# Improper Medicare Fee-For-Service Payments Report - May 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.

Strong outcome-oriented performance measures are a good way to assess the degree to which a government program is accomplishing its mission and to identify improvement opportunities. This May 2006 Report describes the performance measurement process for Carriers/DMERCs/FIs/QIOs.

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

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

- CERT randomly selecting a sample of 116,417 claims submitted to Carriers/DMERCs/FIs during the reporting period.
- HPMP randomly selecting a sample of 39,821 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*. CMS has accelerated the reporting periods of both the CERT program and the HPMP. Beginning with this report, the CERT reporting period has been accelerated by three months and the HPMP has accelerated its schedule by six. The CERT acceleration process has, as a side effect, forced the exclusion of three months worth of data that would normally have been included. More information is available in the section titled "The CERT Program". The following table outlines the reporting periods to date for improper payment reports as well as the changes planned for upcoming reports.

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

# Summary of Findings

### National Error Rate

This report shows that 5.1% of the dollars paid nationally did not comply with one or more Medicare coverage, coding, billing, and payment rules. Projected overpayments were $11.9 B and the underpayments were $1.2 B. Thus, gross improper payments were projected as $13.1 B (i.e., $11.9 B **plus** $1.2 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 | $75.9B | $4.4B | 5.7% | $0.2B | 0.2% | $4.5B | 6.0% |
| DMERC | $10.2B | $0.8B | 7.7% | $0B | 0.1% | $0.8B | 7.8% |
| FI | $71.5B | $2.3B | 3.2% | $0.2B | 0.2% | $2.5B | 3.5% |
| QIOs | $99.8B | $4.4B | 4.4% | $0.9B | 0.9% | $5.3B | 5.3% |
| **All Medicare FFS** | **$257.4B** | **$11.9B** | **4.6%** | **$1.2B** | **0.5%** | **$13.1B** | **5.1%** |

# Corrective Actions Taken to Date

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

1. Using the First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) that generates state-specific hospital billing reports to help QIOs analyze administrative claims data and target interventions with hospitals,
2. Increasing and refining one-on-one educational contacts with providers found to be billing in error,
3. Developing projects with the QIOs addressing state-specific admissions necessity, coding concerns, and billing, as well as, conducting surveillance and monitoring of inpatient payment error trends by error type,
4. Distributing FATHOM generated hospital-specific reports to hospitals,
5. Providing targeted education to hospitals with high numbers of medically unnecessary admissions,
6. Developing and distributing QIO-specific payment error cause analyses, and
7. Conducting national training on the use of FATHOM reports in compliance efforts.
8. Developing a reporting tool that provides monthly updates to 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 with this

May report 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. Although the May and November 2006 reports will be partially effected, 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.

# FINDINGS

## National Medicare FFS Error Rate

The national paid claims error rate in the Medicare FFS program for this reporting period is 5.1% (which equates to $13.1 B). The 95% confidence interval for Medicare FFS program paid claims error rate was 4.7% - 5.5%. The 90% confidence interval (required to be reported by IPIA) was 4.7% - 5.4%.

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 | $75.9B | $4.4B | 5.7% | $0.2B | 0.2% | $4.5B | 6.0% |
| DMERC | $10.2B | $0.8B | 7.7% | $0B | 0.1% | $0.8B | 7.8% |
| FI | $71.5B | $2.3B | 3.2% | $0.2B | 0.2% | $2.5B | 3.5% |
| QIOs | $99.8B | $4.4B | 4.4% | $0.9B | 0.9% | $5.3B | 5.3% |
| **All Medicare FFS** | **$257.4B** | **$11.9B** | **4.6%** | **$1.2B** | **0.5%** | **$13.1B** | **5.1%** |

