BETOS) | Paid Claims Error Rate | | | | | |
|---|---|---|---|---|---|---|
| | Including No Doc Claims | Number of Line Items (Sample) | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| Hospital visit - subsequent | 16.4% | 6,599 | $697,290,652 | 0.8% | 14.7% - 18.0% | 14.5% |
| Office visits - established | 6.0% | 18,012 | $550,916,139 | 0.2% | 5.6% - 6.4% | 5.3% |
| Consultations | 16.4% | 2,585 | $511,039,729 | 0.7% | 15.0% - 17.9% | 15.3% |
| Other drugs | 10.8% | 2,357 | $393,504,681 | 6.9% | ( 2.7%) - 24.3% | 3.0% |
| Minor procedures - other (Medicare fee schedule) | 15.4% | 6,529 | $351,976,530 | 1.2% | 13.0% - 17.8% | 14.0% |
| Hospital visit - initial | 20.4% | 918 | $213,310,368 | 1.4% | 17.6% - 23.1% | 19.4% |
| Ambulance | 5.1% | 2,362 | $156,728,494 | 1.1% | 2.9% - 7.2% | 4.6% |
| Office visits - new | 15.2% | 1,240 | $139,587,680 | 1.1% | 13.0% - 17.5% | 14.0% |
| Nursing home visit | 13.0% | 1,835 | $123,611,333 | 1.0% | 11.0% - 14.9% | 10.3% |
| Emergency room visit | 6.6% | 1,623 | $89,876,560 | 0.8% | 5.0% - 8.3% | 5.1% |
| Other tests - other | 7.6% | 1,865 | $76,064,549 | 2.1% | 3.6% - 11.7% | 5.4% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Hospital visit - critical care | 16.2% | 286 | $75,060,519 | 5.9% | 4.6% - 27.7% | 15.7% |
| No Service Code | 4.1% | 886 | $69,584,906 | 1.0% | 2.1% - 6.1% | 3.5% |
| Lab tests - other (non-Medicare fee schedule) | 3.6% | 12,958 | $56,356,350 | 0.7% | 2.3% - 4.9% | 2.2% |
| Oncology - radiation therapy | 4.6% | 534 | $43,585,781 | 1.5% | 1.7% - 7.4% | 3.8% |
| Standard imaging - nuclear medicine | 3.2% | 993 | $41,944,856 | 2.3% | ( 1.3%) - 7.7% | 2.8% |
| Chiropractic | 8.8% | 1,993 | $41,910,504 | 1.3% | 6.3% - 11.4% | 8.3% |
| Chemotherapy | 1.8% | 374 | $39,554,307 | 0.9% | 0.1% - 3.6% | 1.8% |
| Specialist - other | 17.3% | 368 | $37,568,881 | 4.9% | 7.6% - 27.0% | 16.0% |
| Major procedure - Other | 5.2% | 285 | $37,288,066 | 3.8% | ( 2.2%) - 12.6% | 4.5% |
| Specialist - pathology | 3.9% | 1,347 | $34,262,628 | 1.3% | 1.5% - 6.4% | 2.4% |
| Anesthesia | 2.6% | 1,004 | $32,325,876 | 0.6% | 1.4% - 3.8% | 2.3% |
| Specialist - ophthalmology | 1.7% | 3,030 | $30,805,437 | 0.3% | 1.0% - 2.4% | 1.5% |
| Advanced imaging - CAT: other | 2.5% | 1,240 | $28,466,251 | 0.6% | 1.2% - 3.7% | 1.9% |
| Minor procedures - musculoskeletal | 3.6% | 936 | $27,460,525 | 1.3% | 1.1% - 6.1% | 2.4% |
| Eye procedure - other | 3.9% | 211 | $26,813,543 | 2.4% | ( 0.7%) - 8.6% | 3.9% |
| Other tests - electrocardiograms | 6.1% | 2,741 | $23,042,840 | 0.7% | 4.8% - 7.5% | 4.9% |
| Standard imaging - musculoskeletal | 3.6% | 2,604 | $22,167,622 | 0.7% | 2.1% - 5.0% | 2.1% |
| All Codes With Less Than 30 Lines | 2.1% | 317 | $20,661,208 | 0.9% | 0.3% - 3.9% | 1.7% |
| Ambulatory procedures - skin | 1.7% | 1,610 | $19,525,549 | 0.4% | 0.9% - 2.5% | 1.5% |
| Minor procedures - skin | 1.6% | 1,479 | $18,602,855 | 0.8% | 0.2% - 3.1% | 0.5% |
| Specialist - psychiatry | 2.1% | 1,799 | $17,772,065 | 0.6% | 1.0% - 3.1% | 1.5% |
| Echography - other | 5.6% | 430 | $17,143,406 | 2.3% | 0.9% - 10.2% | 2.8% |
| Home visit | 9.9% | 173 | $15,377,435 | 2.6% | 4.8% - 15.0% | 6.6% |
| Other - Medicare fee schedule | 15.4% | 247 | $15,310,178 | 3.8% | 7.8% - 22.9% | 14.4% |
| Ambulatory procedures - other | 2.2% | 728 | $14,885,164 | 0.6% | 1.0% - 3.4% | 1.8% |
| Echography - heart | 1.2% | 1,689 | $14,537,855 | 0.4% | 0.5% - 2.0% | 0.8% |
| Standard imaging - other | 5.5% | 850 | $14,264,811 | 1.6% | 2.4% - 8.5% | 3.4% |
| Other tests - EKG monitoring | 11.0% | 129 | $13,717,186 | 7.0% | ( 2.6%) - 24.7% | 11.0% |
