Improper Medicare Fee-For-Service Payments Report - November 2006

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 approximately 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.

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 for publication in November 2003.

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

- CERT randomly selecting a sample of 139,312 claims submitted to Carriers/DMERCs/FIs during the reporting period.
- HPMP randomly selecting a sample of 40,982 acute care inpatient hospital discharges.
- 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*. The following table outlines the reporting periods to date for improper payment reports as well as any 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 occurring in the 12 month period ending March 31, 2002
November 2004	Claims submitted in the 12 month period ending December 31, 2003	Discharges occurring in the 12 month period ending June 30, 2003
November 2005	Claims submitted in the 12 month period ending December 31, 2004	Short-term Acute Care: Discharges occurring in the 12 month period ending June 30, 2004 Long-term Acute Care and Denied Claims: Claims processed in the 12 month period ending December 31, 2004
November 2006	Claims submitted in the 12 month period ending March 31, 2006	Discharges occurring in the 12 month period ending December 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. One requirement is the use of gross figures when reporting improper payment amounts and rates. A gross improper payment amount is calculated by **adding** underpayments to overpayments. Unless labeled otherwise, figures in this report are gross figures; historical figures that were originally reported as net numbers have been converted for consistency.

Summary of Findings

National Error Rate

This report shows that 4.4% of the dollars paid nationally did not comply with one or more Medicare coverage, coding, billing, and payment rules. Projected overpayments were $9.8 B and the underpayments were $1.0 B. Thus, gross improper payments were projected as $10.8 B (i.e., $9.8 B **plus** $1.0 B).

Contractor Type Error Rates

The following table displays the error rates and improper payment amounts for the Medicare FFS Program for this reporting period.

Error Rates and Projected Improper Payments by Contractor Type

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$72.9B	$3.5B	4.8%	$0.2B	0.2%	$3.7B	5.0%
DMERC	$9.2B	$0.7B	7.4%	$0B	0.1%	$0.7B	7.5%
FI	$63B	$1.3B	2.0%	$0.2B	0.3%	$1.5B	2.3%
QIOs	$101.7B	$4.3B	4.3%	$0.6B	0.6%	$4.9B	4.9%
All Medicare FFS	**$246.8B**	**$9.8B**	**4.0%**	**$1B**	**0.4%**	**$10.8B**	**4.4%**

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.

The following table lists the contractor, provider, and service type with the highest error rates and improper payments. When comparing contractors, services, or provider types, it is important to note that the highest error rate does not necessarily indicate 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	14.5%	$90.5 M	First Coast Service Options FL, Carrier	$922.1 M	11.9%
Error Rates by Service Type	Surgical Dressings	75.7%	$176.3 M	OPPS/Laboratory/ Ambulatory	$752.0 M	4.0%
Error Rates by Provider Type	Obstetrics/Gynecology	23.8%	$136.6 M			

Goals

One of the performance goals for CMS is the reduction of improper payments made under the FFS program to 5.1% or less by the November 2006 reporting period. Based on the findings in the report, CMS has exceeded this goal by a large margin. The current error rate of 4.4% exceeds the performance goal for the 2008 reporting period. Because of this dramatic improvement, CMS is revising this goal for future years.

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. Continuing one-on-one educational contacts with providers with indicators of high levels of payment errors,
3. Developing projects with the QIOs addressing state-specific admissions necessity, coding, and billing concerns,
4. Distributing FATHOM generated hospital-specific reports,
5. Developing and distributing QIO-specific payment error cause analyses,
6. Conducting national training on the use of FATHOM reports in compliance efforts, and
7. Providing monthly updates to QIO-specific and national error rates.

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 has accelerated the sampling and review process; beginning in 2006 the interval between the last sampled claim for a report and it's publication has been reduced from 11 months to 8 months.
2. 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).
3. 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.

4. 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. The full impact of this change will not be seen until 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) 2005, more than 43 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 $339.4 B.[1] The Medicare budget represents almost 15% 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 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 in this reporting period was 139,312 paid and denied claims. The sample size for error rates concerning QIOs for the reporting period was 40,982 discharges.

[1] 2006 CMS Statistics: U.S. Department of Health and Human Services, CMS pub. No 03455, October 2006

Types of Error Rates Produced

To better measure the performance of the Carriers/DMERCs/FIs 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. This rate includes fully denied claims for Carriers/DMERCs/FIs/QIOs. The paid claims error rate is the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied and is a good indicator of how claim errors in the Medicare FFS Program impact the trust fund. CMS calculated the gross rate by adding underpayments to overpayments and dividing that sum by total dollars paid.

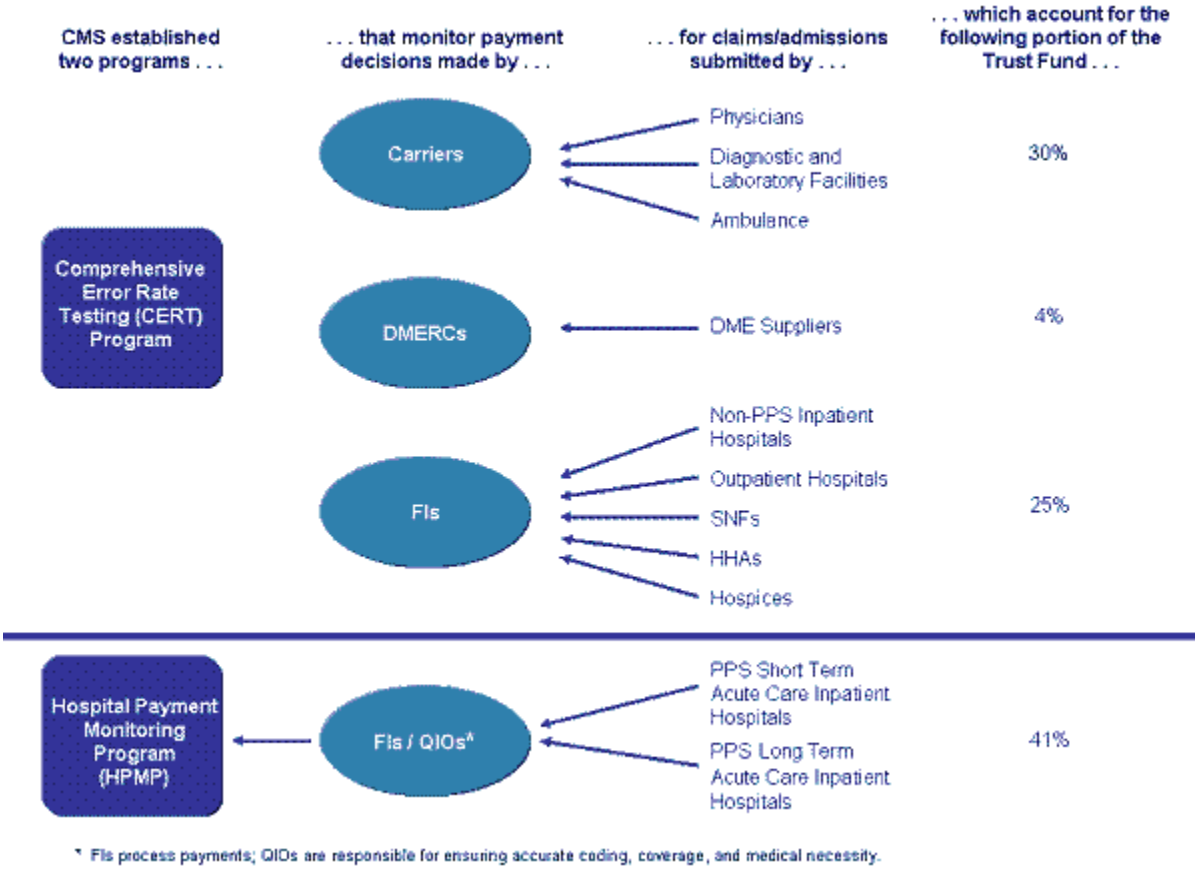
Provider Compliance Error Rate

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. CMS does not collect covered charge data from FIs; therefore, current FI data is insufficient for calculating a provider compliance error rate. This rate is not generated for QIOs.

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 prospective payment system (PPS) short-term and long-term acute care inpatient hospital discharges. The CERT program monitors all other claims. The following figure (Figure 1) 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 Produced
CERT	Carrier/DMERC/FI	✓	✓
	Carrier-Specific	✓	✓
	DMERC-Specific	✓	✓
	FI-Specific	✓	Not Produced
	Type of Service	✓	✓
	Type of Provider	✓	✓
HPMP	QIO Specific	✓	Not Produced
	Type of Service	✓	Not Produced
	Type of Provider	✓	Not Produced

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 139,312 claims from Carriers/DMERCs/FIs. The CERT Contractor randomly selected about 187 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 30 days, the CERT Contractor sent up to three subsequent letters in addition to follow-up 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 attempted to complete the review process before the final production of the report. Claims that completed the review process were included in the report. Claims for which the CERT contractor received no documentation were counted as no documentation errors.

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. 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. As of the November 2005 report, all Carriers/DMERCs/FIs have the opportunity to ensure that all overturned appeals are entered into the appeals tracking system in sufficient time for production of the error rates.

Variation from the General Methodology

Readers should note that the CERT sample spans from April 2005 to March 2006 while CMS payment data is reported by calendar year. Therefore, the CERT program used payment data from calendar year 2005 to generate the projected improper payments in this report.

CERT also purposefully reduced the samples size for certain contractors during the last four months of sampling period. This reduction was performed because of an increase in percentage of claims that were reviewable versus those that were not. The resources required to review claims limit the number of claims that can be reviewed in the time allotted for the report. The reduction was necessary in order to stay within the budgeted sample size. Although this action led to claims being sampled at different levels within the sample period for some contractors, CERT analyzed the impact of this issue and determined that the standard estimation methodology did not need to be altered.

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.

The following jurisdictions transitioned contractors during the reporting period:

Carefirst MD/DC to Highmark Medicare Services MD/DC
Medicare NW UT/OR/ID to Noridian UT/OR/ID
Regence UT to Noridian UT

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 40,982 claims from 52 states and jurisdictions (all 50 states plus Puerto Rico and Washington, D.C.).

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 error rates were weighted 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.

Since error rates are calculated as the sum of overpayments and underpayments divided by the original dollars paid, estimated error rates >100% are possible. In particular, this situation can occur when very large underpayments are found among sampled records. The size of the associated confidence interval which represents the extent of variability should always be considered when evaluating estimated payment error rates.

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

In the CERT program, Carriers/DMERCs/FIs are notified of detected overpayments so that they can implement the necessary adjustments. Carriers/DMERCs/FIs are also notified of underpayments but they are not currently required to make payments to providers for underpayments identified in the CERT program. Carriers/DMERCs/FIs are encouraged to make payments to providers in underpayment cases identified by the CERT program. For more information about overpayments see Appendix F, for underpayments, see Appendix G. Sampled claims for which providers failed to submit documentation were considered overpayments.

QIOs in the HPMP notified FIs of adjustments necessary due to overpayment and underpayment errors identified by the program. When a QIO determined that a DRG coding change was required, the FI was also informed of the appropriate DRG. In addition, the FI was 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 were responsible for determining payment adjustments for claims found to be in error. The QIOs did not determine adjustment amounts nor did they 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 $214.9 M in appeals reversals from the error rates contained in this 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. All known appeal determinations that reversed a QIO's decision are considered when computing error rates.

The CERT program identified $983,871 in actual overpayments and, as of the final cut-off date for this report, Carriers/DMERCs/FIs had collected $635,803 of those overpayments. The HPMP identified $14.5 M in overpayments and, as of the final cutoff date for this report, the FIs had processed $10.8 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 2006, reduce the percent of improper payments under Medicare FFS to 5.1%.

  STATUS: <u>This goal was met</u>. The national paid claims error rate for the November 2006 reporting period was 4.4%. Because of the dramatic decrease in the paid claims error rate, CMS has revised the goal for future years.
- By November 2007, reduce the percent of improper payments under Medicare FFS to 4.3%.
- By November 2008, reduce the percent of improper payments under Medicare FFS to 4.2%.
- By November 2009, reduce the percent of improper payments under Medicare FFS to 4.1%.

2. Reduce the Contractor-Specific Paid Claim Error Rate

- 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.

  STATUS: <u>This goal was met.</u> During the November 2006 reporting period, 81% 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 2005 (5.2%).
- 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 2006, decrease the Provider Compliance Error Rate 20% over the November 2005 level.

  STATUS: <u>This goal was not met</u>. Due to system limitations, CMS did not collect covered charge data from FIs during this reporting period. CMS was therefore unable to produce this rate for FIs during the November 2006 reporting period. The DMERC provider compliance error rate increased by 4% and the Carrier provider compliance error rate declined by 3% when compared to their 2005 levels.
- 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. 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 this reporting period is 4.4% (which equates to $10.8 B). The 95% confidence interval for Medicare FFS program paid claims error rate was 4.0% - 4.7%. The 90% confidence interval (required to be reported by IPIA) was 4.1% - 4.6%.

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

Table 3a: Error Rates and Projected Improper Payments by Contractor Type

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$72.9B	$3.5B	4.8%	$0.2B	0.2%	$3.7B	5.0%
DMERC	$9.2B	$0.7B	7.4%	$0B	0.1%	$0.7B	7.5%
FI	$63B	$1.3B	2.0%	$0.2B	0.3%	$1.5B	2.3%
QIOs	$101.7B	$4.3B	4.3%	$0.6B	0.6%	$4.9B	4.9%
All Medicare FFS	**$246.8B**	**$9.8B**	**4.0%**	**$1B**	**0.4%**	**$10.8B**	**4.4%**

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

Table 3b: 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%

[2] The 2003 entries were adjusted to account for high non-response rates. Including non-response, the national projected improper payments would have been $21.5B and the national paid claims error rate would have been 10.8%.

2005	$234.1 B	$11.2 B	4.8%	$0.9 B	0.4%	$12.1 B	5.2%
2006	$246.8 B	$9.8 B	4.0%	$1.0 B	0.4%	$10.8 B	4.4%

Paid Claims Error Rate by Error Type

Table 3c summarizes the percent of the total dollars improperly allowed by error category for this and previous reports.

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

Type Of Error	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross
No Doc Errors	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%
Insufficient Doc Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%
Medically Unnecessary Errors	5.1%	4.2%	3.9%	2.6%	2.9%	2.7%	3.6%	1.1%	1.6%	1.6%	1.4%
Incorrect Coding Errors	1.2%	1.7%	1.3%	1.3%	1.0%	1.1%	0.9%	0.7%	1.2%	1.5%	1.6%
Other Errors	1.1%	0.5%	0.7%	0.9%	0.4%	-0.2%	0.0%	0.1%	0.2%	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%**	**4.4%**
CORRECT PAYMENTS	86.2%	88.6%	92.9 %	92.0%	93.2 %	93.7%	93.7%	90.2%	89.9%	94.8%	95.6%

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

Table 3d: Type of Error Comparison for 2005 and 2006 [4]

Type of Error	Nov 2005 Report	November 2006 Report				
	Total	Total	Carrier	DMERC	FI	QIO
No Documentation Errors	0.7%	0.6%	0.3%	0.1%	0.0%	0.1%
Insufficient Documentation Errors	1.1%	0.6%	0.4%	0.0%	0.2%	0.0%
Medically Unnecessary Errors	1.6%	1.4%	0.0%	0.1%	0.1%	1.2%
Incorrect Coding Errors	1.5%	1.6%	0.7%	0.0%	0.3%	0.6%
Other Errors	0.2%	0.2%	0.0%	0.0%	0.0%	0.2%
Improper Payments	5.2%	4.4%	1.5%	0.3%	0.6%	2.0%

[3] The 2003 entries were adjusted to account for high non-response rates. Including non-response, the national projected improper payments would have been $21.5B and the national paid claims error rate would have been 10.8%.

[4] Some columns may not sum correctly due to rounding.

No Documentation Errors

No documentation means the provider did not submit any medical record documentation to support the services provided.[5] No documentation errors accounted for 0.6% of the total dollars all Medicare FFS contractors allowed during the 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:[6]

Carrier	DMERC	FI	QIO	Total
0.3%	0.1%	0.0%	0.1%	0.6%

Table 4a is a combined list of the services with the highest projected improper payments due to no documentation errors for all contractor types. All series 4 tables are sorted in descending order by projected improper payments.