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

**Table 3b: National Error Rates by Year[1]**

| Year | Total Dollars Paid | Overpayments | | Underpayments | | Overpayments + Underpayments | |
|---|---|---|---|---|---|---|---|
| | | Payment | Rate | Payment | Rate | Improper Payments | Rate |
| **1996** | $168.1 B | $23.5B | 14.0% | $0.3 B | 0.2% | $23.8 B | 14.2% |
| **1997** | $177.9 B | $20.6B | 11.6% | $0.3 B | 0.2% | $20.9 B | 11.8% |
| **1998** | $177.0 B | $13.8B | 7.8% | $1.2 B | 0.6% | $14.9 B | 8.4% |
| **1999** | $168.9 B | $14.0B | 8.3% | $0.5 B | 0.3% | $14.5 B | 8.6% |
| **2000** | $174.6 B | $14.1B | 8.1% | $2.3 B | 1.3% | $16.4 B | 9.4% |
| **2001** | $191.3 B | $14.4B | 7.5% | $2.4 B | 1.3% | $16.8 B | 8.8% |
| **2002** | $212.8 B | $15.2B | 7.1% | $1.9 B | 0.9% | $17.1 B | 8.0% |
| **2003** | $199.1 B | $20.5B | 10.3% | $0.9 B | 0.5% | $12.7 B | 6.4% |
| **2004** | $213.5 B | $20.8B | 9.7% | $0.9 B | 0.4% | $21.7 B | 10.1% |
| **2005** | $234.1 B | $11.2 B | 4.8% | $0.9 B | 0.4% | $12.1 B | 5.2% |
| **May 2006** | $257.4 B | $11.9 B | 4.6% | $1.2 B | 0.5% | $13.1 B | 5.1% |