| Echography - abdomen/pelvis | 5.5% | 423 | $13,411,855 | 2.3% | 1.1% - 10.0% | 4.8% |
| Lab tests - automated general profiles | 4.2% | 2,851 | $12,431,727 | 0.6% | 2.9% - 5.4% | 3.0% |
| Dialysis services | 9.1% | 215 | $11,804,237 | 3.6% | 2.1% - 16.2% | 7.6% |
| Endoscopy - colonoscopy | 1.5% | 320 | $10,686,210 | 0.9% | ( 0.3%) - 3.2% | 1.3% |
| Oncology - other | 2.4% | 377 | $10,321,615 | 1.0% | 0.5% - 4.3% | 2.1% |
| Major procedure, cardiovascular-Other | 1.0% | 434 | $10,219,833 | 0.6% | ( 0.2%) - 2.3% | 0.9% |
| Other tests - cardiovascular stress tests | 3.0% | 540 | $9,950,665 | 1.4% | 0.4% - 5.7% | 1.5% |
| Lab tests - blood counts | 3.5% | 2,772 | $8,960,866 | 0.5% | 2.5% - 4.5% | 2.1% |
| Standard imaging - chest | 2.6% | 2,952 | $8,917,990 | 0.4% | 1.8% - 3.4% | 1.5% |
| Echography - carotid arteries | 3.5% | 261 | $8,403,015 | 2.6% | ( 1.5%) - 8.5% | 1.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Endoscopy - cystoscopy | 2.4% | 123 | $6,761,596 | 2.1% | ( 1.6%) - 6.5% | 2.4% |
| Lab tests - other (Medicare fee schedule) | 2.6% | 379 | $6,401,226 | 1.1% | 0.5% - 4.7% | 2.0% |
| Echography - eye | 4.8% | 204 | $5,021,605 | 3.0% | ( 1.1%) - 10.7% | 4.8% |
| Standard imaging - breast | 1.3% | 736 | $4,894,790 | 0.8% | ( 0.3%) - 3.0% | 0.4% |
| Lab tests - routine venipuncture (non Medicare fee schedule) | 3.2% | 5,378 | $4,786,838 | 0.3% | 2.6% - 3.8% | 2.1% |
| Imaging/procedure - heart including cardiac catheter | 3.3% | 401 | $4,672,225 | 2.1% | ( 0.8%) - 7.4% | 3.3% |
| Endoscopy - upper gastrointestinal | 1.1% | 238 | $4,464,053 | 0.8% | ( 0.4%) - 2.7% | 0.5% |
| Lab tests - urinalysis | 6.6% | 1,698 | $3,933,999 | 0.8% | 5.0% - 8.2% | 5.0% |
| Advanced imaging - CAT: head | 1.7% | 389 | $3,145,846 | 0.7% | 0.4% - 3.0% | 1.6% |
| Ambulatory procedures - musculoskeletal | 1.7% | 91 | $2,938,561 | 1.6% | ( 1.6%) - 4.9% | 1.7% |
| Imaging/procedure - other | 1.0% | 426 | $2,586,918 | 0.6% | ( 0.2%) - 2.2% | 0.7% |
| Advanced imaging - MRI: other | 0.2% | 358 | $2,520,730 | 0.2% | ( 0.2%) - 0.6% | 0.0% |
| Advanced imaging - MRI: brain | 0.4% | 243 | $2,458,535 | 0.2% | ( 0.1%) - 0.9% | 0.2% |
| Immunizations/Vaccinations | 1.1% | 2,075 | $1,898,934 | 0.5% | 0.1% - 2.0% | 1.0% |
| Other - non-Medicare fee schedule | 3.5% | 468 | $1,614,855 | 1.5% | 0.6% - 6.3% | 2.7% |
| Lab tests - bacterial cultures | 2.8% | 527 | $1,556,859 | 1.0% | 0.9% - 4.7% | 2.1% |
| Lab tests - glucose | 7.4% | 598 | $1,400,753 | 2.3% | 2.8% - 11.9% | 6.0% |
| Major procedure, orthopedic - Knee replacement | 0.5% | 34 | $1,385,312 | 0.5% | ( 0.5%) - 1.5% | 0.5% |
| Endoscopy - laryngoscopy | 2.7% | 45 | $1,098,557 | 0.4% | 2.0% - 3.5% | 2.7% |
| Endoscopy - other | 1.4% | 68 | $1,002,676 | 1.4% | ( 1.4%) - 4.1% | 1.4% |
| Standard imaging - contrast gastrointestinal | 0.5% | 138 | $596,812 | 0.4% | ( 0.2%) - 1.2% | 0.5% |
| Minor procedures - other (non-Medicare fee schedule) | 4.2% | 38 | $443,290 | 3.3% | ( 2.4%) - 10.7% | 4.2% |
| Eye procedure - cataract removal/lens insertion | 0.0% | 331 | $210,887 | 0.0% | ( 0.0%) - 0.0% | 0.0% |
| Medical/surgical supplies | 2.7% | 123 | $84,972 | 0.6% | 1.5% - 3.9% | 2.7% |
| Major procedure, orthopedic - other | 0.0% | 120 | $70,600 | 0.0% | ( 0.0%) - 0.0% | 0.0% |
| Endoscopy - arthroscopy | 0.0% | 33 | N/A | N/A | N/A | N/A |
| Eye procedure - treatment | 0.0% | 51 | N/A | N/A | N/A | N/A |
| Major procedure - explor/decompr/excisdisc | 0.0% | 47 | N/A | N/A | N/A | N/A |
| Major procedure, cardiovascular-Coronary angioplasty (PTCA) | 0.0% | 56 | N/A | N/A | N/A | N/A |
| Major procedure, cardiovascular-CABG | 0.0% | 33 | N/A | N/A | N/A | N/A |