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
Non ESRD epoetin alpha inj (Q0136)	10.8%	$49,232,522	(8.2%) - 29.8%
OTHER KIDNEY & URINARY TRACT PROCEDURES	6.7%	$28,622,980	(6.3%) - 19.7%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.2%	$28,575,103	0.1% - 0.2%
Office/outpatient visit, est (99213)	0.4%	$15,452,029	0.2% - 0.5%
OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	2.0%	$14,755,121	(1.0%) - 4.9%
Darbepoetin alfa injection (J0880)	2.9%	$14,374,622	(2.7%) - 8.6%
Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74)	2.6%	$13,894,302	(0.6%) - 5.9%
Subsequent hospital care (99232)	0.6%	$13,635,306	0.1% - 1.1%
OTHER VASCULAR PROCEDURES W CC	1.1%	$13,017,029	(1.0%) - 3.1%
Psytx, off, 45-50 min (90806)	5.1%	$12,670,311	(4.4%) - 14.6%
Critical care, addl 30 min (99292)	28.0%	$11,763,048	21.4% - 34.6%
IV infusion therapy/diagnost (G0347)	19.2%	$11,624,345	4.8% - 33.6%
Subsequent hospital care (99231)	2.3%	$10,093,993	0.3% - 4.3%
Subsequent hospital care (99233)	0.9%	$10,057,704	0.1% - 1.7%
OTHER VASCULAR PROCEDURES W/O CC	4.6%	$9,824,843	(4.4%) - 13.7%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.3%	$8,840,686	(0.1%) - 0.7%

[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.
[6] Some columns may not sum correctly due to rounding

Initial hospital care (99223)	1.2%	$8,471,301	(0.2%) - 2.6%
O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	0.6%	$7,786,211	(0.5%) - 1.7%
Extracranial study (93880)	2.7%	$7,563,672	(2.4%) - 7.7%
Office/outpatient visit, est (99214)	0.2%	$6,998,316	0.1% - 0.3%
Overall	**0.6%**	**$1,386,033,725**	**0.3% - 0.8%**

The following are examples of No Documentation errors:

- An FI paid $62.15 for an Outpatient Clinic Visit. After repeated attempts from CERT to obtain the supporting medical record from the provider, the provider sent the following statement "Cannot locate documentation for the date of service". As a result the CERT Contractor counted the entire payment as an error.
- A Carrier paid $ 662.44 for an injection of Darbepoetin Alfa, 5 mcg. After repeated attempts from the CERT Contractor to obtain the supporting medical record from the provider, CERT received the following statement from the provider: "There is no date of service for 5/5/2005 in chart". The entire amount was considered an error. The Carrier collected an overpayment of $529.95.
- An FI paid $ 105.16 to a hospital for an Outpatient Clinic Visit. Documentation received from the provider revealed that the charge was submitted under the wrong beneficiary HIC number. The total amount was determined to be in error.
- A hospital submitted a short-term acute care inpatient claim for $3,640.91, which was paid. However, when the substantiating medical record was requested, the hospital failed to provide the record. Thus, the entire payment was recouped.

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.[7]

Insufficient documentation errors accounted for 0.6% of the total dollars allowed during the reporting period. This data breaks down as follows:

Carrier	DMERC	FI	QIO	Total
0.4%	0.0%	0.2%	0.0%	0.6%

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.

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

[7] 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

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. 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 (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	1.4%	$252,717,184	1.0% - 1.7%
Subsequent hospital care (99232)	4.5%	$98,916,844	3.2% - 5.8%
SNF-inpatient (including Part A) (21)	0.5%	$75,037,569	(0.1%) - 1.2%
Subsequent hospital care (99233)	6.2%	$70,826,277	3.4% - 9.1%
ESRD related svs 4+mo 20+yrs (G0317)	8.8%	$44,518,105	3.1% - 14.6%
Chiropractic manipulation (98941)	11.3%	$41,814,339	7.9% - 14.8%
Initial hospital care (99223)	5.0%	$35,249,167	2.3% - 7.7%
Subsequent hospital care (99231)	7.9%	$34,753,978	3.7% - 12.1%
Therapeutic exercises (97110)	4.4%	$28,636,453	2.9% - 6.0%
Clinic-hospital based or independent renal dialysis facility (72)	0.5%	$25,997,646	0.2% - 0.9%
SNF-inpatient or home health visits (Part B only) (22)	2.1%	$23,788,447	1.0% - 3.1%
Office/outpatient visit, est (99213)	0.5%	$20,271,562	0.3% - 0.7%
Office/outpatient visit, est (99211)	11.8%	$18,523,261	8.4% - 15.2%
Chiropractic manipulation (98942)	20.4%	$16,035,608	9.3% - 31.5%
Office/outpatient visit, est (99214)	0.4%	$15,418,735	0.2% - 0.7%
Initial inpatient consult (99254)	2.1%	$14,252,568	0.4% - 3.9%
HHA-outpatient (HHA-A also) (33)	0.3%	$13,101,799	(0.2%) - 0.8%
Critical care, first hour (99291)	2.3%	$11,888,572	(0.5%) - 5.1%
bls (A0428)	1.6%	$11,825,717	(0.1%) - 3.4%
SNF-outpatient (HHA-A also) (23)	5.4%	$11,776,482	(0.2%) - 11.0%
All Other Codes	0.6%	$550,547,101	0.6% - 0.7%
Overall	**1.0%**	**$1,415,897,415**	**0.9% - 1.1%**

The following is an example of an insufficient documentation error:

An FI paid an outpatient hospital $27.12 for three laboratory tests. CERT received the physician's order for the tests only. After repeated attempts by the CERT Contractor to obtain the supporting laboratory reports, the entire amount was considered an error as there was insufficient documentation to support that the labs were performed.

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 1.4% of the total dollars allowed during the reporting period. This data breaks down as follows:

Carrier	DMERC	FI	QIO	Total
0.0%	0.1%	0.1%	1.2%	1.4%

For QIOs, this is predominantly related to hospital stays of short duration where services could have been rendered at a lower level of care. A smaller, but persistent amount of medically unnecessary payment errors is due to unnecessary inpatient admissions associated with discharges to a skilled nursing facility.

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

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
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	12.7%	$158,316,105	9.4% - 15.9%
Blood glucose/reagent strips (A4253)	12.6%	$123,825,802	10.4% - 14.8%
CHEST PAIN	20.3%	$121,037,136	15.4% - 25.3%
MEDICAL BACK PROBLEMS	23.0%	$84,998,443	15.1% - 31.0%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	6.8%	$74,523,023	1.8% - 11.8%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	6.5%	$65,930,051	4.2% - 8.8%
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	3.9%	$65,512,515	(1.2%) - 9.1%

OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	10.9%	$62,186,151	4.3% - 17.4%
SNF-inpatient or home health visits (Part B only) (22)	5.0%	$58,087,891	3.7% - 6.4%
HEART FAILURE & SHOCK	1.4%	$50,325,342	0.8% - 2.0%
MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.3%	$49,595,113	0.0% - 2.6%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	10.0%	$49,040,207	4.9% - 15.1%
RENAL FAILURE	2.8%	$41,402,708	1.4% - 4.2%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	19.9%	$40,646,551	11.2% - 28.7%
DIABETES AGE >35	10.2%	$39,826,790	5.6% - 14.8%
SYNCOPE & COLLAPSE W CC	8.1%	$37,904,118	4.0% - 12.1%
G.I. HEMORRHAGE W CC	2.7%	$36,151,588	1.1% - 4.3%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.9%	$35,445,636	0.9% - 2.9%
OTHER VASCULAR PROCEDURES W CC	2.7%	$32,706,248	(0.2%) - 5.5%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.2%	$32,324,874	0.1% - 0.3%
Overall	**1.4%**	**$3,491,819,051**	**1.3% - 1.5%**

The following are examples of medically unnecessary services:

- An FI paid $626.37 to a provider of physical therapy services in a SNF Part B stay. The medical record documentation submitted by the provider did not support any functioning rehabilitation potential. Documentation stated: “Resident has no rehab potential at this time due to progression of dementia with increasing impairment in cognition and confusion". As a result the reviewer determined that the services were not medically necessary and the entire amount was considered an error.
- A DMERC paid a provider $335.56 for diabetic shoes and custom made inserts. The documentation submitted by the provider did not include a certifying physician statement. The medical necessity letter was signed by the ordering podiatrist only. The documentation submitted did not support the medical necessity or documentation requirements as stated in the DMERC LCD “Therapeutic Shoes for Persons with Diabetes”. As a result the reviewer determined that the services were not medically necessary and the entire amount was considered an error.
- A Medicare beneficiary with symptoms of abdominal pain and vomiting was admitted. No documentation to substantiate the medical necessity for inpatient admission was submitted to the QIO for review. Thus, an adjustment for the full payment of $6,077.76 was submitted.

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 1.6% percentage of the total dollars allowed during the reporting period. This data breaks down as follows:

Carrier	DMERC	FI	QIO	Total
0.7%	0.0%	0.3%	0.6%	1.6%

A common error involved overcoding or undercoding E&M codes 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 lists the services with the highest paid claims error rates due to incorrect coding for Carriers/DMERCs/FIs/QIOs. Table 4e includes only undercoding errors for Carriers/DMERCs/FIs.

Table 4d: Top 20 Services with Incorrect Coding Errors: Carriers/DMERCs/FIs/QIOs

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	Incorrect Coding 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)	2.3%	$435,624,395	(0.3%) - 5.0%
Office/outpatient visit, est (99214)	5.4%	$199,783,103	4.9% - 6.0%
SNF-inpatient (including Part A) (21)	1.1%	$155,000,635	0.7% - 1.4%
SEPTICEMIA AGE >17	2.0%	$54,901,402	0.8% - 3.2%
RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	1.6%	$42,979,889	0.2% - 3.0%
MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.4%	$37,079,745	0.1% - 2.8%
CORONARY BYPASS W CARDIAC CATH	2.4%	$34,252,368	(1.3%) - 6.1%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.2%	$33,344,451	0.7% - 1.7%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	3.2%	$31,396,555	0.7% - 5.7%
OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	4.1%	$30,651,010	1.9% - 6.3%
EPISTAXIS	128.5%	$30,088,687	(122.1%) - 379.0%
OTHER VASCULAR PROCEDURES W CC	2.5%	$30,063,492	0.2% - 4.7%
RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	2.1%	$28,169,774	0.5% - 3.6%

EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2%	$26,528,257	0.2% - 4.3%
RENAL FAILURE	1.7%	$25,313,068	0.8% - 2.6%
SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	9.3%	$23,917,563	(1.2%) - 19.8%
HEART FAILURE & SHOCK	0.7%	$23,512,534	0.2% - 1.1%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	1.7%	$18,493,257	(0.6%) - 4.0%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	1.3%	$16,854,136	0.7% - 2.0%
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	1.9%	$16,745,875	0.7% - 3.2%
Overall	**1.6%**	**$3,925,879,291**	**1.4% - 1.8%**

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

Carriers (HCPCS), DMERCs (HCPCS), and FIs (Type of Bill)	**Underpayment Coding 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)	0.3%	$50,516,543	0.1% - 0.4%
HHA-outpatient (HHA-A also) (33)	1.0%	$45,621,971	0.3% - 1.8%
Office/outpatient visit, est (99213)	0.6%	$23,503,372	0.4% - 0.7%
Office/outpatient visit, est (99212)	3.2%	$22,205,833	2.5% - 3.9%
Clinic-hospital based or independent renal dialysis facility (72)	0.3%	$16,748,581	0.1% - 0.5%
SNF-inpatient (including Part A) (21)	0.1%	$14,244,949	(0.0%) - 0.2%
HHA-inpatient or home health visits (Part B only) (32)	0.2%	$10,626,839	0.0% - 0.3%
Non ESRD epoetin alpha inj (Q0136)	2.2%	$9,883,886	(1.5%) - 5.8%
Mri brain w/o dye (70551)	6.3%	$6,743,153	(5.6%) - 18.3%
Subsequent hospital care (99231)	1.5%	$6,733,558	0.1% - 2.9%
Office/outpatient visit, est (99211)	3.9%	$6,115,032	1.8% - 6.0%
Emergency dept visit (99283)	1.6%	$4,048,179	0.5% - 2.8%
EF complet w/intact nutrient (B4150)	2.7%	$3,576,503	(1.0%) - 6.5%
Therapeutic exercises (97110)	0.4%	$2,557,597	(0.1%) - 0.9%
Hospital-other (Part B) (14)	0.2%	$2,524,785	0.0% - 0.4%
Chiropractic manipulation (98940)	1.7%	$2,376,540	0.0% - 3.3%
Office/outpatient visit, est (99214)	0.1%	$2,026,695	(0.0%) - 0.1%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.1%	$1,843,263	0.0% - 0.2%
Eye exam established pat (92012)	0.5%	$1,788,044	(0.0%) - 1.1%
Subsequent hospital care (99232)	0.1%	$1,660,525	0.0% - 0.2%
All Other Codes	0.1%	$58,267,125	0.1% - 0.1%
Overall	**0.2%**	**$293,612,971**	**0.2% - 0.2%**

The following are examples of coding errors:

- An FI paid $117.01 to a PPS Outpatient hospital for an injection of a single tendon, sheath or ligament. The reviewer determined that the service that was actually provided was an intramuscular injection of Vitamin B12. This resulted in a claim recalculated amount of $21.36, and an overpayment amount of $95.65.
- A Carrier paid a physician $198.73 for an inpatient consult, Current Procedural Terminology (CPT) 99255. This Evaluation and Management service requires 3 of 3 key components: a comprehensive history, a comprehensive examination and high complexity medical decision making. The medical reviewer determined that the documentation supported the comprehensive history, a detailed examination and moderate complexity medical decision making. The reviewer determined that the documentation supported the lower level code of 99253. This resulted in the claim recalculated amount of $100.24 and a $98.49 overpayment to the provider.
- An FI paid $110.29 to a medical center for Intravenous infusion for therapy/diagnosis; up to 1 hour. Upon review of the medical record it was determined that this service was performed for the administration of anesthesia drugs for conscious sedation during a colonoscopy. This service was considered to be included in the payment for the diagnostic procedure and should not have been billed separately. Therefore, $100.29 was recouped from the provider.
- A hospital submitted an inpatient admission claim coded for aspiration pneumonia and hypernatremia. The correct code for admission was dehydration and hypernatremia as the patient aspirated after admission; the payment difference between the two DRGs was $3,595.40.
-

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

Table 4f provides information on the impact of 1 level disagreement between Carriers and providers when coding evaluation and management codes.

Table 4f: 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)	4.6%	$170,627,839	4.2% - 5.1%
Subsequent hospital care (99233)	9.9%	$112,310,767	7.9% - 11.9%
Initial inpatient consult (99254)	8.6%	$57,082,375	6.9% - 10.3%
Office/outpatient visit, est (99215)	10.0%	$55,860,211	8.3% - 11.7%
Office/outpatient visit, est (99213)	1.1%	$48,193,659	0.9% - 1.3%

Office consultation (99244)	5.5%	$46,551,134	4.2% - 6.8%
Subsequent hospital care (99232)	1.9%	$41,719,370	1.3% - 2.5%
Office/outpatient visit, new (99203)	9.4%	$36,610,344	7.5% - 11.4%
Emergency dept visit (99285)	4.3%	$36,077,983	3.0% - 5.6%
Initial hospital care (99222)	8.6%	$26,001,119	6.1% - 11.0%
Office/outpatient visit, new (99204)	5.8%	$20,090,533	4.0% - 7.6%
Office/outpatient visit, est (99212)	2.8%	$19,264,915	2.2% - 3.3%
Office consultation (99243)	4.5%	$18,798,713	3.2% - 5.7%
Nursing fac care, subseq (99313)	6.9%	$13,313,750	4.7% - 9.0%
Nursing fac care, subseq (99312)	2.9%	$9,630,102	1.4% - 4.4%
Initial hospital care (99223)	1.3%	$9,470,927	0.7% - 2.0%
Initial inpatient consult (99253)	3.3%	$8,656,204	1.9% - 4.6%
Subsequent hospital care (99231)	1.5%	$6,790,103	0.1% - 3.0%
Initial inpatient consult (99255)	1.4%	$6,648,923	0.3% - 2.4%
Emergency dept visit (99283)	2.6%	$6,321,658	1.2% - 4.0%
All Other Codes	0.1%	$55,397,696	0.1% - 0.1%
Overall	**1.1%**	**$805,418,323**	**1.0% - 1.2%**

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

Other Errors

Under CERT, *other errors* include instances when provider claims did not meet benefit category requirements or other billing requirements.

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 reporting period. This data breaks down as follows:

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

Table 4g lists the services with other errors and the associated paid claims error rate.

Table 4g: 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	95% Confidence Interval
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	3.8%	$62,866,664	(2.0%) - 9.5%
SNF-inpatient (including Part A) (21)	0.3%	$46,624,390	(0.1%) - 0.7%
Special facility or ASC surgery-hospice (non-hospital based) (81)	0.6%	$28,711,732	(0.4%) - 1.5%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	1.8%	$20,287,723	(0.9%) - 4.6%
HHA-outpatient (HHA-A also) (33)	0.5%	$19,994,154	(0.2%) - 1.1%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	1.5%	$15,385,984	0.3% - 2.8%
PSYCHOSES	5.0%	$14,627,037	4.8% - 5.2%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$13,421,157	(0.0%) - 0.1%
HEART FAILURE & SHOCK	0.3%	$12,369,246	(0.0%) - 0.7%
CHEST PAIN	1.9%	$11,492,391	0.5% - 3.4%
LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	10.9%	$11,480,376	(2.6%) - 24.3%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.2%	$10,692,016	(0.5%) - 2.9%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.4%	$10,196,548	(0.0%) - 0.8%
PRM CARD PACEM IMPL W AMI/HF/SHOCK OR AICD LEAD OR GNRTR PROC	2.8%	$9,629,869	(1.0%) - 6.6%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7%	$9,264,609	0.1% - 1.4%
OTHER KIDNEY & URINARY TRACT PROCEDURES	2.1%	$9,142,150	(1.2%) - 5.4%
ALS 1 (A0426)	12.2%	$8,478,967	8.2% - 16.2%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.7%	$8,448,183	0.2% - 3.3%
SYNCOPE & COLLAPSE W CC	1.7%	$7,813,634	(0.3%) - 3.6%
TRANSURETHRAL PROCEDURES W CC	4.6%	$7,155,616	(4.4%) - 13.6%
Overall	**0.2%**	**$559,291,202**	**0.2% - 0.3%**

The following are examples of other errors:

- **Not Covered or Unallowable Service error:** An FI paid a Skilled Nursing Facility $3,250.26 for a 30 day episode of care. The nurse reviewer found that the beneficiary had not met the 3 day acute inpatient hospital qualifying stay requirement prior to the SNF admission. The beneficiary had been admitted for outpatient observation, discharged, and

then readmitted for one inpatient day prior to transfer to the SNF. The entire amount paid was determined to be in error.