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

# 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 |
|---|---|---|---|---|
| 1.8% | 0.3% | 1.0% | 2.1% | 5.1% |

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**

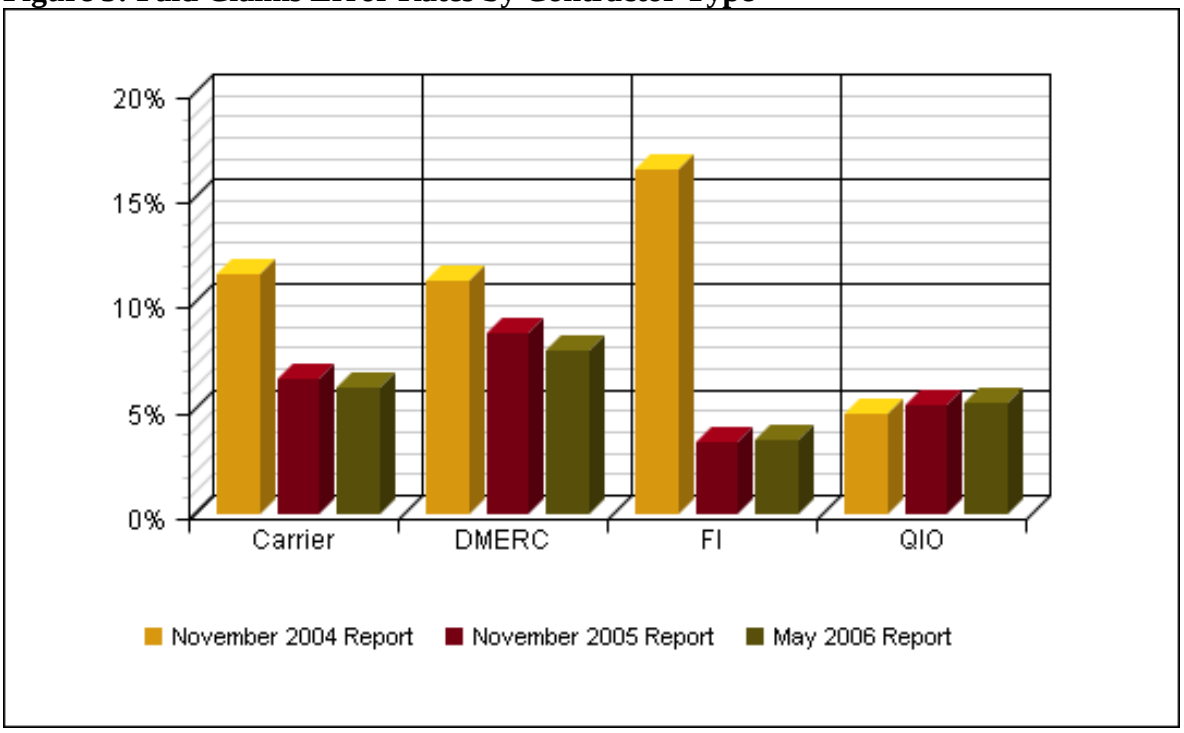
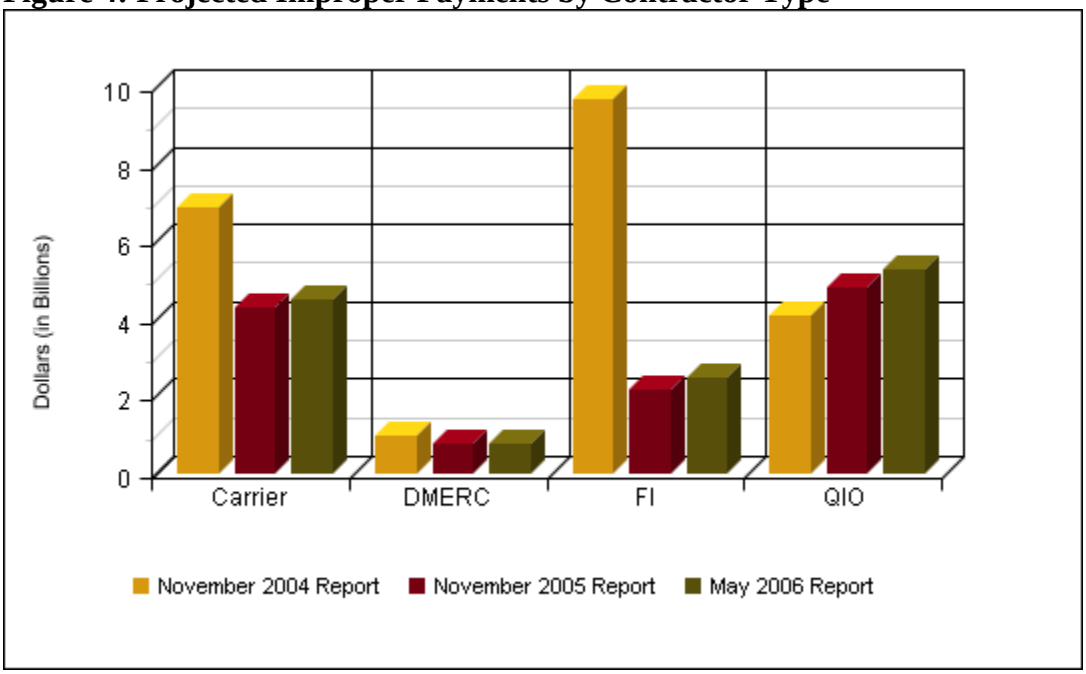