| | | | | | | |
|---|---|---|---|---|---|---|
| Major procedure, cardiovascular-Pacemaker insertion | 0.0% | 38 | N/A | N/A | N/A | N/A |
| **All Type of Services (Incl. Codes Not Listed)** | **6.4%** | **113,798** | **$4,324,962,761** | **0.4%** | **5.5% - 7.2%** | **5.2%** |

**Table 13b: Paid Claims Error Rates by Service Type: DMERCs**

| Service Types Billed to DMERCs (SADMERC Policy Group) | Paid Claims Error Rate | | | | | |
|---|---|---|---|---|---|---|
| | Including No Doc Claims | Number of Line Items (Sample) | Projected Improper Payment Amount Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| Glucose Monitor | 14.3% | 2,490 | $145,486,263 | 1.3% | 11.7% - 16.8% | 12.4% |
| Lower Limb Prostheses | 16.4% | 81 | $88,395,664 | 10.0% | ( 3.2%) - 36.1% | 0.1% |
| Surgical Dressings | 67.8% | 216 | $85,723,445 | 10.7% | 46.8% - 88.8% | 33.5% |
| All Codes With Less Than 30 Lines | 7.7% | 274 | $67,819,588 | 4.2% | ( 0.6%) - 16.0% | 2.9% |
| Ostomy Supplies | 45.9% | 403 | $66,085,648 | 9.6% | 27.0% - 64.7% | 25.8% |
| Nebulizers & Related Drugs | 5.3% | 3,288 | $63,184,597 | 1.0% | 3.2% - 7.3% | 4.8% |
| Oxygen Supplies/Equipment | 2.7% | 2,665 | $59,823,076 | 0.5% | 1.8% - 3.7% | 1.4% |
| Enteral Nutrition | 8.2% | 500 | $44,986,224 | 2.6% | 3.0% - 13.4% | 7.3% |
| Support Surfaces | 22.2% | 113 | $33,995,608 | 10.1% | 2.3% - 42.0% | 8.7% |
| Immunosuppressive Drugs | 11.9% | 128 | $31,737,899 | 4.7% | 2.7% - 21.2% | 8.3% |
| CPAP | 9.1% | 548 | $22,966,181 | 2.2% | 4.7% - 13.4% | 7.7% |
| Lower Limb Orthoses | 13.3% | 167 | $17,326,786 | 6.3% | 1.1% - 25.6% | 11.2% |
| Diabetic Shoes | 5.6% | 200 | $9,766,303 | 2.5% | 0.7% - 10.6% | 5.6% |
| Wheelchairs Manual | 2.9% | 768 | $7,593,687 | 1.2% | 0.4% - 5.3% | 1.8% |
| Lenses | 6.2% | 443 | $5,464,826 | 2.1% | 2.1% - 10.3% | 4.0% |
| Hospital Beds/Accessories | 1.6% | 450 | $5,199,444 | 0.9% | ( 0.2%) - 3.4% | 0.6% |
| Urological Supplies | 8.7% | 258 | $4,087,742 | 4.3% | 0.3% - 17.1% | 7.9% |
| Upper Limb Orthoses | 9.7% | 67 | $3,468,988 | 5.2% | ( 0.5%) - 19.9% | 2.8% |
| Walkers | 3.8% | 173 | $3,308,561 | 1.8% | 0.4% - 7.3% | 3.3% |
| Breast Prostheses | 7.5% | 60 | $3,007,362 | 4.4% | ( 1.2%) - 16.2% | 7.5% |
| Commodes/Bed Pans/Urinals | 5.9% | 102 | $2,991,200 | 3.4% | ( 0.7%) - 12.6% | 3.7% |
| Wheelchairs Seating | 6.2% | 44 | $2,117,482 | 5.5% | ( 4.6%) - 16.9% | 6.2% |
| Infusion Pumps & Related Drugs | 1.2% | 124 | $1,646,407 | 1.2% | ( 1.1%) - 3.6% | 0.2% |
| Spinal Orthoses | 3.3% | 34 | $1,562,148 | 2.5% | ( 1.7%) - 8.3% | 0.0% |
| Patient Lift | 4.5% | 38 | $755,246 | 3.2% | ( 1.7%) - 10.8% | 4.5% |
| Wheelchairs | 0.4% | 471 | $586,294 | 0.2% | ( 0.0%) - 0.9% | 0.4% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Options/Accessories | | | | | | |
| Suction Pump | 5.3% | 36 | $436,969 | 4.3% | ( 3.2%) - 13.7% | 5.3% |
| Respiratory Assist Device | 0.2% | 66 | $204,061 | 0.2% | ( 0.2%) - 0.7% | 0.2% |
| Canes/Crutches | 1.0% | 46 | $91,850 | 1.1% | ( 1.0%) - 3.1% | 1.0% |
| Dialysis Supplies & Equipment | 0.0% | 37 | N/A | N/A | N/A | N/A |
| Orthopedic Footwear | 0.0% | 42 | N/A | N/A | N/A | N/A |
| Tracheostomy Supplies | 0.0% | 30 | N/A | N/A | N/A | N/A |
| _Misc Drugs_ | N/A | 41 | N/A | N/A | N/A | N/A |
| _Routinely Denied Items_ | N/A | 175 | N/A | N/A | N/A | N/A |
| **All Type of Services (Incl. Codes Not Listed)** | **8.6%** | **14,578** | **$779,819,548** | **0.9%** | **6.8% - 10.3%** | **4.9%** |

**Table 13c: Paid Claims Error Rates by Service Type: FIs**

| **Service Types Billed to FIs (Type of Bill)** | **Paid Claims Error Rate** | | | | | |
|---|---|---|---|---|---|---|
| | Including No Doc Claims | Number of Claims (Sample) | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| OPPS, Laboratory (an FI), Ambulatory (Billing an FI) | 4.3% | 47,725 | $861,895,367 | 0.4% | 3.5% - 5.0% | 3.7% |
| SNF | 4.5% | 2,916 | $742,066,217 | 0.6% | 3.3% - 5.6% | 4.1% |
| ESRD | 2.8% | 1,453 | $165,766,948 | 0.5% | 1.8% - 3.8% | 2.6% |
| HHA | 1.7% | 1,984 | $146,149,611 | 0.3% | 1.1% - 2.3% | 1.7% |
| Hospice | 2.1% | 920 | $112,713,377 | 0.7% | 0.7% - 3.5% | 2.0% |
| Other FI Service Types | 4.1% | 5,607 | $83,612,733 | 0.6% | 3.0% - 5.2% | 3.5% |
| Non-PPS Hospital In-patient | 1.2% | 2,228 | $50,658,301 | 0.4% | 0.3% - 2.1% | 0.9% |
| FQHC | 3.0% | 603 | $7,551,508 | 0.8% | 1.5% - 4.4% | 1.4% |
| RHCs | 1.8% | 3,317 | $7,058,272 | 0.3% | 1.2% - 2.4% | 1.1% |
| Free Standing Ambulatory Surgery | 1.2% | 80 | $2,757,616 | 0.9% | ( 0.5%) - 2.9% | 0.7% |
| **All Type of Services (Incl. Codes Not Listed)** | **3.4%** | **66,833** | **$2,180,229,950** | **0.2%** | **3.0% - 3.8%** | **3.1%** |