- **Duplicate Payment error:** A Carrier paid $139.85 to a physician for a comprehensive office visit. Upon review of the Common Working file, the reviewer discovered that another physician within the group practice had billed a 99215 for the same DOS, same diagnosis. It was determined that both providers practiced the same specialty, but had used different UPIN numbers on their claims. A review of the medical records did not support unrelated problems. The entire amount was found to be in error and recouped.
- **Other error:** A Carrier paid $94.27 to an office based physical therapy provider. Upon review of the Common Working File and the medical record, the reviewer discovered that the beneficiary was in an active Home Health episode. Based on Consolidated billing rules, the reviewer determined that the claim should have been billed by the Home Health provider. The entire amount was determined to be in error and was recouped by the Carrier.
- **Billing eror:**A hospital billed for a short-term acute care inpatient stay. The case was determined to be a billing error and the payment was recouped because the provider billed this as an inpatient stay, however, the admission orders in the medical record indicated that an observation stay should have been billed. The dollars paid in error were $6,723.63.

Paid Claims Error Rate by Contractor Type

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

Carrier	DMERC	FI	QIO	Total
1.5%	0.3%	0.6%	2.0%	4.4%

The following figures (Figures 3 and 4) detail the paid claim error rates and projected improper payments by contractor type.

Figure 3: Paid Claims Error Rates by Contractor Type

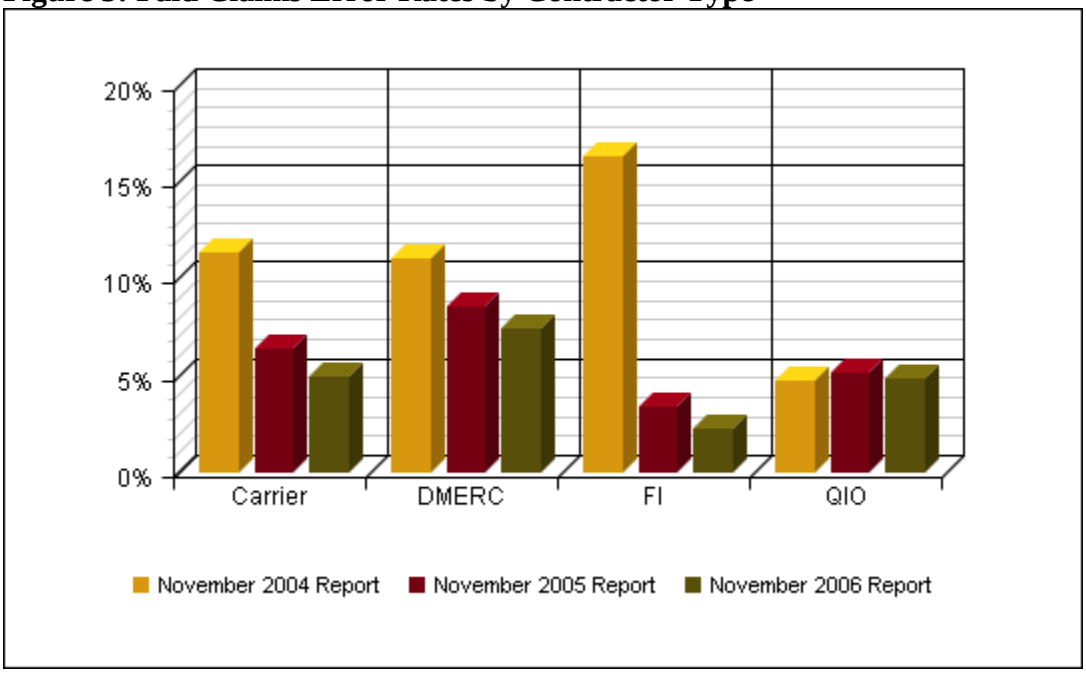
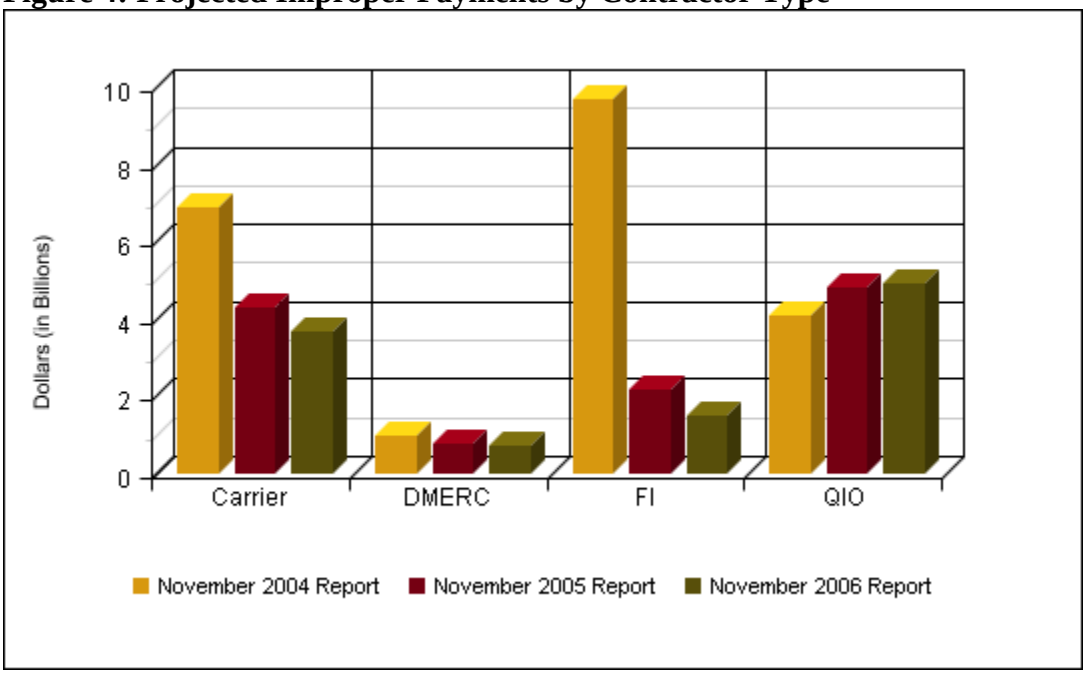


Figure 4: Projected Improper Payments by Contractor Type



Contractor-Specific Error Rates

Carrier-Specific Error Rates

Table 5 contains error rates and improper payment amounts for Carriers. It is sorted in descending order by error rate.

Table 5: Error Rates and Improper Payments: Carriers

Carrier	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval	
Triple S, Inc. PR/VI 00973/00974	14.5%	$90,538,947	4.0%	6.7% - 22.3%	28.7%
First Coast Service Options FL 00590	11.9%	$922,082,602	2.9%	6.1% - 17.6%	25.9%
GHI NY 14330	6.8%	$23,788,864	1.0%	4.9% - 8.7%	28.0%
Empire NJ 00805	5.6%	$131,669,284	0.6%	4.4% - 6.8%	19.3%
Empire NY 00803	5.1%	$198,235,733	0.6%	4.1% - 6.2%	19.0%
Average=	**5.0%**				
BCBS AR RI 00524	5.0%	$10,592,027	0.6%	3.8% - 6.3%	19.7%
Cahaba AL/GA/MS 00510/00511/00512	5.0%	$195,765,746	0.6%	3.9% - 6.2%	18.5%
Trailblazer TX 00900	4.8%	$252,004,653	0.7%	3.5% - 6.1%	18.2%
Regence UT 00823	4.6%	$15,896,171	0.6%	3.5% - 5.8%	20.0%
Palmetto OH/WV 00883/00884	4.6%	$151,857,060	0.6%	3.5% - 5.6%	18.7%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/00836	4.3%	$162,011,991	0.5%	3.3% - 5.4%	18.2%
AdminaStar IN/KY 00630/00660	4.3%	$115,995,101	0.9%	2.6% - 6.1%	14.1%
WPS WI/IL/MI/MN 00951/00952/00953/00954	4.3%	$333,747,570	0.5%	3.4% - 5.1%	12.7%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	4.1%	$179,956,321	0.4%	3.4% - 4.9%	15.1%
Palmetto SC 00880	4.1%	$45,678,381	0.5%	3.1% - 5.1%	19.2%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.9%	$88,049,788	0.4%	3.0% - 4.8%	12.0%
First Coast Service Options CT 00591	3.7%	$41,147,736	0.4%	2.9% - 4.4%	10.7%
NHIC CA 31140/31146	3.7%	$251,760,677	0.5%	2.8% - 4.6%	17.2%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	3.5%	$121,827,234	0.3%	2.9% - 4.1%	15.1%
CIGNA NC 05535	3.3%	$72,395,431	0.5%	2.3% - 4.3%	13.7%
HealthNow NY 00801	3.2%	$39,688,716	0.3%	2.5% - 3.9%	13.8%
HGSA PA 00865	3.1%	$98,888,031	0.3%	2.5% - 3.8%	12.5%
BCBS MT 00751	3.1%	$5,907,611	0.4%	2.3% - 3.8%	12.4%
CIGNA TN 05440	2.9%	$49,625,486	0.3%	2.3% - 3.6%	15.0%
BCBS KS/NE/W MO 00650/00655/00651	2.7%	$38,198,529	0.3%	2.2% - 3.3%	13.6%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	2.7%	$35,901,123	0.3%	2.0% - 3.3%	13.0%
CIGNA ID 05130	2.3%	$4,846,956	0.3%	1.7% - 2.9%	14.5%
Combined	**5.0%**	**$3,678,057,770**	**0.3%**	**4.4% - 5.7%**	**17.2%**

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

DMERC-Specific Error Rates

Table 6 contains DMERC specific error rates and improper payment amounts. It is sorted in descending order by error rate.

Table 6: Error Rates and Improper Payments: DMERCs

DMERCs	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval	
Palmetto Region C 00885	9.9%	$399,008,878	2.9%	4.2% - 15.6%	24.2%
Average=	**7.5%**				
Tricenturion Region A 77011	7.4%	$100,544,508	2.1%	3.2% - 11.6%	14.2%
AdminaStar - Region B 00635	6.9%	$140,678,543	2.1%	2.9% - 11.0%	14.0%
CIGNA Region D 05655	2.9%	$52,827,686	0.5%	2.0% - 3.9%	14.1%
Combined	**7.5%**	**$693,059,615**	**1.4%**	**4.8% - 10.2%**	**18.9%**

FI-Specific Error Rates

Table 7 contains error rates and improper payment amounts for FIs. It is sorted in descending order by error rate.

Table 7: Error Rates and Improper Payments: FIs

FIs	Paid Claims Error Rate			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Empire CT/DE/NY 00308	9.5%	$319,208,634	7.3%	(4.9%) - 23.8%
Medicare NW ID/OR/UT 00350	5.5%	$39,435,540	2.5%	0.7% - 10.3%
COSVI PR/VI 57400	4.5%	$3,466,302	0.9%	2.8% - 6.3%
Highmark Medicare Services DC/MD 00366	3.1%	$120,868,082	0.8%	1.5% - 4.7%
UGS AS/CA/GU/HI/NV/NMI 00454	2.8%	$129,585,931	0.7%	1.5% - 4.2%
BCBS AR AR 00020	2.6%	$7,922,337	0.8%	1.1% - 4.2%
Veritus PA 00363	2.5%	$39,415,903	0.8%	1.0% - 4.0%
Mutual of Omaha (all states) 52280	2.4%	$162,717,260	0.6%	1.3% - 3.6%
Average=	**2.3%**			
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	2.3%	$127,817,797	0.4%	1.6% - 3.0%
Noridian AK/WA 00322	2.3%	$10,324,790	1.2%	(0.0%) - 4.6%
Trispan LA/MO/MS 00230	2.2%	$26,906,941	0.5%	1.3% - 3.2%

UGS WI/MI 00450/00452	2.2%	$118,439,626	0.9%	0.5% - 3.9%
BCBS WY WY 00460	2.2%	$896,038	0.8%	0.6% - 3.8%
Palmetto NC 00382	1.8%	$20,329,615	0.4%	1.0% - 2.6%
UGS VA/WV 00453	1.7%	$19,089,693	0.5%	0.8% - 2.6%
Anthem ME/MA 00180/00181	1.7%	$31,298,359	0.5%	0.7% - 2.6%
First Coast Service Options FL 00090	1.6%	$31,104,048	0.3%	1.0% - 2.2%
BCBS GA GA 00101	1.6%	$25,463,184	0.4%	0.8% - 2.4%
Riverbend NJ/TN 00390	1.4%	$37,187,834	0.3%	0.8% - 2.1%
Palmetto SC 00380	1.3%	$128,547,669	0.4%	0.6% - 2.1%
BCBS AZ AZ 00030	1.3%	$3,482,262	0.3%	0.8% - 1.9%
Cahaba AL 00010	1.3%	$5,478,180	0.4%	0.4% - 2.1%
Anthem NH/VT 00270	1.3%	$3,601,402	0.3%	0.6% - 1.9%
BCBS AR RI 00021	1.2%	$1,390,841	0.3%	0.5% - 1.8%
Noridian MN/ND 00320/00321	1.1%	$9,487,814	0.4%	0.3% - 2.0%
BCBS MT MT 00250	1.1%	$1,772,994	0.4%	0.3% - 2.0%
BCBS KS KS 00150	1.1%	$3,652,421	0.3%	0.6% - 1.5%
Chisholm OK 00340	0.9%	$1,876,504	0.2%	0.4% - 1.3%
Trailblazer CO/NM/TX 00400	0.8%	$25,526,547	0.2%	0.5% - 1.1%
Cahaba IA/SD 00011	0.5%	$16,084,715	0.2%	0.2% - 0.8%
BCBS NE NE 00260	0.4%	$782,129	0.1%	0.2% - 0.7%
Combined	**2.3%**	**$1,473,161,391**	**0.4%**	**1.5% - 3.2%**

QIO-Specific Error Rates

Table 8 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. It is sorted alphabetically by state.

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

QIOs	Paid Claims Error Rate			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Alaska	2.0%	$2,492,911	0.3%	1.5% - 2.6%
Alabama	4.6%	$82,692,803	0.7%	3.2% - 6.0%
Arkansas	6.6%	$67,171,457	0.7%	5.1% - 8.0%
Arizona	6.2%	$90,310,777	0.9%	4.4% - 8.1%
California	5.8%	$469,247,554	1.1%	3.7% - 8.0%
Colorado	3.6%	$31,385,421	0.7%	2.1% - 5.0%
Connecticut	4.2%	$61,736,628	0.7%	2.8% - 5.6%
District of Columbia	4.3%	$19,664,671	0.6%	3.2% - 5.4%
Delaware	4.9%	$16,608,925	0.6%	3.6% - 6.1%
Florida	6.5%	$422,595,049	0.9%	4.8% - 8.2%
Georgia	2.3%	$59,077,346	0.4%	1.5% - 3.1%

[8] 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.