**Figure 4: Projected Improper Payments by Contractor Type**




# 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 | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Triple S, Inc. PR/VI 00973/00974 | 15.8% | $108,676,886 | 4.4% | 7.1% - 24.5% | 15.5% | 25.7% | 25.5% |
| First Coast Service Options FL 00590 | 12.7% | $996,247,537 | 3.1% | 6.6% - 18.8% | 6.0% | 24.5% | 14.3% |
| GHI NY 14330 | 9.2% | $34,848,527 | 1.2% | 6.9% - 11.5% | 8.7% | 26.2% | 25.9% |
| Regence UT 00910 | 7.8% | $27,416,160 | 1.2% | 5.5% - 10.0% | 7.3% | 25.6% | 25.3% |
| Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/00836 | 7.6% | $285,476,073 | 1.6% | 4.5% - 10.8% | 7.1% | 19.6% | 19.2% |
| Empire NY 00803 | 7.2% | $288,134,250 | 0.7% | 5.9% - 8.6% | 6.7% | 20.2% | 19.8% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528 | 7.0% | $285,665,886 | 1.0% | 5.0% - 9.0% | 5.7% | 17.8% | 16.9% |
| Cahaba AL/GA/MS 00510/00511/00512 | 6.7% | $276,645,614 | 0.7% | 5.4% - 8.0% | 6.3% | 21.2% | 20.9% |
| Empire NJ 00805 | 6.7% | $214,074,317 | 0.9% | 5.0% - 8.3% | 6.1% | 19.4% | 19.0% |
| **Average=** | **6.0%** | | | | | | |
| BCBS AR RI 00524 | 5.6% | $12,378,311 | 0.5% | 4.5% - 6.7% | 5.4% | 20.9% | 20.7% |
| CIGNA TN 05440 | 5.4% | $95,530,325 | 0.6% | 4.1% - 6.6% | 4.6% | 15.9% | 15.4% |
| Palmetto OH/WV 00883/00884 | 5.2% | $180,647,476 | 0.6% | 4.0% - 6.4% | 4.5% | 13.5% | 12.9% |
| NHIC CA 31140/31146 | 4.7% | $328,493,442 | 0.6% | 3.6% - 5.8% | 4.3% | 17.4% | 16.9% |
| Palmetto SC 00880 | 4.5% | $50,913,622 | 0.5% | 3.5% - 5.5% | 4.0% | 17.9% | 17.6% |
| AdminaStar IN/KY 00630/00660 | 4.3% | $119,943,743 | 1.0% | 2.5% - 6.2% | 2.9% | 17.5% | 16.8% |
| WPS WI/IL/MI/MN 00951/00952/00953/00954 | 4.3% | $348,537,039 | 0.4% | 3.5% - 5.2% | 3.7% | 14.5% | 14.0% |
| Trailblazer TX 00900 | 4.1% | $219,885,131 | 0.5% | 3.0% - 5.2% | 3.6% | 17.0% | 16.7% |
| HGSA PA 00865 | 3.9% | $131,594,320 | 0.4% | 3.1% - 4.7% | 3.6% | 13.4% | 13.2% |
| NHIC ME/MA/NH/VT 31142/31143/31144/31145 | 3.8% | $89,746,230 | 0.5% | 2.9% - 4.7% | 3.5% | 11.7% | 11.5% |
| First Coast Service Options CT 00591 | 3.8% | $43,897,595 | 0.4% | 3.0% - 4.6% | 3.5% | 13.0% | 12.8% |
| HealthNow NY 00801 | 3.8% | $50,991,441 | 0.4% | 2.9% - 4.7% | 3.5% | 17.4% | 17.2% |
| Noridian CO/ND/WY/IA/SD 00820/00824/00825/00826/00889 | 3.7% | $64,479,669 | 0.6% | 2.5% - 4.9% | 3.4% | 13.5% | 13.3% |
| Trailblazer MD/DE/DC/VA 00901/00902/00903/00904 | 3.7% | $131,940,178 | 0.3% | 3.1% - 4.3% | 3.5% | 15.6% | 15.5% |
| CIGNA NC 05535 | 3.5% | $80,024,333 | 0.4% | 2.7% - 4.4% | 3.1% | 13.5% | 13.2% |
| BCBS KS/NE/W MO 00650/00655/00651 | 3.4% | $50,473,270 | 0.4% | 2.7% - 4.1% | 2.7% | 12.8% | 12.2% |
| BCBS MT 00751 | 3.2% | $6,655,092 | 0.5% | 2.3% - 4.2% | 2.8% | 13.1% | 12.8% |
| CIGNA ID 05130 | 2.9% | $6,071,356 | 0.5% | 1.9% - 3.8% | 2.7% | 15.3% | 15.2% |
| **Combined** | **6.0%** | **$4,529,387,825** | **0.4%** | **5.3% - 6.7%** | **4.8%** | **17.5%** | **16.1%** |