**Table 13d: Paid Claims Error Rates by Service Type: QIOs**

| PPS Acute Care Hospital Service Types Billed to QIOs(DRGs) | Paid Claims Error Rate | | | | | |
|---|---|---|---|---|---|---|
| | Including No Doc Claims | Number of Claims (Sample) | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims |
| CRAN AGE >17 W CC | 8.0% | 99 | $50,274,801 | 4.1% | 0.0% - 15.9% | 8.0% |
| CRAN AGE >17 W/O CC | 5.8% | 43 | $8,691,615 | 4.0% | ( 2.1%) - 13.6% | 5.8% |
| UNKNOWN | 1.5% | 77 | $2,543,291 | 1.4% | ( 1.3%) - 4.2% | 0.0% |
| PERIPH & CRAN NRV & OTH NRV SYS PROC W CC | 7.4% | 49 | $18,514,741 | 5.0% | ( 2.3%) - 17.1% | 7.4% |
| NRV SYS NEOPLS W CC | 5.3% | 54 | $6,602,729 | 3.4% | ( 1.3%) - 11.9% | 5.3% |
| DEGEN NRV SYS DISOR | 17.1% | 177 | $45,777,189 | 3.7% | 9.8% - 24.4% | 17.1% |
| INTRACRAN HEMOR & STROKE W INFARCT | 2.3% | 729 | $32,727,855 | 0.6% | 1.0% - 3.5% | 2.3% |
| NONSPEC CVA & PRECERE OCCL W/O INFARCT | 6.3% | 248 | $23,546,887 | 1.4% | 3.6% - 9.0% | 6.1% |
| NONSPEC CER-VAS DISOR W CC | 1.9% | 39 | $1,975,892 | 1.1% | ( 0.2%) - 4.0% | 1.9% |
| CRAN & PERIPH NRV DISOR W CC | 10.1% | 92 | $18,140,288 | 3.8% | 2.6% - 17.6% | 10.1% |
| NONTRAUM STUPOR & COMA | 17.2% | 36 | $8,735,641 | 10.9% | ( 4.1%) - 38.6% | 17.2% |
| SEIZURE & HEADACHE AGE >17 W CC | 10.1% | 209 | $35,685,425 | 2.8% | 4.7% - 15.6% | 9.6% |
| SEIZURE & HEADACHE AGE >17 W/O CC | 18.2% | 88 | $16,311,919 | 8.1% | 2.3% - 34.1% | 18.2% |
| TRAUM STUPOR & COMA,COMA <1 HR AGE >17 W CC | 4.0% | 52 | $5,027,600 | 4.0% | ( 3.8%) - 11.9% | 4.0% |
| OTH DISORNRV SYS W CC | 12.3% | 76 | $17,978,497 | 3.5% | 5.4% - 19.2% | 12.3% |
| OTH DISORNRV SYS W/O CC | 50.2% | 30 | $12,908,749 | 25.0% | 1.2% - 99.2% | 27.6% |
| DYSEQUILIBRIUM | 22.4% | 122 | $25,332,385 | 5.7% | 11.2% - 33.5% | 22.4% |
| OTITIS MEDIA & URI AGE >17 W CC | 13.6% | 62 | $7,662,634 | 6.5% | 0.9% - 26.3% | 13.6% |
| MAJ CHEST PROC | 0.0% | 141 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| OTH RESP SYS OR PROC W CC | 5.1% | 119 | $39,583,260 | 2.3% | 0.7% - 9.6% | 5.1% |
| PULM EMBOLISM | 1.1% | 169 | $3,556,993 | 0.7% | ( 0.3%) - 2.6% | 1.1% |
| RESP INFECTS & INFLAM AGE >17 W CC | 2.7% | 559 | $37,897,319 | 0.9% | 1.0% - 4.4% | 2.6% |
| RESP NEOPLS | 7.2% | 201 | $31,836,241 | 2.5% | 2.2% - 12.2% | 7.2% |
| PLEURAL EFFUSION W CC | 7.0% | 79 | $10,093,857 | 2.9% | 1.3% - 12.7% | 7.0% |
| PULM EDEMA & RESP FAILURE | 3.9% | 243 | $19,594,497 | 1.4% | 1.0% - 6.7% | 2.4% |
| CHRONIC OBS PULM DISEASE | 1.9% | 1318 | $37,172,133 | 0.4% | 1.2% - 2.6% | 1.9% |
| SIMPLE PNEU & PLEURISY AGE >17 W CC | 1.7% | 1836 | $50,117,502 | 0.3% | 1.1% - 2.3% | 1.6% |
| SIMPLE PNEU & PLEURISY AGE >17 W/O CC | 4.7% | 140 | $6,203,944 | 1.9% | 1.1% - 8.3% | 4.7% |