Hawaii	2.6%	$6,535,731	0.4%	1.8% - 3.3%
Iowa	3.6%	$32,038,220	0.5%	2.6% - 4.6%
Idaho	3.1%	$8,022,518	0.5%	2.1% - 4.0%
Illinois	5.3%	$239,114,882	0.8%	3.8% - 6.9%
Indiana	4.9%	$104,956,564	0.8%	3.4% - 6.5%
Kansas	3.0%	$24,332,056	0.6%	1.8% - 4.1%
Kentucky	5.3%	$95,124,944	0.8%	3.8% - 6.9%
Louisiana	3.1%	$46,374,643	0.5%	2.2% - 4.0%
Massachusetts	9.6%	$238,640,053	0.9%	7.9% - 11.4%
Maryland	4.5%	$117,657,072	0.8%	2.9% - 6.1%
Maine	5.2%	$25,055,620	0.8%	3.7% - 6.7%
Michigan	5.7%	$238,314,651	0.8%	4.1% - 7.3%
Minnesota	5.5%	$87,482,021	0.7%	4.1% - 6.8%
Missouri	2.8%	$64,256,045	0.6%	1.5% - 4.0%
Mississippi	5.9%	$64,571,887	0.9%	4.1% - 7.6%
Montana	1.4%	$3,796,210	0.3%	0.7% - 2.0%
North Carolina	1.4%	$44,919,516	0.3%	0.8% - 2.0%
North Dakota	1.9%	$4,594,551	0.3%	1.3% - 2.5%
Nebraska	1.0%	$5,868,896	0.2%	0.6% - 1.4%
New Hampshire	3.6%	$12,411,348	0.5%	2.6% - 4.6%
New Jersey	3.7%	$129,350,699	0.6%	2.5% - 4.8%
New Mexico	9.5%	$36,262,526	0.9%	7.8% - 11.3%
Nevada	6.1%	$30,693,189	0.7%	4.8% - 7.4%
New York	3.7%	$285,156,299	0.7%	2.3% - 5.1%
Ohio	1.7%	$70,440,852	0.4%	0.9% - 2.4%
Oklahoma	4.1%	$48,464,159	0.8%	2.5% - 5.8%
Oregon	4.8%	$36,955,912	0.7%	3.3% - 6.3%
Pennsylvania	6.4%	$299,851,001	0.8%	4.9% - 7.9%
Puerto Rico	6.1%	$23,192,664	0.8%	4.5% - 7.6%
Rhode Island	4.2%	$13,406,197	0.5%	3.2% - 5.1%
South Carolina	6.3%	$100,075,217	0.7%	4.8% - 7.8%
South Dakota	2.9%	$7,902,388	0.4%	2.2% - 3.7%
Tennessee	3.4%	$80,872,092	0.6%	2.2% - 4.5%
Texas	6.7%	$433,110,883	0.9%	4.8% - 8.5%
Utah	4.5%	$21,095,878	0.6%	3.4% - 5.7%
Virginia	4.0%	$89,321,508	0.7%	2.8% - 5.3%
Vermont	2.4%	$4,171,965	0.3%	1.7% - 3.0%
Washington	2.5%	$36,880,279	0.6%	1.2% - 3.7%
Wisconsin	3.8%	$63,887,348	1.6%	0.6% - 7.0%
West Virginia	4.1%	$33,235,668	0.6%	3.0% - 5.1%
Wyoming	1.1%	$1,137,551	0.2%	0.7% - 1.5%
Short Term	**4.8%**	**$4,632,515,246**	**0.2%**	**4.4% - 5.1%**
Long-term Acute Paid Claims	**6.8%**	**$285,683,976**	**0.6%**	**5.6% - 8.0%**
Denied Claims	**N/A**	**$16,442,686**	**N/A**	**N/A**
Total	**4.9%**	**$4,934,641,908**	**0.2%**	**4.5% - 5.2%**

Error Rates by Type of Service

Table 9 displays the paid claims error rates for each type of service by type of error. This series of tables is sorted in descending order by projected improper payments. 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	95% Confidence Interval	Type of Error				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Other drugs	$573,326,552	12.2%	3.7% - 20.8%	83.6%	1.1%	0.2%	15.1%	0.0%
Consultations	$507,038,019	15.4%	14.0% - 16.7%	2.7%	8.6%	0.0%	88.6%	0.1%
Office visits - established	$487,828,985	5.2%	4.8% - 5.5%	5.8%	13.1%	1.5%	78.6%	1.0%
Hospital visit - subsequent	$479,372,543	11.0%	9.5% - 12.4%	7.3%	47.7%	0.2%	44.5%	0.3%
All Other Codes	$384,368,679	1.4%	1.1% - 1.7%	28.2%	45.1%	4.3%	18.3%	4.1%
Hospital visit - initial	$190,653,155	17.2%	14.5% - 19.9%	5.3%	28.5%	0.0%	65.3%	1.0%
Office visits - new	$167,979,860	15.5%	13.5% - 17.5%	3.8%	1.9%	0.1%	93.8%	0.3%
Minor procedures - other (Medicare fee schedule)	$155,838,882	5.3%	4.2% - 6.3%	15.9%	58.6%	8.3%	17.0%	0.2%
Nursing home visit	$117,502,635	12.1%	10.2% - 14.1%	10.2%	25.2%	3.6%	60.7%	0.3%
Chiropractic	$91,432,131	15.5%	12.5% - 18.5%	0.6%	74.2%	13.0%	11.7%	0.4%
Emergency room visit	$81,170,524	5.2%	4.1% - 6.4%	1.7%	9.8%	0.0%	88.5%	0.0%
Ambulance	$75,735,222	2.3%	1.0% - 3.6%	0.0%	21.7%	48.2%	14.3%	15.8%
Chemotherapy	$68,742,076	3.2%	(0.5%) - 6.8%	79.8%	0.6%	0.0%	6.5%	13.0%
Dialysis services (Non MFS)	$57,028,358	8.4%	3.7% - 13.1%	2.0%	82.2%	0.0%	15.0%	0.8%
Hospital visit - critical care	$49,951,053	8.6%	1.8% - 15.5%	35.3%	27.5%	0.0%	30.0%	7.2%
Other tests - other	$40,677,030	3.0%	0.7% - 5.4%	1.2%	82.7%	11.0%	3.9%	1.3%
Lab tests - other (non-Medicare fee schedule)	$31,848,867	1.8%	1.0% - 2.5%	36.9%	33.5%	22.3%	3.1%	4.2%
Specialist - ophthalmology	$31,830,341	1.7%	1.0% - 2.5%	7.5%	53.6%	4.3%	34.5%	0.0%
All Codes With	$30,074,229	1.6%	(0.3%) -	55.3%	38.0%	1.4%	5.3%	0.0%

Less Than 30 Claims			3.5%					
Specialist - psychiatry	$28,884,098	3.2%	(0.5%) - 6.8%	62.3%	17.9%	3.6%	1.2%	15.0%
Minor procedures - musculoskeletal	$26,774,531	2.8%	(0.2%) - 5.8%	1.7%	70.8%	11.0%	3.1%	13.4%
All Type of Services (Incl. Codes Not Listed)	**$3,678,057,770**	**5.0%**	**4.4% - 5.7%**	**22.9%**	**25.7%**	**3.0%**	**46.8%**	**1.7%**

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	95% Confidence Interval	Type of Error				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Surgical Dressings	$176,320,864	75.7%	52.3% - 99.1%	99.0%	0.0%	1.0%	0.0%	0.0%
Glucose Monitor	$158,218,995	13.6%	11.5% - 15.8%	3.6%	2.6%	86.9%	6.9%	0.0%
All Policy Groups with Less than 30 Claims	$109,302,255	6.8%	1.2% - 12.5%	33.1%	5.9%	60.2%	0.8%	0.0%
Nebulizers & Related Drugs	$55,954,945	6.0%	1.8% - 10.2%	4.2%	11.3%	55.3%	24.6%	4.6%
Support Surfaces	$30,749,629	29.6%	3.1% - 56.1%	99.7%	0.0%	0.3%	0.0%	0.0%
CPAP	$27,821,845	7.4%	2.4% - 12.3%	34.8%	2.8%	60.7%	1.7%	0.0%
Ostomy Supplies	$22,990,712	16.2%	1.2% - 31.2%	54.0%	13.1%	28.9%	1.3%	2.7%
Lower Limb Orthoses	$17,429,493	9.8%	(0.1%) - 19.7%	41.9%	0.0%	55.9%	2.2%	0.0%
Immunosuppressive Drugs	$16,698,871	4.9%	(0.0%) - 9.8%	42.8%	22.1%	31.5%	3.6%	0.0%
Oxygen Supplies/Equipment	$14,516,566	0.7%	0.2% - 1.1%	5.5%	11.1%	63.0%	4.1%	16.3%
Diabetic Shoes	$12,610,011	7.2%	0.2% - 14.3%	12.7%	31.1%	56.3%	0.0%	0.0%
Urological Supplies	$10,838,330	19.5%	2.1% - 36.8%	87.2%	5.7%	7.2%	0.0%	0.0%
Wheelchairs Options/Accessories	$10,422,178	5.9%	0.2% - 11.5%	0.0%	1.9%	96.6%	0.6%	0.9%
Enteral Nutrition	$9,150,690	1.7%	0.0% - 3.3%	59.4%	0.0%	0.7%	40.0%	0.0%

Wheelchairs Manual	$5,572,536	2.5%	1.0% - 4.0%	0.0%	21.6%	51.8%	17.4%	9.3%
Respiratory Assist Device	$3,121,006	3.5%	(1.8%) - 8.9%	70.1%	0.0%	29.9%	0.0%	0.0%
Hospital Beds/Accessories	$2,831,681	1.1%	(0.2%) - 2.4%	0.0%	55.6%	36.0%	0.0%	8.4%
Walkers	$2,352,197	2.5%	0.2% - 4.8%	33.7%	0.0%	66.3%	0.0%	0.0%
All Other Codes	$2,348,030	0.8%	0.1% - 1.6%	22.2%	22.7%	46.0%	9.1%	0.0%
Lenses	$2,064,086	2.4%	(0.4%) - 5.2%	0.0%	13.2%	86.8%	0.0%	0.0%
Patient Lift	$1,744,695	5.9%	(1.1%) - 12.8%	0.0%	51.8%	48.2%	0.0%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$693,059,615**	**7.5%**	**4.8% - 10.2%**	**44.3%**	**5.1%**	**45.0%**	**4.7%**	**0.9%**

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	95% Confidence Interval	Type of Error				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	$751,977,856	4.0%	1.4% - 6.6%	3.9%	31.8%	4.0%	58.5%	1.8%
SNF	$413,051,911	2.6%	1.8% - 3.4%	1.3%	26.8%	21.0%	39.5%	11.4%
HHA	$131,176,555	1.3%	0.7% - 1.9%	4.5%	13.5%	8.0%	56.0%	18.0%
ESRD	$57,244,659	1.1%	0.7% - 1.6%	0.8%	45.4%	0.6%	53.2%	0.0%
Other FI Service Types	$54,893,013	1.8%	1.0% - 2.7%	28.2%	33.5%	3.6%	33.1%	1.6%
Hospice	$30,506,621	0.5%	(0.3%) - 1.3%	0.0%	0.0%	0.0%	5.9%	94.1%
Non-PPS Hospital In-patient	$26,805,372	0.8%	0.3% - 1.4%	2.1%	75.9%	11.3%	9.2%	1.5%
RHCs	$3,090,183	0.8%	0.4% - 1.1%	34.9%	56.5%	7.0%	1.6%	0.0%
Free Standing Ambulatory Surgery	$2,532,747	0.9%	(0.4%) - 2.1%	0.0%	76.3%	0.0%	23.7%	0.0%
FQHC	$1,882,474	0.6%	(0.1%) - 1.4%	63.7%	36.3%	0.0%	0.0%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$1,473,161,391**	**2.3%**	**1.5% - 3.2%**	**4.0%**	**29.6%**	**9.0%**	**49.5%**	**7.8%**

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	95% Confidence Interval	Type of Error				
				No Documentation	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	$187.1M	15.0%	11.6% - 18.3%	1.4%	0.0%	84.6%	9.0%	5.0%
CHEST PAIN	$140.7M	23.6%	18.4% - 28.9%	1.7%	0.0%	86.0%	4.1%	8.2%
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	$136.4M	8.2%	0.5% - 16.0%	0.0%	0.0%	48.0%	5.9%	46.1%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	$113.3M	10.3%	4.1% - 16.5%	0.0%	0.0%	65.8%	16.3%	17.9%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	$99.8M	9.9%	7.1% - 12.6%	1.8%	0.0%	66.1%	16.7%	15.4%
HEART FAILURE & SHOCK	$92.8M	2.6%	1.7% - 3.5%	7.1%	0.0%	54.2%	25.3%	13.3%
MEDICAL BACK PROBLEMS	$90.8M	24.6%	16.5% - 32.6%	0.0%	0.0%	93.6%	3.5%	2.8%
OTHER KIDNEY & URINARY TRACT PROCEDURES	$81.2M	19.0%	3.3% - 34.6%	35.3%	0.0%	35.9%	17.6%	11.3%
OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	$79.4M	10.6%	5.9% - 15.2%	18.6%	0.0%	37.9%	38.6%	5.0%
OTHER VASCULAR PROCEDURES W CC	$76.8M	6.3%	2.1% - 10.4%	16.9%	0.0%	42.6%	39.1%	1.3%
RENAL FAILURE	$74.3M	5.0%	3.2% - 6.8%	3.5%	0.0%	55.7%	34.1%	6.8%

CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	$69.1M	14.1%	8.2% - 20.0%	0.0%	0.0%	71.0%	16.8%	12.2%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	$68.3M	2.4%	1.5% - 3.4%	13.0%	0.0%	23.3%	48.8%	14.9%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	$68.2M	11.9%	5.3% - 18.5%	0.7%	0.0%	91.2%	8.1%	0.0%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	$66.6M	6.8%	3.9% - 9.6%	3.2%	0.0%	47.7%	47.1%	2.0%
MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	$66.3M	1.7%	0.4% - 3.1%	10.1%	0.0%	74.8%	14.8%	0.3%
SEPTICEMIA AGE >17	$63.7M	2.3%	1.1% - 3.6%	0.0%	0.0%	13.8%	86.2%	0.0%
SYNCOPE & COLLAPSE W CC	$54.8M	11.7%	7.0% - 16.3%	0.8%	0.0%	69.2%	15.7%	14.3%
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	$53.7M	6.2%	3.7% - 8.8%	1.2%	0.0%	56.7%	31.2%	10.9%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	$51.3M	25.2%	15.9% - 34.4%	0.0%	0.0%	79.3%	13.0%	7.7%
Overall	**$4,934.6M**	**4.9%**	**4.5% - 5.2%**	**3.6%**	**0.0%**	**59.5%**	**29.2%**	**7.7%**

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. This series of tables is sorted in descending order by projected improper payments.

The CERT program is unable to calculate provider compliance error rates for FIs due to systems limitations.

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

Provider Types Billing to Carriers	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payment Amount	Standard Error	95% Confidence Interval	
Internal Medicine	7.6%	$601,424,011	0.5%	6.7% - 8.5%	19.0%
Cardiology	5.1%	$325,652,570	0.5%	4.0% - 6.1%	16.0%
Pulmonary Disease	19.3%	$291,337,094	10.3%	(0.9%) - 39.5%	25.0%
Family Practice	6.4%	$253,401,309	0.5%	5.4% - 7.5%	19.8%
General Practice	22.2%	$212,369,460	6.2%	10.2% - 34.3%	53.2%
Emergency Medicine	10.7%	$180,887,379	5.0%	0.9% - 20.6%	19.5%
Obstetrics/Gynecology	23.8%	$136,576,170	13.7%	(3.2%) - 50.7%	30.8%
General Surgery	6.6%	$115,182,292	1.4%	3.8% - 9.4%	18.9%
Orthopedic Surgery	4.4%	$114,135,388	0.6%	3.3% - 5.5%	16.7%
Nephrology	8.3%	$113,844,580	1.4%	5.6% - 11.0%	15.4%
Gastroenterology	7.3%	$98,157,283	1.3%	4.8% - 9.8%	15.0%
Hematology/Oncology	2.4%	$92,340,993	0.6%	1.3% - 3.5%	12.0%
Chiropractic	15.3%	$92,309,814	1.5%	12.4% - 18.2%	30.6%
Psychiatry	10.7%	$81,500,712	3.7%	3.5% - 18.0%	20.3%
Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)	2.3%	$75,786,308	0.7%	1.0% - 3.6%	17.0%
Urology	4.2%	$72,463,458	0.7%	2.8% - 5.6%	13.4%
Physical Therapist in Private Practice	6.1%	$65,752,382	1.0%	4.1% - 8.1%	21.5%
Ophthalmology	1.8%	$65,405,586	0.3%	1.3% - 2.3%	11.8%
Neurology	6.0%	$64,840,444	0.9%	4.1% - 7.8%	18.4%
Diagnostic Radiology	1.4%	$59,245,685	0.3%	0.8% - 2.0%	12.8%
Physical Medicine and Rehabilitation	8.9%	$53,141,230	1.5%	6.0% - 11.8%	21.1%
Podiatry	4.0%	$43,685,656	0.5%	3.0% - 5.1%	18.1%
Endocrinology	13.0%	$43,314,802	2.5%	8.0% - 17.9%	20.2%