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 | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Palmetto Region C 00885 | 10.8% | $499,355,694 | 2.9% | 5.1% - 16.5% | 4.8% | 25.2% | 21.0% |
| **Average=** | **7.8%** | | | | | | |
| AdminaStar - Region B 00635 | 6.7% | $148,308,491 | 1.9% | 3.0% - 10.5% | 6.6% | 14.9% | 14.8% |
| Tricenturion Region A 77011 | 4.8% | $70,291,525 | 0.8% | 3.2% - 6.3% | 3.7% | 9.5% | 8.6% |
| CIGNA Region D 05655 | 4.0% | $75,140,066 | 0.6% | 2.8% - 5.1% | 3.8% | 12.2% | 12.1% |
| **Combined** | **7.8%** | **$793,095,776** | **1.4%** | **5.0% - 10.5%** | **4.8%** | **18.3%** | **16.1%** |

# 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 | | | | |
|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No DocClaims |
| Empire CT/DE/NY 00308 | 12.2% | $545,199,710 | 7.7% | ( 2.8%) - 27.2% | 12.2% |
| COSVI PR/VI 57400 | 9.4% | $10,142,685 | 1.7% | 6.0% - 12.8% | 6.8% |
| Mutual of Omaha (all states) 52280 | 5.4% | $447,746,065 | 1.5% | 2.4% - 8.3% | 5.0% |
| BCBS WY WY 00460 | 4.3% | $2,589,253 | 1.2% | 2.1% - 6.6% | 3.9% |
| UGS AS/CA/GU/HI/NV/NMI 00454 | 4.3% | $214,148,475 | 1.0% | 2.3% - 6.2% | 3.7% |
| Medicare NW ID/OR/UT 00350 | 3.8% | $32,727,791 | 0.3% | 3.3% - 4.3% | 3.1% |

