Improper Medicare Fee-For-Service Payments Report - November 2005 Short 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 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

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.

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.

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[1]

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%

[1] 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 summarizes the overpayments, underpayments, improper payments, and error rates by contractor type.

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 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

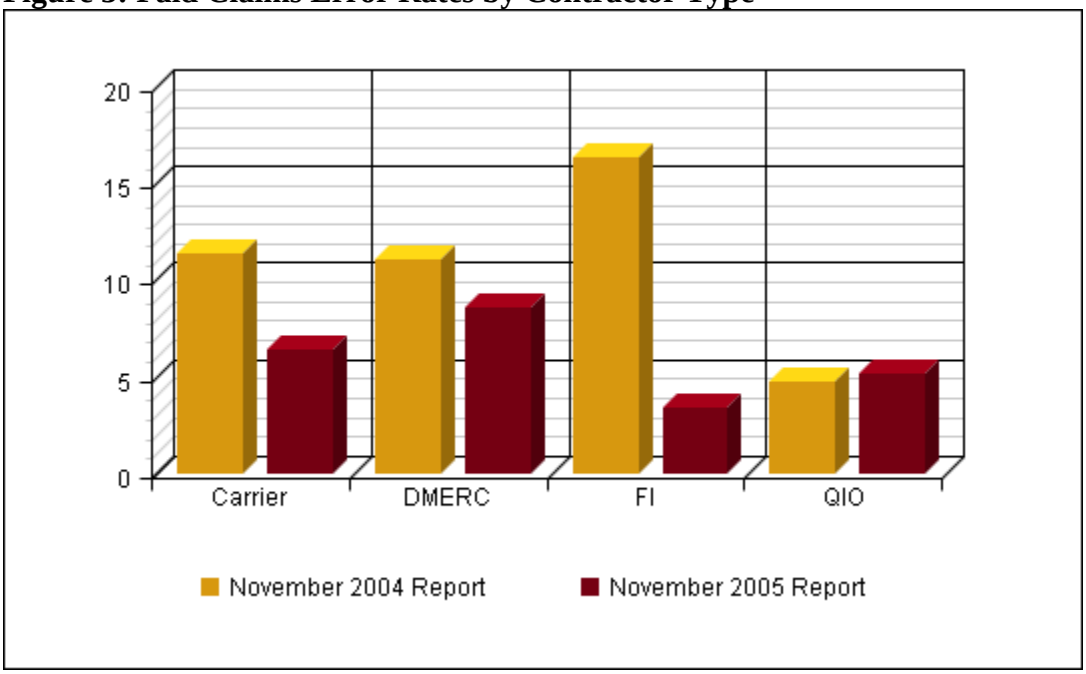
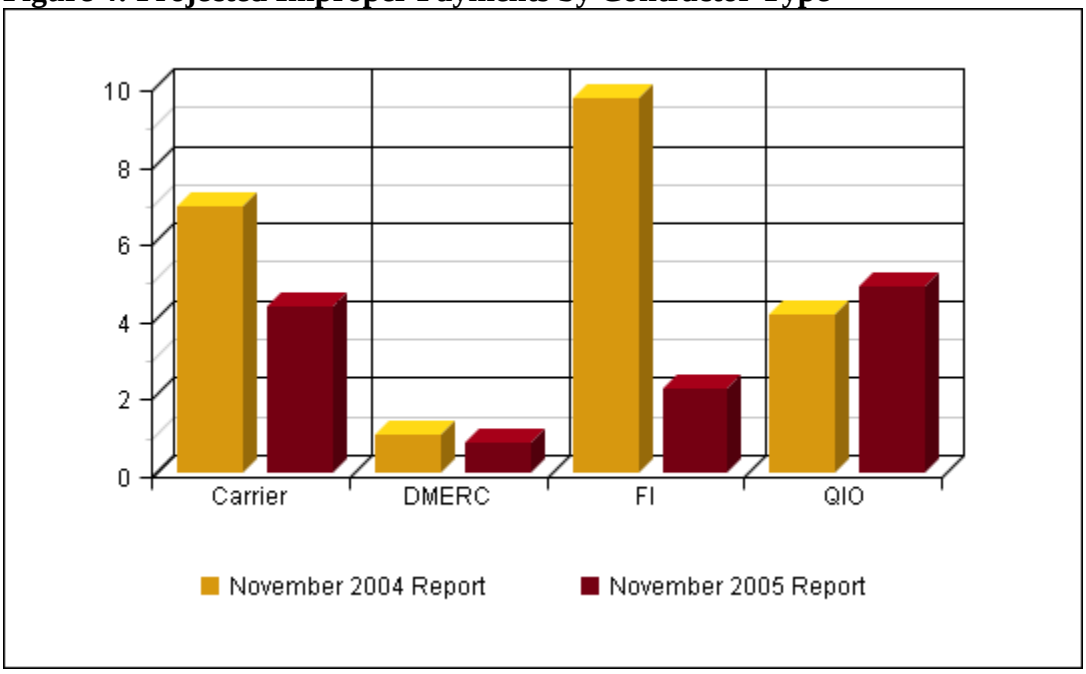


Figure 4: Projected Improper Payments by Contractor Type



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/WA 00831/00832/00833/00834/00835/00836	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 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[2]

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

[2] 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.