Otolaryngology	5.6%	$39,286,923	1.1%	3.5% - 7.7%	18.1%
Infectious Disease	9.7%	$37,198,961	1.9%	5.9% - 13.5%	36.2%
Dermatology	2.0%	$32,150,663	0.3%	1.3% - 2.6%	10.6%
Clinical Laboratory (Billing Independently)	1.2%	$28,667,304	0.3%	0.6% - 1.7%	13.1%
Anesthesiology	2.1%	$27,066,376	0.5%	1.1% - 3.2%	15.0%
Clinical Psychologist	6.8%	$22,067,667	4.9%	(2.7%) - 16.3%	21.2%
Optometry	4.0%	$20,776,278	1.2%	1.7% - 6.3%	20.2%
Nurse Practitioner	4.0%	$20,061,954	0.9%	2.2% - 5.7%	12.4%
Vascular Surgery	4.4%	$19,939,498	1.9%	0.6% - 8.1%	13.0%
Rheumatology	1.9%	$18,456,694	0.5%	0.9% - 2.8%	8.1%
Neurosurgery	5.1%	$17,505,380	1.7%	1.8% - 8.4%	35.6%
Independent Diagnostic Testing Facility (IDTF)	1.1%	$16,029,953	0.7%	(0.2%) - 2.4%	23.9%
Pathology	2.3%	$15,507,521	0.9%	0.6% - 4.0%	14.4%
Medical Oncology	1.0%	$13,357,954	0.3%	0.5% - 1.6%	9.3%
Thoracic Surgery	2.5%	$9,992,566	1.1%	0.4% - 4.6%	12.4%
Critical Care (Intensivists)	7.4%	$9,864,928	2.7%	2.1% - 12.7%	12.2%
Geriatric Medicine	11.8%	$9,822,684	3.4%	5.2% - 18.5%	30.3%
Radiation Oncology	0.7%	$7,834,567	0.3%	0.1% - 1.3%	12.5%
Physician Assistant	1.7%	$6,531,919	0.5%	0.8% - 2.6%	16.3%
Pain Management	3.8%	$5,493,295	1.4%	1.1% - 6.6%	11.3%
All Provider Types With Less Than 30 Lines	2.6%	$5,293,391	0.9%	0.7% - 4.4%	14.7%
Plastic and Reconstructive Surgery	2.6%	$4,834,883	1.0%	0.6% - 4.5%	14.0%
Allergy/Immunology	2.8%	$4,726,848	1.2%	0.3% - 5.2%	19.9%
Occupational Therapist in Private Practice	5.3%	$4,226,087	2.6%	0.2% - 10.4%	12.6%
Cardiac Surgery	1.1%	$3,672,645	0.4%	0.3% - 1.8%	23.4%
Ambulatory Surgical Center	0.2%	$3,582,286	0.2%	(0.2%) - 0.5%	13.5%
Pediatric Medicine	5.3%	$3,268,802	1.5%	2.4% - 8.3%	12.3%
Interventional Pain Management	2.9%	$2,391,201	1.6%	(0.2%) - 6.1%	38.5%
Hematology	1.1%	$2,387,194	0.6%	(0.1%) - 2.3%	10.2%
Osteopathic Manipulative Therapy	5.3%	$2,229,506	3.0%	(0.6%) - 11.2%	41.4%
Audiologist (Billing Independently)	8.3%	$2,160,240	4.4%	(0.4%) - 16.9%	22.2%
Colorectal Surgery (formerly proctology)	2.1%	$1,913,346	0.7%	0.8% - 3.4%	9.9%
Interventional Radiology	0.6%	$1,758,087	0.6%	(0.6%) - 1.9%	4.8%
Hand Surgery	4.3%	$1,699,003	2.5%	(0.7%) - 9.3%	16.2%

Certified Registered Nurse Anesthetist (CRNA)	0.3%	$1,677,976	0.2%	(0.0%) - 0.7%	10.7%
Portable X-Ray Supplier (Billing Independently)	0.3%	$541,317	0.2%	(0.0%) - 0.7%	13.8%
Multispecialty Clinic or Group Practice	2.1%	$369,811	1.4%	(0.6%) - 4.9%	40.0%
Nuclear Medicine	0.3%	$341,675	0.1%	0.1% - 0.5%	9.7%
Clinical Nurse Specialist	1.3%	$334,125	0.9%	(0.4%) - 3.0%	23.9%
Gynecological/Oncology	0.3%	$192,448	0.2%	(0.1%) - 0.7%	0.4%
Public Health or Welfare Agencies (Federal, State, and local)	0.3%	$63,713	0.3%	(0.2%) - 0.8%	9.9%
Clinical Social Worker	0.0%	$25,497	0.0%	(0.0%) - 0.0%	9.9%
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%	12.6%
Radiation Therapy Centers	0.0%	$0	0.0%	0.0% - 0.0%	21.9%
All Provider Types	**5.0%**	**$3,678,057,770**	**0.3%**	**4.4% - 5.7%**	**17.2%**

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

Provider Types Billing to DMERCs	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payment Amount	Standard Error	95% Confidence Interval	
Medical supply company not included in 51, 52, or 53	11.5%	$432,851,619	3.2%	5.2% - 17.8%	22.8%
Pharmacy	5.9%	$217,054,315	0.7%	4.5% - 7.3%	17.5%
Medical Supply Company with Respiratory Therapist	1.7%	$15,408,040	0.5%	0.8% - 2.7%	7.6%
Unknown Supplier/Provider	22.7%	$10,361,387	14.1%	(5.0%) - 50.5%	24.2%
Podiatry	8.3%	$7,041,777	5.5%	(2.6%) - 19.1%	14.7%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	3.7%	$4,855,998	3.2%	(2.6%) - 10.1%	13.8%
Medical supply company with orthotic personnel certified by an accrediting organization	2.8%	$2,460,276	2.4%	(1.9%) - 7.4%	6.5%
All Provider Types With Less Than 30 Lines	1.3%	$981,259	0.9%	(0.4%) - 3.0%	5.8%
Orthopedic Surgery	3.7%	$904,320	3.2%	(2.5%) - 9.9%	21.6%
Optician	2.2%	$534,432	2.2%	(2.1%) - 6.5%	14.2%

Individual prosthetic personnel certified by an accrediting organization	0.2%	$337,267	0.2%	(0.2%) - 0.7%	23.3%
Medical Supply Company with registered pharmacist	1.7%	$268,925	1.8%	(1.8%) - 5.2%	16.3%
Individual orthotic personnel certified by an accrediting organization	0.0%	$0	0.0%	0.0% - 0.0%	6.8%
Medical supply company with prosthetic personnel certified by an accrediting organization	0.0%	$0	0.0%	0.0% - 0.0%	68.2%
Nursing Facility, Other	0.0%	$0	0.0%	0.0% - 0.0%	0.0%
Ophthalmology	0.0%	$0	0.0%	0.0% - 0.0%	17.6%
Optometry	0.0%	$0	0.0%	0.0% - 0.0%	14.5%
Skilled Nursing Facility	0.0%	$0	0.0%	0.0% - 0.0%	5.4%
All Provider Types	**7.5%**	**$693,059,615**	**1.4%**	**4.8% - 10.2%**	**18.9%**

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

Provider Types Billing to FIs	**Paid Claims Error Rate**			
	Error Rate	Projected Improper Payment Amount	Standard Error	95% Confidence Interval
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	4.0%	751,977,856	1.3%	1.4% - 6.6%
SNF	2.6%	413,051,911	0.4%	1.8% - 3.4%
HHA	1.3%	131,176,555	0.3%	0.7% - 1.9%
ESRD	1.1%	57,244,659	0.2%	0.7% - 1.6%
Other FI Service Types	1.8%	54,893,013	0.4%	1.0% - 2.7%
Hospice	0.5%	30,506,621	0.4%	(0.3%) - 1.3%
Non-PPS Hospital In-patient	0.8%	26,805,372	0.3%	0.3% - 1.4%
RHCs	0.8%	3,090,183	0.2%	0.4% - 1.1%
Free Standing Ambulatory Surgery	0.9%	2,532,747	0.6%	(0.4%) - 2.1%
FQHC	0.6%	1,882,474	0.4%	(0.1%) - 1.4%
Overall	**2.3%**	**1,473,161,391**	**0.4%**	**1.5% - 3.2%**

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

Provider Types for Which QIOs are Responsible	**Paid Claims Error Rate**			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Short-term Acute Paid Claims	4.8%	$4,632,515,246	0.2%	4.4% - 5.1%
Long-term Acute Paid Claims	6.8%	$285,683,976	0.6%	5.6% - 8.0%
Denied Claims	N/A	$16,442,686	N/A	N/A
Total	**4.9%**	**$4,934,641,908**	**0.2%**	**4.5% - 5.2%**

CORRECTIVE ACTIONS

No Documentation

CMS continues to make progress lowering the no documentation rate. Historically, the no documentation issue has been more pronounced in the CERT program than in HPMP. This 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 did not respond at all.
- 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

In the past, CMS implemented the following corrective actions to address the no documentation problem:

1. 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.
2. CMS revised the medical record request letters to emphasize that faxing is the most effective way to submit medical records.
3. 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.
4. 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:
    - Calling providers before sending correspondence in order to verify contact information,
    - Offering to fax request letters to providers who can receive faxes,

- Developing a website that allows providers to customize the delivery address for CERT medical record request letters, and
- Developing a clear policy and documentation process to deal with medical records that are lost or damaged due to disaster.

CMS initiated several new corrective actions that will have an impact on future reports.

1. The CERT Documentation Contractor contacted third party providers to request documentation when the billing provider indicated that medical records were possessed by a third party.
2. CMS is implementing a Durable Medical Equipment Accreditation program to ensure the legitimacy of the DME suppliers that bill Medicare and to ensure those suppliers meet all the requirements for participation in the Medicare program.
3. CMS is conducting a pilot that uses claim attachment records to allow providers to submit electronic medical records (EMR). The pilot will help CMS test whether:
    - A Medicare 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 using claim attachment records.

Insufficient Documentation

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.

In the past, CMS undertook 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.

CMS implemented the following new corrective actions in the past year that impacted the insufficient documentation error rate in this report:

1. The CERT program implemented a process to distribute an insufficient documentation report to all Carriers/DMERCs/FIs 60 days prior to the due date of an improper payment report. Carriers/DMERCs/FIs were encouraged to contact providers to obtain missing information that is needed for CERT review of claims.
2. The CERT Documentation Contractor contacted third party providers to request documentation when the billing provider indicated that a portion of the medical record was possessed by a third party.

CMS is implementing the following corrective action that will impact future reports:

1. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce insufficient documentation errors.

Medically Unnecessary Services

The QIOs were responsible for the largest portion of the improper payments due to medically unnecessary services.

CMS undertook the following 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 provided 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 developed and distributed QIO specific payment error cause analyses to improve targeting of QIO efforts to reduce payment errors.
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.

8. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce insufficient medical necessity errors.

Incorrect Coding

Incorrect coding errors occurred when providers submitted documentation that supported a higher or lower code than the code submitted on the claim.

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 considered a resolution passed by the American Medical Association (AMA), the owner of the physician coding system, that recommended 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. CMS continues to evaluate this proposed policy and is conducting a study under MMA 941(d) to explore a simpler, alternative system of requirements for documentation accompanying E&M claims.
3. CMS has tasked each Carrier/DMERC/FI with developing an Error Rate Reduction Plan (ERRP) that targets incorrect coding errors in their jurisdiction.
4. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce incorrect coding errors.

Delay in Producing Error Rate Reports

The time delay in the production of the error rate reports are a result of the trade-off between data completeness and timeliness inherent in the current structure of the CERT and HPMP processes. The processes must allow sufficient time for providers to submit medical records, reviewers to examine the claims, and for the Carriers/DMERCs/FIs to re-price those claims that are found to be in error. In addition, claims in HPMP are sampled three months after discharge in order to allow for hospital claims submission times and for records that undergo QIO case review to go through multiple levels of physician review and appeals. CMS routinely conducts process reviews in orders to identify areas where the program can become more time efficient.

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 has advanced the time period covered by each November report by three months to decrease the time lag between claim sampling and error reporting.

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.

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. These efforts include the use of a wide array of CMS-developed educational products (the Medicare Learning Network products can be viewed at http://www.cms.hhs.gov/MLNProducts) on coverage, payment and billing. In addition to these products, to assist providers in understanding Medicare program requirements, CMS offers national and local provider forums, national and local websites, and dedicated provider contact centers answering over 56M provider calls annually.
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.
4. CMS will develop and install new Correct Coding Initiative edits to reduce improper payments.
5. CMS will use the contractor specific error rates in the contractor performance evaluation program.
6. CMS will continue to provide educational tools and resources that support the contractors' efforts to address provider billing/payment questions accurately and 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. In 2007, 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.
12. CMS provided Carriers/DMERCs/FIs more detailed reports and information to enable them to better identify problem areas and target corrective actions.
13. Because CERT reviews the version of the claims as it appeared at the time of selection some claims have been scored as errors though the provider submitted a corrected claim sometime later. Beginning November 1, 2006, CMS is revising the CERT sampling schedule to allow additional time for provider adjustments or corrections.

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 1.1 MB.

Error Rates by Cluster and Provider Type

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

Alternate No Documentation Rate

Appendix D 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 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.

Error Rates by Type of Service

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

Service Type Billed to Carriers (BETOS codes)	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Hospital visit - initial	17.2%	14.5% - 19.9%	5.3%	28.5%	0.0%	65.3%	1.0%
Office visits - new	15.5%	13.5% - 17.5%	3.8%	1.9%	0.1%	93.8%	0.3%
Chiropractic	15.5%	12.5% - 18.5%	0.6%	74.2%	13.0%	11.7%	0.4%
Consultations	15.4%	14.0% - 16.7%	2.7%	8.6%	0.0%	88.6%	0.1%
Other drugs	12.2%	3.7% - 20.8%	83.6%	1.1%	0.2%	15.1%	0.0%
Nursing home visit	12.1%	10.2% - 14.1%	10.2%	25.2%	3.6%	60.7%	0.3%
Hospital visit - subsequent	11.0%	9.5% - 12.4%	7.3%	47.7%	0.2%	44.5%	0.3%
Hospital visit - critical care	8.6%	1.8% - 15.5%	35.3%	27.5%	0.0%	30.0%	7.2%

Dialysis services (Non MFS)	8.4%	3.7% - 13.1%	2.0%	82.2%	0.0%	15.0%	0.8%
Minor procedures - other (Medicare fee schedule)	5.3%	4.2% - 6.3%	15.9%	58.6%	8.3%	17.0%	0.2%
Emergency room visit	5.2%	4.1% - 6.4%	1.7%	9.8%	0.0%	88.5%	0.0%
Office visits - established	5.2%	4.8% - 5.5%	5.8%	13.1%	1.5%	78.6%	1.0%
Chemotherapy	3.2%	(0.5%) - 6.8%	79.8%	0.6%	0.0%	6.5%	13.0%
Specialist - psychiatry	3.2%	(0.5%) - 6.8%	62.3%	17.9%	3.6%	1.2%	15.0%
Other tests - other	3.0%	0.7% - 5.4%	1.2%	82.7%	11.0%	3.9%	1.3%
Minor procedures - musculoskeletal	2.8%	(0.2%) - 5.8%	1.7%	70.8%	11.0%	3.1%	13.4%
Ambulance	2.3%	1.0% - 3.6%	0.0%	21.7%	48.2%	14.3%	15.8%
Lab tests - other (non-Medicare fee schedule)	1.8%	1.0% - 2.5%	36.9%	33.5%	22.3%	3.1%	4.2%
Specialist - ophthalmology	1.7%	1.0% - 2.5%	7.5%	53.6%	4.3%	34.5%	0.0%
All Codes With Less Than 30 Claims	1.6%	(0.3%) - 3.5%	55.3%	38.0%	1.4%	5.3%	0.0%
All Other Codes	1.4%	1.1% - 1.7%	28.2%	45.1%	4.3%	18.3%	4.1%
All Types of Services	**5.0%**	**4.4% - 5.7%**	**22.9%**	**25.7%**	**3.0%**	**46.8%**	**1.7%**

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

Service Type Billed to DMERCs (SADMERC Policy Group)	**Paid Claims Error Rate**	**95% Confidence Interval**	**Type of Error**				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Surgical Dressings	75.7%	52.3% - 99.1%	99.0%	0.0%	1.0%	0.0%	0.0%
Support Surfaces	29.6%	3.1% - 56.1%	99.7%	0.0%	0.3%	0.0%	0.0%
Urological Supplies	19.5%	2.1% - 36.8%	87.2%	5.7%	7.2%	0.0%	0.0%
Ostomy Supplies	16.2%	1.2% - 31.2%	54.0%	13.1%	28.9%	1.3%	2.7%
Glucose Monitor	13.6%	11.5% - 15.8%	3.6%	2.6%	86.9%	6.9%	0.0%
Lower Limb Orthoses	9.8%	(0.1%) - 19.7%	41.9%	0.0%	55.9%	2.2%	0.0%
CPAP	7.4%	2.4% - 12.3%	34.8%	2.8%	60.7%	1.7%	0.0%
Diabetic Shoes	7.2%	0.2% - 14.3%	12.7%	31.1%	56.3%	0.0%	0.0%
All Policy Groups with Less than 30 Claims	6.8%	1.2% - 12.5%	33.1%	5.9%	60.2%	0.8%	0.0%