| | | | | | |
|---|---|---|---|---|---|
| Trispan LA/MO/MS 00230 | 3.7% | $56,959,133 | 0.7% | 2.4% - 5.1% | 3.3% |
| **Average=** | **3.5%** | | | | |
| Carefirst DC/MD 00366 | 3.4% | $120,338,173 | 0.6% | 2.1% - 4.6% | 3.3% |
| AdminaStar IN/IL/KY/OH 00130/00131/00160/00332 | 3.1% | $208,815,833 | 0.5% | 2.2% - 4.1% | 3.0% |
| Anthem ME/MA 00180/00181 | 3.1% | $64,994,980 | 0.9% | 1.3% - 4.9% | 2.8% |
| Veritus PA 00363 | 2.8% | $56,152,329 | 0.7% | 1.4% - 4.3% | 2.7% |
| BCBS AR AR 00020 | 2.8% | $11,620,168 | 0.6% | 1.7% - 4.0% | 2.7% |
| UGS WI/MI 00450/00452 | 2.7% | $160,873,375 | 0.9% | 0.9% - 4.5% | 2.4% |
| Trailblazer CO/NM/TX 00400 | 2.7% | $97,552,520 | 0.9% | 0.9% - 4.4% | 2.5% |
| Chisholm OK 00340 | 2.6% | $9,671,081 | 1.1% | 0.5% - 4.7% | 2.5% |
| Palmetto NC 00382 | 2.3% | $30,520,362 | 0.5% | 1.4% - 3.3% | 2.3% |
| First Coast Service Options FL 00090 | 2.2% | $50,673,099 | 0.3% | 1.6% - 2.9% | 1.9% |
| UGS VA/WV 00453 | 2.2% | $27,987,977 | 0.5% | 1.2% - 3.1% | 2.1% |
| Riverbend NJ/TN 00390 | 1.9% | $55,193,665 | 0.4% | 1.2% - 2.6% | 1.7% |
| Cahaba GBA 00010 | 1.9% | $26,117,629 | 0.5% | 1.0% - 2.8% | 1.3% |
| Noridian AK/WA 00322 | 1.8% | $10,442,635 | 0.7% | 0.5% - 3.2% | 1.5% |
| BCBS AR RI 00021 | 1.8% | $2,616,856 | 1.5% | ( 1.2%) - 4.8% | 1.8% |
| BCBS AZ AZ 00030 | 1.7% | $5,462,780 | 0.4% | 1.0% - 2.4% | 1.6% |
| Palmetto SC 00380 | 1.6% | $145,683,128 | 0.3% | 1.0% - 2.2% | 1.5% |
| BCBS KS KS 00150 | 1.5% | $6,874,698 | 0.4% | 0.8% - 2.3% | 1.5% |
| Cahaba IA/SD 00011 | 1.5% | $41,975,444 | 0.3% | 0.8% - 2.2% | 1.5% |
| BCBS GA GA 00101 | 1.4% | $26,886,005 | 0.4% | 0.7% - 2.1% | 1.3% |
| BCBS MT MT 00250 | 1.3% | $2,363,580 | 0.5% | 0.4% - 2.2% | 1.2% |
| Anthem NH/VT 00270 | 1.3% | $4,333,763 | 0.3% | 0.7% - 1.9% | 1.3% |
| Noridian MN/ND 00320/00321 | 1.1% | $11,234,063 | 0.2% | 0.6% - 1.6% | 1.1% |
| BCBS NE NE 00260 | 1.1% | $2,527,077 | 0.4% | 0.3% - 1.9% | 1.1% |
| **Combined** | **3.5%** | **$2,490,424,333** | **0.5%** | **2.4% - 4.5%** | **3.3%** |