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
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.

Q & A

Q1. What was the reporting period for this report?
A1. For Carriers/DMERCs/FIs, the report included claims submitted between 01/01/04 and 12/31/04. For QIOs, the report included inpatient PPS hospital discharges between 7/1/03 and 6/30/04.

Q2. Will these rates be updated to reflect late documentation?
A2. Yes. Although CMS will not amend the written report, the rates will be revised in a single October 2006 report update to reflect late documentation. The updates will be available at www.cms.hhs.gov/cert.

Q3. Why did the error rate go from 10.1% in 2004 to 5.2% in 2005?
A3. 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.

Q4. How has CMS fixed the no documentation and insufficient documentation problem?
A4. The CMS significantly improved both the no documentation and the insufficient documentation problem from 2004 to 2005, with 0.7% and 1.1% respective error rates. The corrective actions conducted by CMS in order to combat the no documentation and insufficient documentation issues appear to have been successful.

CMS took the following corrective actions in 2004 to address the non-response problem:

1. 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 required Carriers/DMERCs/FIs to assist in the process of contacting non-responding providers to encourage them to respond.
3. CMS revised the letters requesting medical records by emphasizing that faxing is the most effective way to submit medical records. The CERT contractor has established a fax line for providers that wish to fax medical records rather than mail them.
4. CMS required the CERT contractor to implement an appeals tracking system. The CERT contractor used the appeals information to adjust the errors when the provider appealed a CERT decision and the appeals review concluded that the claim had been correctly processed. 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 non-response. However, because this new system was not in place until late in the year, some of the Carriers/DMERCs/FIs were unable to enter all their appeals of CERT denials prior to the cut-off date for this report. The January update report will contain error rates that include these late appeals.

5. Carriers/DMERCs/FIs provided lists of non-responders with high dollar claims to the OIG for follow-up.
6.

Q5. What educational efforts is CMS undertaking to help lower the error rate?

A5. CMS continues to develop Medicare provider educational material with the official CMS brand, "The Medicare Learning Network". As part of this initiative, CMS has developed over 250 national provider education articles annually which outline, on a flow basis and in plain language, the coverage, billing and coding rules associated with Medicare program changes. These articles can be easily accessed through a search engine on www.cms.hhs.gov/medlearn/matters, which will pull articles, by year, based on user entered key words or phrases.

In 2005 CMS will step up its efforts to expand the current FAQ database available on http://www.cms.hhs.gov/ by generating and posting FAQs of interest to FFS Medicare providers. FAQs will be automatically generated from Medlearn Matters article, solicited from FIs and carriers (who interact directly with the providers who bill them), and from over 50 national associations.

As part of the effort to centrally locate information and make it easily accessible, CMS has established customized provider webpages on www.cms.hhs.gov/providers that house much of the information individual provider types need including links to relevant program instructions, FAQs, and educational resource material.

Q6. Why is CMS presenting gross error rates rather than net error rates?

A6. In order to promote consistency in improper payment reporting across federal agencies, Improper Payments Information Act (IPIA) requires agencies to follow a number of methodological requirements when calculating error rates and improper payment estimates. IPIA mandates that agencies use gross figures when reporting improper payment amounts and rates. In the past, the OIG and CMS reported Medicare FFS error rates and improper payment estimates using net figures. A gross improper payment amount is calculated by adding underpayments to overpayments. A net improper payment amount is calculated by subtracting underpayments from overpayments. All of the numbers reported in the November 2005 report are gross.

Q7. Why can't some of the improper payments from the 2005 report be compared to the 2004 report?

A7. In previous reports the CERT program and the HPMP calculated improper payment estimates in a slightly different manner. Unlike HPMP, the CERT program did not exclude coinsurance and deductibles from the payment data used to calculate projected improper payments. This issue specifically effected contractor, service type, and provider type estimates. In earlier reports, the national improper payment estimates excluded coinsurance and

deductibles, while other CERT only estimates included them. For consistency and accuracy, the CERT program switched to excluding coinsurance and deductibles in all of its calculations for the 2005 report. This change does not impact comparisons of the current paid claims error rate to previous reports. The exclusion of coinsurance and deductibles effects all of the payment totals used in CERT calculations equally; therefore, the paid claims error rate is unaffected by this change.

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.

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