Nebulizers & Related Drugs	6.0%	1.8% - 10.2%	4.2%	11.3%	55.3%	24.6%	4.6%
Patient Lift	5.9%	(1.1%) - 12.8%	0.0%	51.8%	48.2%	0.0%	0.0%
Wheelchairs Options/ Accessories	5.9%	0.2% - 11.5%	0.0%	1.9%	96.6%	0.6%	0.9%
Immunosuppressive Drugs	4.9%	(0.0%) - 9.8%	42.8%	22.1%	31.5%	3.6%	0.0%
Respiratory Assist Device	3.5%	(1.8%) - 8.9%	70.1%	0.0%	29.9%	0.0%	0.0%
Wheelchairs Manual	2.5%	1.0% - 4.0%	0.0%	21.6%	51.8%	17.4%	9.3%
Walkers	2.5%	0.2% - 4.8%	33.7%	0.0%	66.3%	0.0%	0.0%
Lenses	2.4%	(0.4%) - 5.2%	0.0%	13.2%	86.8%	0.0%	0.0%
Enteral Nutrition	1.7%	0.0% - 3.3%	59.4%	0.0%	0.7%	40.0%	0.0%
Hospital Beds/Accessories	1.1%	(0.2%) - 2.4%	0.0%	55.6%	36.0%	0.0%	8.4%
All Other Codes	0.8%	0.1% - 1.6%	22.2%	22.7%	46.0%	9.1%	0.0%
Oxygen Supplies/ Equipment	0.7%	0.2% - 1.1%	5.5%	11.1%	63.0%	4.1%	16.3%
All Types of Services	**7.5%**	**4.8% - 10.2%**	**44.3%**	**5.1%**	**45.0%**	**4.7%**	**0.9%**

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

Service Type Billed to FIs (Type of Bill)	**Paid Claims Error Rate**	**95% Confidence Interval**	**Type of Error**				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	4.0%	1.4% - 6.6%	3.9%	31.8%	4.0%	58.5%	1.8%
SNF	2.6%	1.8% - 3.4%	1.3%	26.8%	21.0%	39.5%	11.4 %
Other FI Service Types	1.8%	1.0% - 2.7%	28.2%	33.5%	3.6%	33.1%	1.6%
HHA	1.3%	0.7% - 1.9%	4.5%	13.5%	8.0%	56.0%	18.0 %
ESRD	1.1%	0.7% - 1.6%	0.8%	45.4%	0.6%	53.2%	0.0%
Free Standing Ambulatory Surgery	0.9%	(0.4%) - 2.1%	0.0%	76.3%	0.0%	23.7%	0.0%
Non-PPS Hospital In-patient	0.8%	0.3% - 1.4%	2.1%	75.9%	11.3%	9.2%	1.5%
RHCs	0.8%	0.4% - 1.1%	34.9%	56.5%	7.0%	1.6%	0.0%
FQHC	0.6%	(0.1%) - 1.4%	63.7%	36.3%	0.0%	0.0%	0.0%
Hospice	0.5%	(0.3%) - 1.3%	0.0%	0.0%	0.0%	5.9%	94.1 %
All Types of Services	**2.3%**	**1.5% - 3.2%**	**4.0%**	**29.6%**	**9.0%**	**49.5%**	**7.8%**

Table 11d: Top 20 Service Type Error Rates: QIOs[9]

Service Types for Which QIOs are Responsible (DRG)	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
EPISTAXIS	130.3%	(120.2%) - 380.9%	0.0%	0.0%	0.6%	98.6%	0.8%
FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	43.3%	(0.0%) - 86.6%	0.0%	0.0%	51.5%	3.0%	45.4%
SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	38.7%	18.0% - 59.3%	0.0%	0.0%	81.0%	15.3%	3.6%
BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	37.7%	15.3% - 60.2%	0.0%	0.0%	99.2%	0.8%	0.0%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	31.5%	(1.4%) - 64.4%	0.0%	0.0%	67.2%	26.8%	6.0%
OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	28.3%	3.7% - 52.9%	5.4%	0.0%	72.8%	21.8%	(0.0%)
ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	28.1%	7.6% - 48.6%	39.9%	0.0%	60.1%	0.0%	(0.0%)
DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	27.8%	(2.9%) - 58.6%	0.0%	0.0%	33.6%	14.8%	51.6%
URINARY STONES W CC, &/OR ESW LITHOTRIPSY	26.0%	1.7% - 50.3%	0.0%	0.0%	84.2%	12.9%	2.8%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	25.2%	15.9% - 34.4%	0.0%	0.0%	79.3%	13.0%	7.7%
MEDICAL BACK PROBLEMS	24.6%	16.5% - 32.6%	0.0%	0.0%	93.6%	3.5%	2.8%
CHEST PAIN	23.6%	18.4% - 28.9%	1.7%	0.0%	86.0%	4.1%	8.2%
SIGNS & SYMPTOMS W CC	23.3%	8.5% - 38.1%	0.0%	0.0%	73.3%	14.5%	12.2%
DYSEQUILIBRIUM	22.5%	10.0% - 35.1%	5.6%	0.0%	93.2%	0.6%	0.6%

[9] Some error rates on this table may exceed 100%. For further information see "Weighting and Determining the Final Results."

INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	22.0%	(20.9%) - 64.9%	0.0%	0.0%	0.0%	100.0%	0.0%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	20.8%	11.2% - 30.4%	0.0%	0.0%	72.3%	17.3%	10.4%
SYNCOPE & COLLAPSE W/O CC	20.8%	10.9% - 30.7%	0.0%	0.0%	94.8%	1.9%	3.3%
SKIN ULCERS	19.6%	2.8% - 36.5%	0.0%	0.0%	74.9%	25.1%	(0.0%)
OTHER KIDNEY & URINARY TRACT PROCEDURES	19.0%	3.3% - 34.6%	35.3%	0.0%	35.9%	17.6%	11.3%
VIRAL ILLNESS AGE >17	18.9%	(3.2%) - 41.1%	0.0%	0.0%	82.0%	0.5%	17.6%
Overall	**4.9%**	**4.5% - 5.2%**	**3.6%**	**0.0%**	**59.5%**	**29.2%**	**7.7%**

Error Rates by Type of Error

Table 12a: Error Rates for Each Cluster by Type of Error: Carriers

Carriers	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Triple S, Inc. PR/VI 00973/00974	14.5%	0.3%	2.4%	0.9%	10.8%	0.0%
First Coast Service Options FL 00590	11.9%	7.1%	2.3%	0.1%	2.4%	0.0%
GHI NY 14330	6.8%	0.4%	3.3%	0.2%	2.8%	0.1%
Empire NJ 00805	5.6%	0.3%	1.6%	0.1%	3.6%	0.0%
Empire NY 00803	5.1%	0.2%	1.6%	0.1%	3.1%	0.1%
BCBS AR RI 00524	5.0%	0.2%	1.3%	0.5%	2.9%	0.2%
Cahaba AL/GA/MS 00510/00511/00512	5.0%	0.5%	1.2%	0.3%	2.6%	0.5%
Trailblazer TX 00900	4.8%	0.7%	1.3%	0.4%	2.3%	0.1%
Regence UT 00823	4.6%	0.5%	2.3%	0.2%	1.7%	0.0%
Palmetto OH/WV 00883/00884	4.6%	0.5%	1.5%	0.0%	2.5%	0.0%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/008	4.3%	0.2%	1.5%	0.2%	2.4%	0.0%
AdminaStar IN/KY 00630/00660	4.3%	1.2%	0.7%	0.4%	2.1%	0.0%
WPS WI/IL/MI/MN 00951/00952/00953/00954	4.3%	0.6%	1.5%	0.1%	2.0%	0.1%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	4.1%	0.6%	1.1%	0.2%	2.2%	0.1%
Palmetto SC 00880	4.1%	0.5%	1.3%	0.1%	2.2%	0.0%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.9%	0.4%	0.9%	0.0%	2.6%	0.0%
First Coast Service Options CT	3.7%	0.2%	1.2%	0.1%	2.1%	0.1%

00591						
NHIC CA 31140/31146	3.7%	0.4%	0.6%	0.1%	2.3%	0.2%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	3.5%	0.2%	0.8%	0.1%	2.4%	0.0%
CIGNA NC 05535	3.3%	0.1%	1.2%	0.1%	1.7%	0.3%
HealthNow NY 00801	3.2%	0.2%	1.1%	0.1%	1.7%	0.0%
HGSA PA 00865	3.1%	0.2%	0.7%	0.0%	2.2%	0.0%
BCBS MT 00751	3.1%	0.3%	1.5%	0.2%	1.1%	0.1%
CIGNA TN 05440	2.9%	0.2%	1.0%	0.1%	1.6%	0.0%
BCBS KS/NE/W MO 00650/00655/00651	2.7%	0.5%	1.0%	0.1%	1.2%	0.0%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	2.7%	0.3%	0.9%	0.1%	1.3%	0.0%
CIGNA ID 05130	2.3%	0.1%	0.7%	0.2%	1.4%	0.0%
Combined	**5.0%**	**1.2%**	**1.3%**	**0.2%**	**2.4%**	**0.1%**

Table 12b: Error Rates for Each Cluster by Type of Error: DMERCs

DMERC	**Paid Claims Error Rate**	**Type of Error**				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Palmetto Region C 00885	9.9%	6.9%	0.4%	2.1%	0.5%	0.1%
Tricenturion Region A 77011	7.4%	1.7%	0.6%	4.6%	0.3%	0.2%
AdminaStar - Region B 00635	6.9%	0.1%	0.4%	6.2%	0.2%	0.0%
CIGNA Region D 05655	2.9%	0.1%	0.3%	2.2%	0.3%	0.0%
Combined	**7.5%**	**3.3%**	**0.4%**	**3.4%**	**0.4%**	**0.1%**

Table 12c: Error Rates for Each Cluster by Type of Error: FIs

FI	**Paid Claims Error Rate**	**Type of Error**				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Empire CT/DE/NY 00308	9.5%	0.0%	0.4%	0.3%	8.8%	0.0%
Medicare NW ID/OR/UT 00350	5.5%	0.5%	3.8%	0.3%	0.9%	0.1%
COSVI PR/VI 57400	4.5%	1.2%	2.6%	0.2%	0.5%	0.0%
Highmark Medicare Services DC/MD 00366	3.1%	0.0%	1.1%	0.4%	0.7%	0.9%
UGS AS/CA/GU/HI/NV/NMI 00454	2.8%	0.1%	0.5%	0.7%	1.4%	0.2%
BCBS AR AR 00020	2.6%	0.2%	0.7%	0.1%	1.5%	0.0%
Veritus PA 00363	2.5%	0.0%	0.9%	0.4%	1.2%	0.0%
Mutual of Omaha (all states) 52280	2.4%	0.1%	1.1%	0.1%	1.1%	0.2%
AdminaStar IN/IL/KY/OH	2.3%	0.0%	1.1%	0.2%	0.9%	0.0%

00130/00131/00160/00332						
Noridian AK/WA 00322	2.3%	1.2%	0.4%	0.1%	0.5%	0.1%
Trispan LA/MO/MS 00230	2.2%	0.2%	0.4%	0.6%	0.9%	0.1%
UGS WI/MI 00450/00452	2.2%	0.3%	1.0%	0.2%	0.6%	0.1%
BCBS WY WY 00460	2.2%	0.1%	0.9%	0.0%	0.4%	0.7%
Palmetto NC 00382	1.8%	0.0%	0.8%	0.4%	0.4%	0.1%
UGS VA/WV 00453	1.7%	0.0%	0.2%	0.1%	1.2%	0.1%
Anthem ME/MA 00180/00181	1.7%	0.1%	0.5%	0.1%	1.0%	0.0%
First Coast Service Options FL 00090	1.6%	0.1%	0.7%	0.2%	0.5%	0.0%
BCBS GA GA 00101	1.6%	0.1%	0.5%	0.1%	0.8%	0.0%
Riverbend NJ/TN 00390	1.4%	0.1%	0.6%	0.2%	0.5%	0.1%
Palmetto SC 00380	1.3%	0.1%	0.3%	0.1%	0.4%	0.4%
BCBS AZ AZ 00030	1.3%	0.0%	0.5%	0.0%	0.8%	0.0%
Cahaba AL 00010	1.3%	0.5%	0.3%	0.1%	0.4%	0.0%
Anthem NH/VT 00270	1.3%	0.0%	0.7%	0.2%	0.4%	0.0%
BCBS AR RI 00021	1.2%	0.0%	0.5%	0.2%	0.5%	0.0%
Noridian MN/ND 00320/00321	1.1%	0.0%	0.5%	0.1%	0.6%	0.0%
BCBS MT MT 00250	1.1%	0.0%	0.7%	0.0%	0.4%	0.0%
BCBS KS KS 00150	1.1%	0.0%	0.3%	0.3%	0.4%	0.0%
Chisholm OK 00340	0.9%	0.1%	0.2%	0.0%	0.5%	0.0%
Trailblazer CO/NM/TX 00400	0.8%	0.1%	0.3%	0.1%	0.3%	0.0%
Cahaba IA/SD 00011	0.5%	0.0%	0.1%	0.0%	0.4%	0.0%
BCBS NE NE 00260	0.4%	0.0%	0.2%	0.0%	0.2%	0.0%
Combined	**2.3%**	**0.1%**	**0.7%**	**0.2%**	**1.2%**	**0.2%**

Table 12d: Error Rates for Each Cluster by Type of Error: QIOs

QIO	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Alaska	2.0%	0.2%	N/A	0.7%	0.4%	0.8%
Alabama	4.6%	0.0%	N/A	2.4%	2.1%	0.1%
Arkansas	6.6%	0.1%	N/A	4.6%	1.3%	0.5%
Arizona	6.2%	0.6%	N/A	1.3%	3.1%	1.3%
California	5.8%	0.3%	N/A	2.0%	2.1%	1.5%
Colorado	3.6%	0.3%	N/A	1.5%	1.1%	0.6%
Connecticut	4.2%	0.0%	N/A	2.5%	1.4%	0.3%
District of Columbia	4.3%	0.8%	N/A	2.4%	1.1%	0.0%
Delaware	4.9%	0.1%	N/A	3.7%	1.0%	0.1%
Florida	6.5%	0.0%	N/A	3.7%	2.8%	0.0%
Georgia	2.3%	0.0%	N/A	0.9%	0.5%	0.9%
Hawaii	2.6%	0.0%	N/A	0.6%	1.7%	0.2%
Iowa	3.6%	0.0%	N/A	1.5%	1.7%	0.3%
Idaho	3.1%	0.0%	N/A	1.6%	1.2%	0.2%
Illinois	5.3%	0.1%	N/A	3.4%	1.8%	0.1%

Indiana	4.9%	0.6%	N/A	3.7%	0.7%	0.0%
Kansas	3.0%	0.5%	N/A	1.3%	0.9%	0.2%
Kentucky	5.3%	0.0%	N/A	4.2%	1.1%	0.1%
Louisiana	3.1%	0.3%	N/A	1.5%	0.9%	0.4%
Massachusetts	9.6%	0.0%	N/A	9.0%	0.4%	0.3%
Maryland	4.5%	0.5%	N/A	4.0%	0.0%	0.0%
Maine	5.2%	0.0%	N/A	4.5%	0.5%	0.2%
Michigan	5.7%	0.0%	N/A	3.2%	1.7%	0.8%
Minnesota	5.5%	0.3%	N/A	4.0%	1.1%	0.0%
Missouri	2.8%	0.0%	N/A	1.9%	0.3%	0.5%
Mississippi	5.9%	0.3%	N/A	3.0%	1.8%	0.8%
Montana	1.4%	0.0%	N/A	0.6%	0.2%	0.6%
North Carolina	1.4%	0.1%	N/A	0.7%	0.3%	0.2%
North Dakota	1.9%	0.0%	N/A	1.4%	0.5%	0.0%
Nebraska	1.0%	0.0%	N/A	0.6%	0.3%	0.0%
New Hampshire	3.6%	0.0%	N/A	2.7%	0.6%	0.3%
New Jersey	3.7%	0.2%	N/A	3.1%	0.3%	0.0%
New Mexico	9.5%	0.1%	N/A	4.1%	3.9%	1.4%
Nevada	6.1%	0.1%	N/A	3.7%	1.4%	0.8%
New York	3.7%	0.6%	N/A	1.3%	1.8%	0.0%
Ohio	1.7%	0.0%	N/A	1.2%	0.1%	0.4%
Oklahoma	4.1%	0.5%	N/A	2.4%	1.3%	0.0%
Oregon	4.8%	0.2%	N/A	3.2%	0.6%	0.8%
Pennsylvania	6.4%	0.1%	N/A	2.9%	3.4%	0.0%
Puerto Rico	6.1%	0.2%	N/A	3.9%	2.0%	0.0%
Rhode Island	4.2%	0.0%	N/A	3.1%	1.0%	0.0%
South Carolina	6.3%	0.0%	N/A	5.0%	1.2%	0.1%
South Dakota	2.9%	0.2%	N/A	2.4%	0.2%	0.1%
Tennessee	3.4%	0.1%	N/A	0.9%	2.0%	0.4%
Texas	6.7%	0.0%	N/A	5.2%	0.9%	0.6%
Utah	4.5%	0.1%	N/A	2.5%	0.8%	1.3%
Virginia	4.0%	0.2%	N/A	2.9%	0.9%	0.0%
Vermont	2.4%	0.0%	N/A	1.8%	0.3%	0.3%
Washington	2.5%	0.0%	N/A	2.1%	0.3%	0.1%
Wisconsin	3.8%	0.0%	N/A	1.3%	2.5%	0.0%
West Virginia	4.1%	0.1%	N/A	3.2%	0.5%	0.3%
Wyoming	1.1%	0.1%	N/A	0.7%	0.1%	0.2%
Short-Term	**4.8%**	**0.2%**	**N/A**	**2.8%**	**1.4%**	**0.4%**
Long-term Acute Paid Claims	**6.8%**	**0.2%**	**N/A**	**4.8%**	**1.8%**	**0.0%**
Denied	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**4.9%**	**0.2%**	**N/A**	**2.9%**	**1.4%**	**0.4%**