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

## QIO-Specific Error Rates

Table 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[2]**

| QIOs | Paid Claims Error Rate | | | | | Provider Compliance Error Rate | |
|---|---|---|---|---|---|---|---|
| | Including No Doc Claims | Projected Improper Payments Including No Doc Claims | Standard Error | 95% Confidence Interval | Excluding No Doc Claims | Including No Doc Claims | Excluding No Doc Claims |
| Alabama | 4.7% | $84,297,045 | 0.8% | 3.2% - 6.3% | 4.4% | N/A | N/A |
| Alaska | 2.4% | $2,797,056 | 0.3% | 1.7% - 3.0% | 2.2% | N/A | N/A |
| Arizona | 5.9% | $81,658,433 | 0.9% | 4.1% - 7.7% | 5.7% | N/A | N/A |
| Arkansas | 7.4% | $73,706,691 | 0.8% | 5.8% - 9.0% | 7.4% | N/A | N/A |
| California | 7.0% | $544,506,841 | 1.2% | 4.7% - 9.3% | 6.5% | N/A | N/A |
| Colorado | 3.2% | $27,716,679 | 0.7% | 1.9% - 4.6% | 2.9% | N/A | N/A |
| Connecticut | 5.1% | $74,488,337 | 0.7% | 3.6% - 6.5% | 5.1% | N/A | N/A |
| Delaware | 5.3% | $17,983,307 | 0.7% | 4.0% - 6.6% | 5.2% | N/A | N/A |
| District of Columbia | 6.5% | $29,785,805 | 1.0% | 4.5% - 8.6% | 4.5% | N/A | N/A |
| Florida | 9.5% | $605,900,358 | 3.2% | 3.2% - 15.9% | 9.5% | N/A | N/A |
| Georgia | 2.9% | $72,538,118 | 0.6% | 1.8% - 4.0% | 2.8% | N/A | N/A |
| Hawaii | 2.3% | $5,728,342 | 0.4% | 1.6% - 3.0% | 2.3% | N/A | N/A |
| Idaho | 3.1% | $7,798,994 | 0.5% | 2.1% - 4.1% | 3.1% | N/A | N/A |
| Illinois | 3.9% | $171,779,780 | 0.6% | 2.7% - 5.0% | 3.9% | N/A | N/A |
| Indiana | 5.3% | $109,439,042 | 0.8% | 3.7% - 6.8% | 4.7% | N/A | N/A |
| Iowa | 3.5% | $31,461,784 | 0.6% | 2.4% - 4.6% | 3.4% | N/A | N/A |
| Kansas | 3.0% | $24,179,077 | 0.4% | 2.1% - 3.9% | 2.8% | N/A | N/A |
| Kentucky | 5.3% | $91,179,102 | 0.8% | 3.8% - 6.9% | 4.9% | N/A | N/A |
| Louisiana | 4.0% | $59,920,643 | 0.6% | 2.8% - 5.1% | 3.9% | N/A | N/A |
| Maine | 4.7% | $22,233,576 | 0.6% | 3.6% - 5.8% | 4.7% | N/A | N/A |
| Maryland | 2.9% | $72,208,675 | 0.5% | 1.8% - 3.9% | 2.6% | N/A | N/A |
| Massachusetts | 9.7% | $236,819,818 | 1.0% | 7.6% - 11.7% | 9.6% | N/A | N/A |
| Michigan | 5.7% | $234,166,000 | 0.8% | 4.1% - 7.2% | 5.7% | N/A | N/A |
| Minnesota | 4.8% | $77,228,597 | 0.7% | 3.5% - 6.2% | 4.3% | N/A | N/A |
| Mississippi | 5.4% | $58,576,819 | 0.8% | 3.9% - 6.9% | 5.0% | N/A | N/A |
| Missouri | 3.4% | $76,210,237 | 0.7% | 2.0% - 4.7% | 3.4% | N/A | N/A |
| Montana | 1.2% | $3,305,209 | 0.3% | 0.7% - 1.8% | 1.2% | N/A | N/A |
| Nebraska | 1.3% | $7,256,998 | 0.3% | 0.8% - 1.8% | 1.3% | N/A | N/A |
| Nevada | 6.7% | $32,395,187 | 0.9% | 4.8% - 8.5% | 6.1% | N/A | N/A |
| New Hampshire | 3.6% | $12,615,753 | 0.5% | 2.6% - 4.6% | 3.6% | N/A | N/A |
| New Jersey | 4.7% | $161,747,364 | 0.6% | 3.4% - 5.9% | 4.6% | N/A | N/A |
| New Mexico | 9.0% | $33,425,006 | 1.0% | 7.1% - 10.9% | 8.8% | N/A | N/A |
| New York | 4.4% | $330,676,868 | 0.7% | 3.0% - 5.7% | 3.8% | N/A | N/A |
| North Carolina | 2.3% | $71,025,171 | 0.4% | 1.5% - 3.0% | 2.1% | N/A | N/A |
| North Dakota | 2.4% | $5,718,194 | 0.3% | 1.7% - 3.1% | 2.3% | N/A | N/A |
| Ohio | 1.6% | $65,312,167 | 0.3% | 0.9% - 2.2% | 1.6% | N/A | N/A |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Oklahoma | 4.5% | $51,260,865 | 0.9% | 2.8% - 6.1% | 4.5% | N/A | N/A |
| Oregon | 5.2% | $39,982,418 | 0.7% | 3.8% - 6.6% | 5.0% | N/A | N/A |
| Pennsylvania | 6.0% | $275,639,627 | 0.8% | 4.4% - 7.5% | 6.0% | N/A | N/A |
| Puerto Rico | 6.7% | $27,157,965 | 0.9% | 5.0% - 8.4% | 6.7% | N/A | N/A |
| Rhode Island | 5.0% | $15,925,379 | 0.6% | 3.8% - 6.2% | 4.7% | N/A | N/A |
| South Carolina | 5.7% | $88,866,222 | 0.7% | 4.4% - 7.0% | 5.7% | N/A | N/A |
| South Dakota | 3.5% | $9,317,915 | 0.5% | 2.4% - 4.6% | 3.4% | N/A | N/A |
| Tennessee | 3.9% | $93,676,736 | 0.6% | 2.7% - 5.2% | 3.8% | N/A | N/A |
| Texas | 6.7% | $423,632,342 | 0.8% | 5.0% - 8.3% | 6.4% | N/A | N/A |
| Utah | 5.8% | $26,401,872 | 0.7% | 4.4% - 7.2% | 5.3% | N/A | N/A |
| Vermont | 2.4% | $4,234,784 | 0.4% | 1.7% - 3.2% | 2.4% | N/A | N/A |
| Virginia | 3.8% | $82,011,133 | 0.6% | 2.5% - 5.0% | 3.6% | N/A | N/A |
| Washington | 1.8% | $25,933,510 | 0.3% | 1.1% - 2.4% | 1.8% | N/A | N/A |
| West Virginia | 3.9% | $32,210,604 | 0.6% | 2.8% - 5.0% | 3.9% | N/A | N/A |
| Wisconsin | 4.3% | $71,728,519 | 1.7% | 1.0% - 7.6% | 4.1% | N/A | N/A |
| Wyoming | 0.8% | $834,121 | 0.2% | 0.5% - 1.2% | 0.8% | N/A | N/A |
| **Total** | **5.3%** | **$5,288,464,344** | **0.3%** | **4.8% - 5.8%** | **5.1%** | **N/A** | **N/A** |