| | | | | | | |
|---|---|---|---|---|---|---|
| INTERSTITIAL LUNG DISEASE W CC | 2.8% | 63 | $2,909,019 | 1.7% | ( 0.6%) - 6.1% | 2.8% |
| PNEUMOTHORAX W CC | 0.0% | 43 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| BRONCHITIS & ASTHMA AGE >17 W CC | 2.4% | 165 | $5,411,457 | 0.8% | 0.8% - 4.1% | 2.0% |
| BRONCHITIS & ASTHMA AGE >17 W/O CC | 12.9% | 81 | $8,948,079 | 7.0% | ( 0.9%) - 26.7% | 12.9% |
| RESP SIGNS & SYM W CC | 33.1% | 85 | $25,228,678 | 12.9% | 7.7% - 58.4% | 33.1% |
| OTH RESP SYS DX W CC | 12.7% | 85 | $13,632,399 | 4.9% | 3.1% - 22.3% | 12.7% |
| CAR VALVE & OTH MAJ CAR-THOR PROC W CAR CATH | 1.5% | 68 | $15,146,327 | 1.4% | ( 1.4%) - 4.3% | 1.5% |
| CAR VALVE & OTH MAJ CAR-THOR PROC W/O CAR CATH | 0.1% | 120 | $986,093 | 0.1% | ( 0.1%) - 0.2% | 0.1% |
| COR BYPASS W CAR CATH | 0.0% | 254 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| OTH CAR-THOR PROC | 0.0% | 30 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| COR BYPASS W/O CAR CATH | 1.0% | 182 | $13,109,431 | 0.6% | ( 0.1%) - 2.2% | 0.8% |
| MAJ CAR-VAS PROC W CC | 1.4% | 182 | $18,475,590 | 1.0% | ( 0.5%) - 3.4% | 1.4% |
| MAJ CAR-VAS PROC W/O CC | 0.0% | 39 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| AMP-CIRC SYS DISOR EXC UP LIMB & TOE | 1.1% | 123 | $6,670,918 | 0.9% | ( 0.6%) - 2.9% | 1.1% |
| PRM CAR PACE IMPL W AMI/HF/SHCK/AICD LEAD/GEN PROC | 3.6% | 49 | $17,290,960 | 2.5% | ( 1.4%) - 8.5% | 3.6% |
| OTH PERMANENT CAR PACER IMPLANT | 6.4% | 324 | $106,660,784 | 2.0% | 2.5% - 10.2% | 6.4% |
| OTH CIRC SYS OR PROC | 9.9% | 100 | $51,615,571 | 3.1% | 3.8% - 16.0% | 9.4% |
| CIRC DISOR W AMI & MAJ COMP, DISCH ALIVE | 1.6% | 471 | $19,988,356 | 0.6% | 0.5% - 2.7% | 1.0% |
| CIRC DISOR W AMI W/O MAJ COMP, DISCH ALIVE | 5.2% | 246 | $11,943,823 | 2.0% | 1.3% - 9.2% | 5.2% |
| CIRC DISOR EXC AMI,W CARD CATH & COMPLEX DX | 5.4% | 417 | $51,123,102 | 1.8% | 1.8% - 8.9% | 5.4% |
| CIRC DISOR EXC AMI,W CARD CATH W/O COMPLEX DX | 17.9% | 331 | $95,642,678 | 3.5% | 11.1% - 24.7% | 16.2% |
| HEART FAILURE & SHOCK | 2.5% | 2078 | $91,771,878 | 0.5% | 1.5% - 3.4% | 2.4% |
| PERIPH -VAS DISOR W CC | 11.0% | 295 | $48,744,487 | 3.6% | 4.1% - 18.0% | 8.7% |
| PERIPH -VAS DISOR W/O CC | 10.5% | 82 | $6,828,041 | 3.8% | 3.0% - 18.0% | 10.5% |
| ATHEROSCLEROSIS W CC | 7.7% | 356 | $24,381,898 | 2.6% | 2.6% - 12.8% | 7.6% |
| ATHEROSCLEROSIS W/O CC | 30.3% | 30 | $5,139,692 | 13.3% | 4.3% - 56.4% | 24.6% |
| HYPERTENSION | 7.9% | 119 | $9,718,749 | 2.2% | 3.6% - 12.3% | 7.4% |
| CAR ARRHYTHMIA & CONDUCTION DISOR W CC | 3.9% | 693 | $33,288,633 | 0.8% | 2.2% - 5.5% | 3.6% |
| CAR ARRHYTHMIA & CONDUCTION DISOR W/O CC | 9.4% | 275 | $16,881,805 | 2.6% | 4.2% - 14.5% | 9.4% |
| ANGINA PECTORIS | 26.0% | 151 | $17,817,360 | 9.1% | 8.2% - 43.7% | 20.7% |
| SYNCOPE & COLLAPSE W CC | 5.7% | 341 | $26,883,327 | 1.4% | 2.9% - 8.5% | 5.7% |

| | | | | | | |
|---|---|---|---|---|---|---|
| SYNCOPE & COLLAPSE W/O CC | 14.4% | 172 | $21,056,774 | 3.2% | 8.0% - 20.7% | 13.9% |
| CHEST PAIN | 19.2% | 734 | $120,948,214 | 2.3% | 14.8% - 23.7% | 19.1% |
| OTH CIRC SYS DX W CC | 3.9% | 296 | $26,258,368 | 1.0% | 1.9% - 5.8% | 3.9% |
| RECTAL RESECTION W CC | 0.0% | 34 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| MAJ SMALL & LARGE BOWEL PROC W CC | 2.2% | 476 | $58,855,457 | 1.1% | ( 0.0%) - 4.4% | 1.0% |
| MAJ SMALL & LARGE BOWEL PROC W/O CC | 4.1% | 83 | $6,773,618 | 2.2% | ( 0.2%) - 8.4% | 4.1% |
| PERITONEAL ADHESIOLYSIS W CC | 2.7% | 72 | $10,244,930 | 1.9% | ( 1.1%) - 6.5% | 2.7% |
| STOM,ESOPH & DUOD PROC AGE >17 W CC | 0.8% | 93 | $5,609,403 | 0.6% | ( 0.3%) - 2.0% | 0.8% |
| STOM,ESOPH & DUOD PROC AGE >17 W/O CC | 24.0% | 34 | $11,299,330 | 23.5% | ( 22.0%) - 70.0% | 24.0% |
| HERNIA PROC EXC INGUIN & FEM AGE >17 W CC | 10.8% | 52 | $16,109,123 | 6.2% | ( 1.5%) - 23.0% | 10.8% |
| HERNIA PROC EXC INGUIN & FEM AGE >17 W/O CC | 14.4% | 32 | $7,146,637 | 9.4% | ( 4.0%) - 32.8% | 14.1% |
| INGUINL & FEMOR HERNIA PROC AGE >17 W CC | 9.1% | 35 | $6,129,437 | 5.1% | ( 0.8%) - 19.0% | 9.1% |
| OTH DIG SYS OR PROC W CC | 15.8% | 73 | $44,732,970 | 9.6% | ( 3.1%) - 34.7% | 7.7% |
| DIG W CC | 8.4% | 119 | $19,934,312 | 3.5% | 1.7% - 15.2% | 8.4% |
| G.I. HEMOR W CC | 4.5% | 846 | $64,056,181 | 0.9% | 2.7% - 6.3% | 4.3% |
| G.I. HEMOR W/O CC | 9.6% | 106 | $8,246,767 | 3.2% | 3.3% - 15.8% | 9.6% |
| COMPLICATED PEPTIC ULCER | 1.6% | 44 | $1,371,876 | 1.4% | ( 1.1%) - 4.3% | 1.6% |
| INFLAMMATORY BOWEL DISEASE | 3.4% | 35 | $2,908,315 | 2.3% | ( 1.0%) - 7.8% | 3.4% |
| G.I. OBSTRUCTION W CC | 5.7% | 297 | $26,492,746 | 2.2% | 1.5% - 10.0% | 5.7% |
| G.I. OBSTRUCTION W/O CC | 3.1% | 101 | $1,973,844 | 1.4% | 0.3% - 5.9% | 3.1% |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W CC | 13.9% | 890 | $173,704,625 | 1.6% | 10.8% - 17.1% | 13.8% |
| ESOPH,GASTROENT & MISC DIG DISOR AGE >17 W/O CC | 24.0% | 276 | $56,195,850 | 4.8% | 14.6% - 33.4% | 24.0% |
| OTH DIG SYS DX AGE >17 W CC | 9.0% | 284 | $50,191,983 | 2.1% | 4.8% - 13.1% | 8.8% |
| OTH DIG SYS DX AGE >17 W/O CC | 24.6% | 38 | $9,726,276 | 11.0% | 3.0% - 46.2% | 24.6% |
| CHOLE EXC BY LAP W/O C.D.E. W CC | 5.0% | 61 | $12,908,914 | 3.2% | ( 1.2%) - 11.1% | 5.0% |
| CIRRHOSIS & ALCIC HEPATITIS | 3.2% | 77 | $6,028,992 | 2.2% | ( 1.1%) - 7.5% | 3.2% |
| HEPATOBILIARY SYS/PANCREAS | 7.7% | 93 | $16,517,415 | 4.0% | ( 0.2%) - 15.5% | 6.1% |
| DISORPANCREAS EXC | 7.4% | 233 | $33,302,593 | 3.3% | 1.0% - 13.8% | 7.0% |
| DISORLIVER EXC MALIG,CIRR,ALC HEPA W CC | 3.0% | 100 | $6,335,059 | 1.7% | ( 0.3%) - 6.4% | 2.0% |
| DISORTHE BILIARY TRACT W CC | 6.5% | 94 | $13,746,989 | 3.3% | ( 0.1%) - 13.0% | 6.5% |