Paid Claims Error Rate by Service Type

Table series 13 displays the paid claims error rate by service type for each contractor type. Each table is sorted by projected improper payments from highest to lowest. All estimates 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				
	Error Rate	Number of Line Items (Sample)	Projected Improper Payments	Standard Error	95% Confidence Interval
Other drugs	12.2%	2,450	$573,326,552	4.4%	3.7% - 20.8%
Consultations	15.4%	2,412	$507,038,019	0.7%	14.0% - 16.7%
Office visits - established	5.2%	17,013	$487,828,985	0.2%	4.8% - 5.5%
Hospital visit - subsequent	11.0%	6,303	$479,372,543	0.7%	9.5% - 12.4%
Hospital visit - initial	17.2%	846	$190,653,155	1.4%	14.5% - 19.9%
Office visits - new	15.5%	1,249	$167,979,860	1.0%	13.5% - 17.5%
Minor procedures - other (Medicare fee schedule)	5.3%	7,492	$155,838,882	0.5%	4.2% - 6.3%
Nursing home visit	12.1%	1,699	$117,502,635	1.0%	10.2% - 14.1%
Chiropractic	15.5%	2,095	$91,432,131	1.5%	12.5% - 18.5%
Emergency room visit	5.2%	1,581	$81,170,524	0.6%	4.1% - 6.4%
Ambulance	2.3%	2,577	$75,735,222	0.7%	1.0% - 3.6%
Chemotherapy	3.2%	313	$68,742,076	1.9%	(0.5%) - 6.8%
Dialysis services (Non MFS)	8.4%	237	$57,028,358	2.4%	3.7% - 13.1%
Hospital visit - critical care	8.6%	274	$49,951,053	3.5%	1.8% - 15.5%
Other tests - other	3.0%	1,898	$40,677,030	1.2%	0.7% - 5.4%
Lab tests - other (non-Medicare fee schedule)	1.8%	12,549	$31,848,867	0.4%	1.0% - 2.5%
Specialist - ophthalmology	1.7%	3,125	$31,830,341	0.4%	1.0% - 2.5%
All Codes With Less Than 30 Claims	1.6%	379	$30,074,229	1.0%	(0.3%) - 3.5%
Specialist - psychiatry	3.2%	1,767	$28,884,098	1.8%	(0.5%) - 6.8%
Minor procedures - musculoskeletal	2.8%	1,056	$26,774,531	1.5%	(0.2%) - 5.8%
Advanced imaging - MRI: other	1.4%	395	$24,632,741	0.6%	0.2% - 2.7%
Standard imaging - nuclear medicine	1.2%	1,236	$23,205,612	0.6%	0.0% - 2.4%
Standard imaging - musculoskeletal	3.1%	2,707	$22,138,564	0.7%	1.8% - 4.5%
Lab tests - other (Medicare fee schedule)	1.6%	1,765	$21,394,815	0.5%	0.6% - 2.5%
Major procedure - Other	1.9%	255	$17,225,518	1.1%	(0.3%) - 4.1%
Other tests - electrocardiograms	4.5%	2,609	$17,153,945	0.6%	3.3% - 5.7%
Anesthesia	1.1%	976	$15,156,203	0.3%	0.4% - 1.7%
Advanced imaging - MRI: brain	1.9%	188	$15,062,714	1.3%	(0.6%) - 4.4%
Echography - carotid arteries	5.1%	256	$14,652,514	3.4%	(1.6%) - 11.7%
Endoscopy - colonoscopy	1.9%	332	$14,339,539	1.1%	(0.3%) - 4.0%

Echography - other	2.9%	554	$13,997,290	1.3%	0.3% - 5.4%
Major procedure, cardiovascular-Coronary angioplasty (PTCA)	5.0%	62	$12,982,279	0.9%	3.2% - 6.8%
Major procedure, cardiovascular-Other	1.1%	342	$10,941,587	1.0%	(0.8%) - 3.0%
Echography - abdomen/pelvis	4.0%	417	$10,924,047	2.7%	(1.3%) - 9.3%
Ambulatory procedures - other	1.9%	745	$10,638,009	0.8%	0.3% - 3.5%
Specialist - other	4.4%	351	$10,380,833	1.5%	1.6% - 7.3%
Home visit	6.6%	184	$10,270,812	1.9%	2.8% - 10.3%
Standard imaging - chest	2.6%	2,851	$9,890,914	0.6%	1.4% - 3.8%
Minor procedures - skin	0.9%	1,462	$9,400,891	0.3%	0.3% - 1.5%
Other - Medicare fee schedule	6.9%	310	$8,456,916	2.5%	1.9% - 11.8%
Dialysis services	8.0%	135	$7,752,145	4.8%	(1.5%) - 17.5%
Standard imaging - other	2.9%	736	$7,582,086	1.0%	1.0% - 4.9%
Ambulatory procedures - skin	0.5%	1,645	$6,254,419	0.1%	0.2% - 0.8%
Other tests - cardiovascular stress tests	1.8%	481	$6,107,076	0.8%	0.3% - 3.3%
Advanced imaging - CAT: other	0.4%	1,155	$5,110,982	0.2%	0.1% - 0.7%
Oncology - radiation therapy	0.5%	558	$4,685,506	0.3%	(0.1%) - 1.1%
Other tests - EKG monitoring	3.5%	145	$4,497,852	1.4%	0.7% - 6.2%
Lab tests - blood counts	1.7%	2,677	$4,412,350	0.3%	1.0% - 2.3%
Echography - eye	3.4%	205	$4,192,982	1.3%	0.9% - 5.9%
Standard imaging - breast	1.2%	905	$4,025,359	0.6%	(0.1%) - 2.4%
Immunizations/Vaccinations	1.3%	2,233	$3,704,727	0.4%	0.6% - 2.0%
Advanced imaging - CAT: head	1.2%	465	$3,693,951	0.8%	(0.3%) - 2.7%
Echography - heart	0.3%	1,662	$3,339,707	0.2%	(0.0%) - 0.6%
Lab tests - routine venipuncture (non Medicare fee schedule)	2.0%	5,141	$3,080,440	0.3%	1.4% - 2.7%
Imaging/procedure - other	1.1%	542	$2,940,869	0.6%	(0.1%) - 2.2%
Lab tests - automated general profiles	0.9%	2,739	$2,718,423	0.3%	0.4% - 1.4%
Eye procedure - other	0.6%	189	$2,666,812	0.6%	(0.5%) - 1.7%
Oncology - other	0.9%	471	$2,424,068	0.5%	(0.1%) - 1.9%
Lab tests - urinalysis	3.8%	1,539	$2,129,171	0.6%	2.5% - 5.0%
Endoscopy - bronchoscopy	2.3%	40	$1,795,010	0.4%	1.5% - 3.2%
Endoscopy - other	1.1%	77	$1,439,088	1.0%	(1.0%) - 3.1%
Endoscopy - upper gastrointestinal	0.3%	221	$1,438,916	0.2%	(0.1%) - 0.7%
Standard imaging - contrast gastrointestinal	1.4%	129	$1,111,461	0.8%	(0.2%) - 3.1%
Lab tests - glucose	5.7%	505	$1,079,928	2.7%	0.5% - 10.9%
Ambulatory procedures - musculoskeletal	0.3%	93	$980,558	0.3%	(0.3%) - 0.9%
Endoscopy - cystoscopy	0.3%	145	$976,422	0.3%	(0.3%) - 0.9%
Other - non-Medicare fee schedule	1.8%	456	$691,471	0.9%	(0.1%) - 3.6%
Lab tests - bacterial cultures	1.0%	596	$691,053	0.4%	0.2% - 1.7%
Medical/surgical supplies	0.0%	58	$103	0.0%	(0.0%) - 0.0%
Endoscopy - laryngoscopy	0.0%	42	N/A	N/A	N/A
Enteral and parenteral	0.0%	35	N/A	N/A	N/A
Eye procedure - cataract	0.0%	260	N/A	N/A	N/A

removal/lens insertion					
Imaging/procedure - heart including cardiac catheter	0.0%	433	N/A	N/A	N/A
Major procedure - explor/decompr/excisdisc	0.0%	54	N/A	N/A	N/A
Major procedure, cardiovascular-Pacemaker insertion	0.0%	46	N/A	N/A	N/A
Major procedure, orthopedic - other	0.0%	128	N/A	N/A	N/A
No Service Code	0.0%	59	N/A	N/A	N/A
Orthotic devices	0.0%	50	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**5.0%**	**112,362**	**$3,678,057,770**	**0.3%**	**4.4% - 5.7%**

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

Service Types Billed to DMERCs (SADMERC Policy Group)	Paid Claims Error Rate				
	Error Rate	Number of Line Items (Sample)	Projected Improper Payment Amount	Standard Error	95% Confidence Interval
Surgical Dressings	75.7%	195	$176,320,864	11.9%	52.3% - 99.1%
Glucose Monitor	13.6%	2,719	$158,218,995	1.1%	11.5% - 15.8%
All Policy Groups with Less than 30 Claims	6.8%	627	$109,302,255	2.9%	1.2% - 12.5%
Nebulizers & Related Drugs	6.0%	2,525	$55,954,945	2.1%	1.8% - 10.2%
Support Surfaces	29.6%	64	$30,749,629	13.5%	3.1% - 56.1%
CPAP	7.4%	743	$27,821,845	2.5%	2.4% - 12.3%
Ostomy Supplies	16.2%	329	$22,990,712	7.7%	1.2% - 31.2%
Lower Limb Orthoses	9.8%	142	$17,429,493	5.1%	(0.1%) - 19.7%
Immunosuppressive Drugs	4.9%	221	$16,698,871	2.5%	(0.0%) - 9.8%
Oxygen Supplies/Equipment	0.7%	2,506	$14,516,566	0.2%	0.2% - 1.1%
Diabetic Shoes	7.2%	189	$12,610,011	3.6%	0.2% - 14.3%
Urological Supplies	19.5%	224	$10,838,330	8.8%	2.1% - 36.8%
Wheelchairs Options/Accessories	5.9%	402	$10,422,178	2.9%	0.2% - 11.5%
Enteral Nutrition	1.7%	460	$9,150,690	0.8%	0.0% - 3.3%
Wheelchairs Manual	2.5%	624	$5,572,536	0.8%	1.0% - 4.0%
Respiratory Assist Device	3.5%	70	$3,121,006	2.7%	(1.8%) - 8.9%
Hospital Beds/Accessories	1.1%	409	$2,831,681	0.7%	(0.2%) - 2.4%
Walkers	2.5%	174	$2,352,197	1.2%	0.2% - 4.8%
Lenses	2.4%	360	$2,064,086	1.4%	(0.4%) - 5.2%
Patient Lift	5.9%	54	$1,744,695	3.5%	(1.1%) - 12.8%
Upper Limb Orthoses	3.1%	60	$838,143	2.2%	(1.1%) - 7.4%
Commodes/Bed Pans/Urinals	1.7%	90	$698,881	1.4%	(1.0%) - 4.5%
Canes/Crutches	4.5%	52	$564,786	4.4%	(4.1%) - 13.2%
Repairs/DME	2.1%	33	$212,720	2.0%	(1.7%) - 5.9%
Suction Pump	0.4%	35	$33,501	0.4%	(0.4%) - 1.1%

Infusion Pumps & Related Drugs	0.0%	165	N/A	N/A	N/A
Wheelchairs Seating	0.0%	31	N/A	N/A	N/A
Routinely Denied Items	N/A	76	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**7.5%**	**13,579**	**$693,059,615**	**1.4%**	**4.8% - 10.2%**

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

Service Types Billed to FIs (Type of Bill)	Paid Claims Error Rate				
	Error Rate	Number of Claims (Sample)	Projected Improper Payments	Standard Error	95% Confidence Interval
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	4.0%	44,128	$751,977,856	1.3%	1.4% - 6.6%
SNF	2.6%	2,762	$413,051,911	0.4%	1.8% - 3.4%
HHA	1.3%	1,920	$131,176,555	0.3%	0.7% - 1.9%
ESRD	1.1%	1,260	$57,244,659	0.2%	0.7% - 1.6%
Other FI Service Types	1.8%	6,626	$54,893,013	0.4%	1.0% - 2.7%
Hospice	0.5%	875	$30,506,621	0.4%	(0.3%) - 1.3%
Non-PPS Hospital In-patient	0.8%	2,733	$26,805,372	0.3%	0.3% - 1.4%
RHCs	0.8%	3,353	$3,090,183	0.2%	0.4% - 1.1%
Free Standing Ambulatory Surgery	0.9%	83	$2,532,747	0.6%	(0.4%) - 2.1%
FQHC	0.6%	577	$1,882,474	0.4%	(0.1%) - 1.4%
All Type of Services (Incl. Codes Not Listed)	**2.3%**	**64,317**	**$1,473,161,391**	**0.4%**	**1.5% - 3.2%**

Table 13d: Paid Claims Error Rates by Service Type: QIOs[10]

PPS Acute Care Hospital Service Types Billed to QIOs(DRGs)	Paid Claims Error Rate				
	Error Rate	Number of Claims (Sample)	Projected Improper Payments	Standard Error	95% Confidence Interval
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	15.0%	937	$187,082,865	1.7%	11.6% - 18.3%
CHEST PAIN	23.6%	651	$140,684,158	2.7%	18.4% - 28.9%
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	8.2%	145	$136,371,770	4.0%	0.5% - 16.0%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	10.3%	299	$113,304,004	3.1%	4.1% - 16.5%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	9.9%	744	$99,778,098	1.4%	7.1% - 12.6%
HEART FAILURE & SHOCK	2.6%	2016	$92,837,802	0.5%	1.7% - 3.5%
MEDICAL BACK PROBLEMS	24.6%	295	$90,780,428	4.1%	16.5% - 32.6%
OTHER KIDNEY & URINARY TRACT PROCEDURES	19.0%	109	$81,193,238	8.0%	3.3% - 34.6%
OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	10.6%	326	$79,400,460	2.4%	5.9% - 15.2%

[10] Some error rates on this table may exceed 100%. For further information see "Weighting and Determining the Final Results."

OTHER VASCULAR PROCEDURES W CC	6.3%	262	$76,812,888	2.1%	2.1% - 10.4%
RENAL FAILURE	5.0%	618	$74,328,319	0.9%	3.2% - 6.8%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	14.1%	256	$69,093,147	3.0%	8.2% - 20.0%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	2.4%	1786	$68,261,315	0.5%	1.5% - 3.4%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	11.9%	319	$68,213,412	3.4%	5.3% - 18.5%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	6.8%	694	$66,603,196	1.5%	3.9% - 9.6%
MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.7%	1294	$66,321,336	0.7%	0.4% - 3.1%
SEPTICEMIA AGE >17	2.3%	875	$63,669,187	0.6%	1.1% - 3.6%
SYNCOPE & COLLAPSE W CC	11.7%	388	$54,753,458	2.4%	7.0% - 16.3%
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	6.2%	613	$53,711,183	1.3%	3.7% - 8.8%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	25.2%	238	$51,260,586	4.7%	15.9% - 34.4%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	5.5%	357	$49,698,819	1.8%	1.9% - 9.1%
RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	1.8%	371	$48,730,484	0.7%	0.4% - 3.2%
G.I. HEMORRHAGE W CC	3.5%	859	$47,815,292	0.9%	1.8% - 5.3%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	2.3%	1297	$43,491,122	0.5%	1.3% - 3.4%
DIABETES AGE >35	10.9%	278	$42,364,753	2.4%	6.2% - 15.5%
MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.5%	473	$40,228,595	0.7%	0.2% - 2.9%
DEGENERATIVE NERVOUS SYSTEM DISORDERS	15.2%	163	$39,976,366	4.0%	7.4% - 23.1%
TRANSIENT ISCHEMIA	10.3%	320	$38,106,705	2.3%	5.7% - 14.9%
RED BLOOD CELL DISORDERS AGE >17	7.2%	334	$35,409,639	2.1%	3.1% - 11.4%
EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.0%	169	$35,328,601	1.2%	0.6% - 5.3%
CORONARY BYPASS W CARDIAC CATH	2.4%	158	$34,252,368	1.9%	(1.3%) - 6.1%
NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	10.4%	83	$33,381,255	3.4%	3.7% - 17.2%
SEIZURE & HEADACHE AGE >17 W CC	9.7%	180	$32,730,034	2.4%	4.9% - 14.5%
OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	9.3%	184	$31,457,234	2.5%	4.5% - 14.1%
PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	13.1%	58	$30,768,690	10.0%	(6.6%) - 32.8%
EPISTAXIS	130.3%	37	$30,527,299	127.8%	(120.2%) - 380.9%