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

# Q & A

**Q1. What was the reporting period for this report?**
**A1.** For Carriers/DMERCs/FIs, the report included claims submitted between October 1, 2004 and September 30, 2005. For QIOs, the report included inpatient PPS hospital discharges between July 1, 2004 and June 30, 2005.

**Q2. Will these rates be updated to reflect late documentation?**
**A2.** No. All documentation that arrived before the cut off date for this report has been included. CMS discontinued the production of quarterly updates to the reports in November 2005.

**Q3. Why did CMS produce a May report?**
**A3.** This report is designed to act as a mid-year report on the progress made by CMS toward the November GPRA goals.

**Q4. What educational efforts is CMS undertaking to help lower the error rate?**
**A4.** CMS continues to develop Medicare provider educational material with the official CMS brand, "The Medicare Learning Network". As part of this initiative, CMS has developed over 250 national provider education articles annually which outline, on a flow basis and in plain language, the coverage, billing and coding rules associated with Medicare program changes. These articles can be easily accessed through a search engine on www.cms.hhs.gov/medlearn/matters, which will pull articles, by year, based on user entered key words or phrases.

In 2006 CMS continues its efforts to expand the current FAQ database available on http://www.cms.hhs.gov/ by generating and posting FAQs of interest to FFS Medicare providers. FAQs will be automatically generated from Medlearn Matters article, solicited from FIs and carriers (who interact directly with the providers who bill them), and from over 50 national associations.

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

**Q5. Why can't some of the improper payment calculations be compared across reports?**
**A5.** In previous reports the CERT program and the HPMP calculated improper payment estimates in a slightly different manner. Unlike HPMP, the CERT program did not exclude coinsurance and deductibles from the payment data used to calculate projected improper payments. This issue specifically effected contractor, service type, and provider type estimates. In earlier reports, the national improper payment estimates excluded coinsurance and deductibles, while other CERT only estimates included them. For consistency and accuracy, the CERT program switched to excluding coinsurance and deductibles in all of its calculations beginning with the 2005 report. This change does not impact comparisons of the current paid claims error rate to previous reports. The exclusion of coinsurance and deductibles effects all of the payment totals used in CERT calculations equally; therefore, the paid claims error rate is unaffected by this change.