| | | | | | | |
|---|---|---|---|---|---|---|
| MAJ JOINT & LIMB REATTACH PROC - LOW EXT | 1.1% | 1680 | $58,499,306 | 0.4% | 0.3% - 1.9% | 0.8% |
| HIP & FEMUR PROC EXC MAJ JOINT AGE >17 W CC | 0.2% | 426 | $2,035,539 | 0.1% | ( 0.0%) - 0.3% | 0.1% |
| HIP & FEMUR PROC EXC MAJ JOINT AGE >17 W/O CC | 6.6% | 92 | $12,399,996 | 3.8% | ( 0.8%) - 14.1% | 6.6% |
| AMP-MUS-SKEL SYS & CON TISUE DISOR | 5.1% | 36 | $6,114,551 | 4.1% | ( 3.1%) - 13.2% | 5.1% |
| BIOPSIESMUS-SKEL SYS & CON TIS | 13.1% | 57 | $28,531,397 | 5.5% | 2.3% - 23.9% | 13.1% |
| WND DEB & SKN GRFT EXC HAND-MUS-SKEL & CON TIS DIS | 5.0% | 57 | $17,629,629 | 3.4% | ( 1.7%) - 11.8% | 5.0% |
| LOW EXT & HUM PROC EXC HIP,FT,FEMUR AGE >17 W CC | 0.5% | 110 | $1,367,592 | 0.3% | ( 0.0%) - 1.1% | 0.5% |
| LOW EXT & HUM PROC EXC HIP,FT,FEMUR AGE >17 W/O CC | 10.4% | 85 | $12,224,824 | 7.5% | ( 4.2%) - 25.1% | 3.8% |
| MAJ SHLD/ELBOW PROC,/OTH UP EXTITY PROC W CC | 17.2% | 34 | $12,886,597 | 11.5% | ( 5.3%) - 39.8% | 17.2% |
| SHLD,ELBOW/FOREARM PROC,EXC MAJ JOINT PROC,W/O CC | 22.9% | 37 | $9,929,707 | 9.9% | 3.4% - 42.3% | 22.9% |
| OTH MUS-SKEL SYS & CON TIS OR PROC W CC | 8.4% | 47 | $14,099,033 | 4.1% | 0.3% - 16.4% | 8.4% |
| OTH MUS-SKEL SYS & CON TIS OR PROC W/O CC | 3.5% | 36 | $1,698,677 | 2.5% | ( 1.3%) - 8.4% | 3.5% |
| FRACTURESHIP & PELVIS | 3.1% | 134 | $4,352,161 | 1.1% | 1.0% - 5.3% | 3.1% |
| PATHOLOGICAL FRACTURES & MUS-SKEL & CON TIS | 9.3% | 139 | $21,562,858 | 3.3% | 2.8% - 15.8% | 9.3% |
| CON TIS DISOR W CC | 5.4% | 30 | $5,297,236 | 3.1% | ( 0.8%) - 11.5% | 5.4% |
| MEDICAL BACK PROB | 24.3% | 340 | $93,340,159 | 3.4% | 17.6% - 31.1% | 24.2% |
| BONE DISEASES & SPEC ARTHROPATHIES W CC | 14.9% | 49 | $9,373,012 | 5.9% | 3.3% - 26.5% | 14.9% |
| SIGNS & SYMMUS-SKEL SYS & CON TISUE | 31.7% | 88 | $19,681,317 | 10.1% | 11.9% - 51.4% | 31.5% |
| TENDONITIS,MYOSITIS & BURSITIS | 9.6% | 51 | $6,630,316 | 3.4% | 2.9% - 16.3% | 9.6% |
| AFTERCARE,MUS-SKEL SYS & CON TIS | 6.5% | 43 | $3,407,576 | 3.3% | 0.1% - 12.9% | 6.1% |
| FX,SPRN,STRN & DISL UPARM,LOWLEG EX FT AGE >17 W CC | 16.2% | 61 | $15,267,487 | 6.4% | 3.7% - 28.6% | 16.2% |
| FX,SPRN,STRN&DISL UPARM,LOWLEG EX FT AGE >17 W/O CC | 36.2% | 33 | $7,139,321 | 14.6% | 7.5% - 64.9% | 36.2% |
| OTH MUS-SKEL SYS & CON TIS DX | 14.2% | 32 | $4,476,072 | 7.4% | ( 0.3%) - 28.8% | 14.2% |
| TOTAL MAST- W CC | 0.0% | 31 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| TOTAL MAST- W/O CC | 9.6% | 47 | $4,073,223 | 8.2% | ( 6.6%) - 25.8% | 9.6% |