CELLULITIS AGE >17 W CC	5.8%	367	$30,469,292	1.4%	3.0% - 8.6%
INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	1.7%	829	$29,546,756	0.4%	0.8% - 2.5%
RESPIRATORY NEOPLASMS	6.2%	193	$29,119,412	2.3%	1.6% - 10.8%
RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	2.1%	502	$28,792,005	0.8%	0.5% - 3.7%
PULMONARY EDEMA & RESPIRATORY FAILURE	3.9%	302	$27,964,778	1.5%	1.0% - 6.8%
PSYCHOSES	9.5%	216	$27,945,052	5.1%	(0.4%) - 19.5%
SYNCOPE & COLLAPSE W/O CC	20.8%	137	$27,548,570	5.1%	10.9% - 30.7%
SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	10.7%	75	$27,368,720	5.5%	(0.1%) - 21.4%
SIGNS & SYMPTOMS W CC	23.3%	88	$27,303,141	7.6%	8.5% - 38.1%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	1.2%	582	$26,664,135	0.3%	0.5% - 1.9%
PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	11.0%	61	$26,180,665	5.4%	0.5% - 21.5%
PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	12.2%	150	$26,028,359	3.9%	4.5% - 19.9%
OTHER RESP SYSTEM O.R. PROCEDURES W CC	3.2%	136	$25,220,946	1.6%	0.0% - 6.4%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	11.4%	64	$25,161,300	6.9%	(2.0%) - 24.9%
O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.9%	184	$25,012,034	0.9%	0.1% - 3.7%
DYSEQUILIBRIUM	22.5%	126	$24,671,207	6.4%	10.0% - 35.1%
G.I. OBSTRUCTION W CC	5.5%	295	$24,596,969	1.8%	1.8% - 9.1%
BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	37.7%	61	$23,526,866	11.4%	15.3% - 60.2%
CIRRHOSIS & ALCOHOLIC HEPATITIS	11.0%	94	$23,230,397	6.5%	(1.7%) - 23.7%
SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	38.7%	78	$22,952,627	10.5%	18.0% - 59.3%
ATHEROSCLEROSIS W CC	7.8%	307	$22,728,115	1.9%	4.1% - 11.6%
SKIN ULCERS	19.6%	79	$22,493,355	8.6%	2.8% - 36.5%
URINARY STONES W CC, &/OR ESW LITHOTRIPSY	26.0%	75	$20,821,454	12.4%	1.7% - 50.3%
OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	4.5%	90	$20,648,280	2.7%	(0.7%) - 9.7%
FRACTURES OF HIP & PELVIS	14.4%	136	$20,542,220	4.8%	5.0% - 23.7%
PRM CARD PACEM IMPL W AMI/HF/SHOCK OR AICD LEAD OR GNRTR PROC	5.8%	49	$19,879,161	2.7%	0.6% - 11.0%
OTHER DISORDERS OF NERVOUS SYSTEM W CC	12.8%	95	$19,720,650	4.2%	4.5% - 21.1%
OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	9.5%	69	$19,622,572	5.6%	(1.5%) - 20.4%
PERIPHERAL VASCULAR DISORDERS W CC	4.6%	251	$19,487,346	1.1%	2.4% - 6.8%

OTHER VASCULAR PROCEDURES W/O CC	9.0%	97	$19,066,843	5.0%	(0.9%) - 18.8%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	20.8%	130	$18,534,861	4.9%	11.2% - 30.4%
PLEURAL EFFUSION W CC	12.1%	79	$17,992,852	5.4%	1.6% - 22.7%
OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	7.9%	53	$17,918,555	5.6%	(3.1%) - 18.8%
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	11.1%	253	$17,846,713	3.7%	3.8% - 18.4%
ORGANIC DISTURBANCES & MENTAL RETARDATION	18.8%	66	$17,816,671	9.9%	(0.6%) - 38.3%
HYPERTENSION	15.3%	115	$17,194,360	5.3%	5.0% - 25.7%
BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	8.3%	51	$17,105,863	5.5%	(2.5%) - 19.1%
KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	8.2%	35	$17,044,520	6.1%	(3.7%) - 20.1%
OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	8.2%	35	$16,253,393	4.3%	(0.2%) - 16.5%
SPINAL FUSION EXCEPT CERVICAL W/O CC	5.1%	83	$16,174,971	3.9%	(2.6%) - 12.8%
DISORDERS OF THE BILIARY TRACT W CC	6.7%	107	$16,083,035	3.8%	(0.8%) - 14.2%
OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	28.3%	30	$15,806,666	12.6%	3.7% - 52.9%
BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	6.0%	120	$15,541,807	2.3%	1.6% - 10.4%
MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	6.2%	95	$15,159,135	2.8%	0.7% - 11.6%
CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.3%	459	$15,153,481	0.5%	0.3% - 2.3%
DISORDERS OF PANCREAS EXCEPT MALIGNANCY	3.7%	227	$15,051,302	1.7%	0.3% - 7.0%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	12.9%	167	$15,023,489	4.5%	4.1% - 21.7%
PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI	4.5%	79	$14,506,032	2.1%	0.4% - 8.6%
INTERSTITIAL LUNG DISEASE W CC	13.8%	51	$14,254,315	7.3%	(0.6%) - 28.2%
TRANSURETHRAL PROCEDURES W CC	9.2%	70	$14,150,630	5.3%	(1.3%) - 19.6%
HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	9.8%	63	$13,988,836	6.1%	(2.1%) - 21.8%
CRANIAL & PERIPHERAL NERVE DISORDERS W CC	8.0%	78	$13,810,481	4.1%	(0.1%) - 16.1%
INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	22.0%	35	$13,793,096	21.9%	(20.9%) - 64.9%
LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	5.3%	80	$13,741,246	3.5%	(1.5%) - 12.1%
SEIZURE & HEADACHE AGE >17 W/O CC	17.0%	65	$13,733,905	6.9%	3.5% - 30.5%

STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	2.0%	107	$13,614,383	1.7%	(1.4%) - 5.4%
CONNECTIVE TISSUE DISORDERS W CC	13.2%	35	$13,540,832	10.1%	(6.6%) - 33.1%
EXTRACRANIAL PROCEDURES W CC	3.4%	162	$13,425,416	1.7%	0.0% - 6.7%
POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	7.2%	102	$13,178,208	3.2%	0.9% - 13.4%
OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	11.2%	30	$12,389,702	8.5%	(5.5%) - 27.9%
COAGULATION DISORDERS	8.4%	44	$11,958,302	3.8%	0.9% - 15.9%
FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	12.6%	93	$11,922,716	5.0%	2.9% - 22.3%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	14.6%	100	$11,871,372	4.8%	5.2% - 23.9%
RESPIRATORY SIGNS & SYMPTOMS W CC	15.9%	64	$11,860,899	6.9%	2.4% - 29.3%
LYMPHOMA & NON-ACUTE LEUKEMIA W CC	3.4%	99	$11,527,373	1.1%	1.3% - 5.5%
CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	5.8%	87	$11,520,696	2.9%	0.1% - 11.4%
LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	10.9%	80	$11,480,376	6.9%	(2.6%) - 24.3%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	31.5%	39	$11,478,447	16.8%	(1.4%) - 64.4%
ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	28.1%	50	$11,350,359	10.5%	7.6% - 48.6%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	2.0%	153	$11,100,244	1.6%	(1.0%) - 5.1%
ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	9.1%	129	$10,932,139	2.6%	4.0% - 14.2%
HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	6.7%	87	$10,780,601	4.7%	(2.6%) - 15.9%
CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	4.7%	50	$10,715,385	4.1%	(3.3%) - 12.7%
DIGESTIVE MALIGNANCY W CC	4.1%	115	$10,663,205	1.4%	1.3% - 6.8%
ANGINA PECTORIS	15.6%	93	$10,589,738	7.0%	1.9% - 29.3%
SPINAL FUSION EXCEPT CERVICAL W CC	1.5%	130	$10,265,319	1.0%	(0.4%) - 3.4%
BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	5.1%	172	$10,236,828	2.1%	1.0% - 9.2%
HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	0.8%	454	$9,989,977	0.4%	0.0% - 1.6%
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	0.9%	440	$9,927,055	0.5%	(0.1%) - 1.9%
VIRAL ILLNESS AGE >17	18.9%	53	$9,854,872	11.3%	(3.2%) - 41.1%
LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6%	181	$9,710,332	0.8%	0.0% - 3.3%

COMPLICATED PEPTIC ULCER	11.3%	42	$9,541,535	7.4%	(3.2%) - 25.9%
PULMONARY EMBOLISM	2.9%	170	$9,465,435	2.4%	(1.9%) - 7.7%
NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	11.2%	47	$9,137,553	7.0%	(2.5%) - 24.9%
TRANSURETHRAL PROSTATECTOMY W/O CC	17.1%	92	$8,975,890	7.1%	3.2% - 31.1%
TENDONITIS, MYOSITIS & BURSITIS	12.1%	50	$8,782,912	6.1%	0.2% - 24.0%
NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	7.2%	45	$8,765,684	3.9%	(0.3%) - 14.8%
WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.1%	33	$8,685,653	2.9%	(2.6%) - 8.8%
THYROID PROCEDURES	16.0%	43	$8,683,239	9.7%	(3.1%) - 35.1%
G.I. HEMORRHAGE W/O CC	11.8%	103	$8,607,141	4.2%	3.6% - 20.1%
BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.1%	68	$8,518,496	2.1%	(1.1%) - 7.2%
OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	8.1%	86	$8,517,649	3.5%	1.2% - 15.1%
DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	27.8%	31	$8,281,019	15.7%	(2.9%) - 58.6%
BRONCHITIS & ASTHMA AGE >17 W/O CC	13.3%	96	$8,252,791	5.3%	3.0% - 23.7%
HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	18.2%	35	$8,088,523	7.3%	3.9% - 32.5%
DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	3.4%	101	$7,743,294	2.1%	(0.7%) - 7.4%
FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	43.3%	41	$7,715,498	22.1%	(0.0%) - 86.6%
ENDOCRINE DISORDERS W CC	5.7%	72	$7,399,965	2.2%	1.4% - 9.9%
BRONCHITIS & ASTHMA AGE >17 W CC	3.5%	150	$7,165,846	1.1%	1.4% - 5.6%
TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	10.1%	55	$6,866,627	3.9%	2.4% - 17.8%
COMPLICATIONS OF TREATMENT W CC	4.0%	101	$6,797,175	1.4%	1.3% - 6.6%
VAGINA, CERVIX & VULVA PROCEDURES	11.4%	66	$6,647,377	8.1%	(4.4%) - 27.2%
OTITIS MEDIA & URI AGE >17 W CC	11.3%	68	$6,620,885	4.5%	2.5% - 20.1%
CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	2.5%	180	$6,371,523	1.1%	0.3% - 4.8%
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	6.3%	96	$6,334,028	3.9%	(1.3%) - 14.0%
AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	6.1%	34	$6,253,877	4.9%	(3.5%) - 15.6%
LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	5.2%	71	$6,101,448	3.4%	(1.4%) - 11.9%

MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	3.0%	84	$6,020,820	2.9%	(2.8%) - 8.7%
MAJOR MALE PELVIC PROCEDURES W/O CC	9.3%	44	$5,963,065	6.1%	(2.7%) - 21.3%
G.I. OBSTRUCTION W/O CC	9.6%	87	$5,709,713	5.1%	(0.5%) - 19.7%
CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.1%	50	$5,649,990	1.1%	(1.0%) - 3.1%
CERVICAL SPINAL FUSION W/O CC	4.1%	62	$5,633,127	3.1%	(2.1%) - 10.2%
CELLULITIS AGE >17 W/O CC	6.2%	92	$4,917,038	2.6%	1.2% - 11.3%
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	3.8%	65	$4,709,506	2.5%	(1.0%) - 8.7%
FEVER OF UNKNOWN ORIGIN AGE >17 W CC	5.7%	65	$4,660,019	3.8%	(1.8%) - 13.1%
PNEUMOTHORAX W CC	5.8%	50	$4,605,132	4.6%	(3.2%) - 14.8%
OTHER O.R. PROCEDURES FOR INJURIES W CC	1.6%	61	$4,464,617	0.8%	0.0% - 3.1%
NONTRAUMATIC STUPOR & COMA	9.6%	43	$4,438,619	3.8%	2.2% - 17.0%
CRANIOTOMY AGE >17 W CC	0.8%	96	$4,234,114	0.6%	(0.4%) - 2.0%
MAJOR MALE PELVIC PROCEDURES W CC	6.1%	40	$4,216,417	3.2%	(0.2%) - 12.3%
ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	13.2%	44	$3,933,757	7.7%	(1.8%) - 28.2%
TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	2.4%	65	$3,711,141	1.6%	(0.6%) - 5.5%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	0.4%	217	$3,421,100	0.2%	(0.1%) - 0.8%
POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	1.8%	125	$3,296,234	0.8%	0.2% - 3.4%
CIRCULATORY DISORDERS W AMI, EXPIRED	1.3%	100	$3,281,889	1.1%	(0.9%) - 3.6%
OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.0%	56	$3,139,896	0.8%	(0.5%) - 2.5%
AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	6.3%	54	$3,123,050	2.5%	1.4% - 11.2%
RECTAL RESECTION W CC	2.0%	45	$3,059,525	2.0%	(1.9%) - 5.9%
PERCUTANEOUS CARDIOVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI	1.5%	59	$2,901,806	1.1%	(0.6%) - 3.6%
FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	4.0%	82	$2,865,784	2.6%	(1.2%) - 9.1%
INFLAMMATORY BOWEL DISEASE	3.4%	51	$2,829,458	1.9%	(0.3%) - 7.1%
RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	2.0%	60	$2,709,365	1.1%	(0.1%) - 4.2%
TOTAL MASTECTOMY FOR MALIGNANCY W CC	4.4%	51	$2,512,509	4.4%	(4.1%) - 12.9%
MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.7%	73	$2,385,700	1.6%	(1.5%) - 4.9%
PERIPHERAL VASCULAR DISORDERS W/O CC	3.7%	83	$2,059,872	1.4%	0.9% - 6.5%
MAJOR CARDIOVASCULAR PROCEDURES W CC	0.1%	180	$1,967,051	0.1%	(0.0%) - 0.3%

ANAL & STOMAL PROCEDURES W CC	3.3%	34	$1,852,207	2.0%	(0.7%) - 7.2%
EXTRACRANIAL PROCEDURES W/O CC	0.8%	142	$1,705,922	0.8%	(0.7%) - 2.3%
HIV W MAJOR RELATED CONDITION	1.0%	45	$1,663,469	0.7%	(0.3%) - 2.2%
CORONARY BYPASS W/O CARDIAC CATH	0.2%	124	$1,530,298	0.2%	(0.2%) - 0.6%
CERVICAL SPINAL FUSION W CC	0.8%	47	$1,521,895	0.4%	0.0% - 1.7%
TRANSURETHRAL PROSTATECTOMY W CC	1.1%	103	$1,291,089	0.8%	(0.4%) - 2.6%
NERVOUS SYSTEM NEOPLASMS W CC	1.0%	67	$1,248,433	0.5%	(0.1%) - 2.0%
MAJOR CHEST PROCEDURES	0.1%	145	$1,043,799	0.1%	(0.1%) - 0.3%
O.R. PROCEDURES FOR OBESITY	0.8%	43	$1,022,866	0.7%	(0.6%) - 2.1%
CRANIOTOMY AGE >17 W/O CC	0.9%	32	$1,012,708	0.8%	(0.7%) - 2.4%
AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	0.1%	94	$782,121	0.1%	(0.1%) - 0.4%
MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	0.9%	38	$623,315	0.7%	(0.5%) - 2.3%
PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI	0.1%	49	$243,228	0.1%	(0.0%) - 0.3%
AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	0.2%	34	$155,928	0.2%	(0.1%) - 0.5%
TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.4%	40	$143,119	0.4%	(0.3%) - 1.1%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	0.0%	95	$0	0.0%	0.0% - 0.0%
CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	0.0%	35	$0	0.0%	0.0% - 0.0%
REVISION OF HIP OR KNEE REPLACEMENT	0.0%	50	$0	0.0%	0.0% - 0.0%
TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK DIAG W/O MAJ O.R.	0.0%	64	$0	0.0%	0.0% - 0.0%
TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK DIAG W MAJ O.R.	0.0%	66	$0	0.0%	0.0% - 0.0%
CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	0.0%	33	$0	0.0%	0.0% - 0.0%
KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	0.0%	73	$0	0.0%	0.0% - 0.0%
KIDNEY TRANSPLANT	0.0%	33	$0	0.0%	0.0% - 0.0%
PANCREAS, LIVER & SHUNT PROCEDURES W CC	0.0%	30	$0	0.0%	0.0% - 0.0%
PERITONEAL ADHESIOLYSIS W CC	0.0%	78	$0	0.0%	0.0% - 0.0%
OTHER CARDIOTHORACIC PROCEDURES	0.0%	35	$0	0.0%	0.0% - 0.0%

CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	0.0%	112	$0	0.0%	0.0% - 0.0%
CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	0.0%	52	$0	0.0%	0.0% - 0.0%
Overall	**4.9%**	**N/A**	**$4,934,641,908**	**0.2%**	**4.5% - 5.2%**

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.

Division of 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, and the promotion of efficient practices in a manner commensurate with the Group's goals.

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