| | | | | | | |
|---|---|---|---|---|---|---|
| SKIN GRFT &/OR DEBRID-SKN ULCER/CELLUL W CC | 3.8% | 74 | $11,323,219 | 2.6% | ( 1.3%) - 8.9% | 3.6% |
| SKIN ULCERS | 23.2% | 72 | $27,549,346 | 7.5% | 8.5% - 38.0% | 20.7% |
| CELLULITIS AGE >17 W CC | 1.6% | 320 | $8,010,530 | 0.6% | 0.3% - 2.8% | 1.6% |
| CELLULITIS AGE >17 W/O CC | 11.4% | 117 | $9,703,302 | 5.4% | 0.9% - 22.0% | 11.4% |
| TRAUMSKIN,SUBCU TISS & BREAST AGE >17 W CC | 19.8% | 60 | $13,895,122 | 5.6% | 8.9% - 30.7% | 19.8% |
| OR PROC-OBESITY | 2.0% | 31 | $2,653,143 | 1.9% | ( 1.8%) - 5.7% | 0.0% |
| DIABETES AGE >35 | 12.6% | 291 | $51,975,787 | 3.1% | 6.6% - 18.7% | 12.6% |
| NUT & MISC METAB DISOR AGE >17 W CC | 9.8% | 797 | $113,667,162 | 1.4% | 7.0% - 12.5% | 9.6% |
| NUT & MISC METAB DISOR AGE >17 W/O CC | 15.3% | 146 | $16,903,661 | 3.9% | 7.7% - 22.9% | 15.3% |
| ENDOCRINE DISOR W CC | 7.5% | 88 | $9,974,104 | 5.0% | ( 2.3%) - 17.3% | 7.5% |
| KID,URETER & MAJ BLSD PROC-NEOPL | 0.0% | 59 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| KID,URETER & MAJ BLSD PROC-NON-NEOPL W CC | 17.8% | 45 | $38,026,078 | 11.1% | ( 3.8%) - 39.5% | 17.8% |
| TRANSURETHRAL PROC W CC | 11.4% | 93 | $19,127,700 | 5.2% | 1.2% - 21.6% | 11.4% |
| OTH KID & URINARY TRACT OR PROC | 10.6% | 115 | $51,368,631 | 3.0% | 4.6% - 16.6% | 10.6% |
| RENAL FAILURE | 4.7% | 500 | $58,496,330 | 1.2% | 2.3% - 7.1% | 4.7% |
| KID & URINARY TRACT INFECTS AGE >17 W CC | 4.2% | 638 | $42,242,171 | 1.0% | 2.3% - 6.1% | 3.9% |
| KID & URINARY TRACT INFECTS AGE >17 W/O CC | 19.3% | 95 | $16,678,089 | 6.3% | 7.0% - 31.7% | 19.3% |
| URINARY STONES W CC,&/OR ESW LITHOTRIPSY | 14.0% | 65 | $11,798,986 | 5.5% | 3.1% - 24.9% | 14.0% |
| OTH KID & URINARY TRACT DX AGE >17 W CC | 9.5% | 159 | $32,140,109 | 4.9% | ( 0.1%) - 19.0% | 9.5% |
| MAJ MALE PELVIC PROC W CC | 1.1% | 42 | $882,391 | 0.8% | ( 0.5%) - 2.6% | 1.1% |
| MAJ MALE PELVIC PROC W/O CC | 3.5% | 36 | $2,378,616 | 2.4% | ( 1.3%) - 8.2% | 3.5% |
| TRANSURETHRAL PROSTAT W CC | 1.0% | 109 | $1,479,691 | 0.6% | ( 0.2%) - 2.2% | 0.4% |
| TRANSURETHRAL PROSTAT W/O CC | 1.5% | 82 | $1,059,974 | 0.7% | 0.1% - 2.8% | 1.5% |
| FEMALE REPROD SYS RECONS PROC | 16.3% | 89 | $14,604,972 | 8.4% | ( 0.3%) - 32.8% | 16.3% |
| UTER & ADNEXA PROC-NON- W CC | 3.7% | 65 | $5,084,603 | 2.2% | ( 0.5%) - 8.0% | 3.7% |
| UTER & ADNEXA PROC-NON- W/O CC | 2.2% | 98 | $2,550,767 | 1.2% | ( 0.1%) - 4.6% | 2.2% |
| VAGINA,CERVIX & VULVA PROC | 4.4% | 57 | $2,969,204 | 3.1% | ( 1.6%) - 10.4% | 4.4% |
| RED BLOOD CELL DISOR AGE >17 | 6.9% | 336 | $35,004,777 | 1.8% | 3.3% - 10.5% | 6.9% |
| COAGULATION DISOR | 4.8% | 55 | $7,724,201 | 2.1% | 0.7% - 9.0% | 4.8% |
| RETICULOENDOTHELIAL & IMMUNITY DISOR W CC | 1.8% | 66 | $2,365,569 | 1.4% | ( 0.9%) - 4.5% | 1.8% |
| LYMPHOMA & NON-ACUTE | 2.9% | 97 | $9,005,859 | 1.6% | ( 0.3%) - 6.1% | 2.9% |

| | | | | | | |
|---|---|---|---|---|---|---|
| LEUK W CC | | | | | | |
| CHEMOTHAPY W/O ACUTE LEUK AS SEC DX | 5.3% | 69 | $10,864,315 | 3.0% | ( 0.6%) - 11.1% | 5.3% |
| OR PROC-INFECTIOUS & PARASITIC DISEASES | 0.6% | 142 | $6,196,475 | 0.3% | 0.0% - 1.1% | 0.6% |
| SEPTICEMIA AGE >17 | 2.1% | 644 | $36,812,372 | 0.5% | 1.1% - 3.1% | 2.0% |
| POSTOPERATIVE & POST-TRAUM INFECTS | 3.0% | 107 | $5,449,805 | 1.4% | 0.2% - 5.9% | 2.7% |
| FEVERUNKNOWN ORIGIN AGE >17 W CC | 8.6% | 60 | $6,682,407 | 4.9% | ( 1.1%) - 18.3% | 8.6% |
| VIRAL ILL AGE >17 | 3.5% | 45 | $1,651,624 | 2.1% | ( 0.6%) - 7.5% | 3.5% |
| ACUTE ADJUST REACT & PSYCHOSOC DYSFUNCT | 23.0% | 65 | $11,871,293 | 9.5% | 4.4% - 41.5% | 23.0% |
| ORGAN DISTURB & MENTAL RETARD | 18.0% | 86 | $19,943,046 | 8.2% | 2.0% - 34.0% | 18.0% |
| PSYCHOSES | 5.6% | 196 | $17,128,277 | 2.6% | 0.5% - 10.7% | 2.0% |
| OTH OR PROC-INJURIES W CC | 4.2% | 59 | $11,417,659 | 2.3% | ( 0.4%) - 8.8% | 4.2% |
| POISON & TOXIC EFFECTSDRUGS AGE >17 W CC | 5.3% | 138 | $8,953,835 | 1.6% | 2.1% - 8.4% | 5.3% |
| COMPLICATIONSTREATMENT W CC | 6.3% | 87 | $10,671,104 | 3.4% | ( 0.3%) - 12.8% | 6.3% |
| SIGNS & SYM W CC | 19.7% | 110 | $22,172,015 | 4.6% | 10.7% - 28.8% | 19.7% |
| EXT OR PROC UNRELATEDPRIN DX | 4.5% | 161 | $53,564,435 | 1.7% | 1.2% - 7.9% | 4.5% |
| BILAT/MULT MAJ JOINT PROC LOW EXTITY | 0.0% | 41 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| RESP SYS DX WITH VENTILATOR SUPPORT | 0.9% | 335 | $15,423,101 | 0.5% | ( 0.1%) - 1.9% | 0.9% |
| NON-EXT OR PROC UNRELATEDPRIN DX | 15.5% | 75 | $44,643,481 | 5.6% | 4.6% - 26.5% | 15.5% |
| OTH -VAS PROC W CC | 5.5% | 344 | $90,291,762 | 1.5% | 2.5% - 8.4% | 4.9% |
| OTH -VAS PROC W/O CC | 10.7% | 90 | $21,415,470 | 4.6% | 1.7% - 19.6% | 10.7% |
| TRACH W VENT 96+ HRS/PDX EXC FACE,MTH & NECK DX | 0.6% | 122 | $18,753,796 | 0.6% | ( 0.5%) - 1.6% | 0.6% |
| HIV W MAJ RELATED CONDITION | 1.4% | 34 | $2,385,683 | 1.3% | ( 1.1%) - 3.9% | 0.1% |
| MAJ JOINT & LIMB REATTACHMENT PROCUP EXTITY | 1.0% | 77 | $1,943,109 | 1.0% | ( 1.0%) - 3.0% | 0.0% |
| LAPAROSCOPIC CHOLE W/O C.D.E. W CC | 5.2% | 209 | $33,235,425 | 2.5% | 0.4% - 10.1% | 5.2% |
| LAPAROSCOPIC CHOLE W/O C.D.E. W/O CC | 21.4% | 66 | $29,223,451 | 9.1% | 3.6% - 39.3% | 21.4% |
| SPINAL FUSION EXC CERVICAL W CC | 4.7% | 94 | $26,857,899 | 3.5% | ( 2.2%) - 11.7% | 4.7% |
| SPINAL FUSION EXC CERVICAL W/O CC | 0.0% | 63 | $0 | 0.0% | 0.0% - 0.0% | 0.0% |
| BACK & NECK PROC EXC SPINAL FUSION W CC | 2.5% | 129 | $7,451,295 | 1.4% | ( 0.1%) - 5.2% | 2.5% |
| BACK & NECK PROC EXC SPINAL FUSION W/O CC | 3.7% | 173 | $8,907,222 | 1.5% | 0.8% - 6.7% | 3.7% |

| | | | | | | |
|---|---|---|---|---|---|---|
| CAR DEFIBRILLATOR IMPLANT W/O CAR CATH | 1.8% | 64 | $14,644,448 | 1.3% | ( 0.7%) - 4.4% | 1.8% |
| PERCU CAR-VAS PROC W AMI | 0.9% | 175 | $6,720,615 | 0.7% | ( 0.4%) - 2.3% | 0.9% |
| PERCU CAR-VAS PROC W NON-DRUG ELUT STENT W/O AMI | 3.6% | 313 | $39,214,061 | 1.5% | 0.6% - 6.7% | 3.6% |
| PERCU CARVASC PROC W/O COR ARTERY STENT/AMI | 7.3% | 137 | $33,476,204 | 3.1% | 1.3% - 13.3% | 7.3% |
| CERVICAL SPINAL FUSION W CC | 0.6% | 41 | $1,023,035 | 0.5% | ( 0.3%) - 1.5% | 0.6% |
| CERVICAL SPINAL FUSION W/O CC | 2.4% | 50 | $3,086,837 | 2.4% | ( 2.2%) - 7.1% | 0.0% |
| ALC/DRUG ABUSE/DEPEN W CC | 10.2% | 107 | $13,369,709 | 4.6% | 1.2% - 19.1% | 10.2% |
| ALC/DRUG ABUSE/DEPEN W/O REHAB THERAPY W/O CC | 0.3% | 33 | $94,339 | 0.3% | ( 0.2%) - 0.8% | 0.3% |
| TRANSIENT ISCHEMIA | 11.7% | 388 | $51,546,349 | 2.5% | 6.7% - 16.6% | 11.7% |
| PERCU CAR-VAS PROC W DRUG-ELUT STENT W AMI | 0.3% | 170 | $2,204,650 | 0.2% | ( 0.1%) - 0.6% | 0.3% |
| PERCU CAR-VAS PROC W DRUG-ELUT STENT W/O AMI | 2.6% | 509 | $64,771,582 | 0.9% | 0.7% - 4.5% | 2.5% |
| EXTRACRAN PROC W CC | 1.7% | 110 | $5,937,371 | 1.3% | ( 0.9%) - 4.3% | 1.7% |
| EXTRACRAN PROC W/O CC | 0.4% | 103 | $746,712 | 0.3% | ( 0.2%) - 0.9% | 0.4% |
| CAR DEFIB IMPLANT W CAR CATH W/O AMI/HF/SHOCK | 0.5% | 44 | $3,158,000 | 0.3% | ( 0.1%) - 1.1% | 0.5% |
| **Overall** | **5.2%** | **N/A** | **$4,845,769,323** | **0.2%** | **4.9% - 5.5%** | **4.9%** |

# CONTACT INFORMATION

### Program Integrity Mission

To preserve and protect the integrity of the CMS programs by proactively developing strategies to identify, deter, and prevent fraud, waste, and abuse through effective partnerships with public and private entities.

### Data Analysis and Evaluation Mission

To guide Program Integrity by providing information to decision-makers through data analyses, improper payment and error rate measurements of CMS programs, management of program integrity funds, and the promotion of efficient practices in a manner commensurate with the Group's goals.

### CMS Contacts

See www.cms.hhs.gov/cert to obtain additional copies of this report.
**CMS CERT Contacts**: Melanie Combs and Jill Nicolaisen (CERT@cms.hhs.gov)
**CMS HPMP Contact**: Anita Bhatia (anita.bhatia@cms.hhs.gov)
**CMS Public Affairs Contact**: Peter Ashkenaz (peter.ashkenaz@cms.hhs.gov)