Improper Medicare Fee-For-Service Payments Report - November 2007

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 all Medicare Administrative Contractors (MACs) which are the new claims processing entities created under the Medicare Prescription Drug Improvement and Modernization Act of 2003. Until the transition to MACs is completed, the CERT program will also report on 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 MACs, Carriers/DMERCs/FIs, and 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, and QIOs erroneously allowed to be paid). To better measure the performance of the Carriers, DMERCs, FIs, and QIOs as well as 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, and 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, and QIOs for this report using a methodology approved by the OIG. This year, for the first time, some data on MACs will be included in this report. The CERT program will utilize the same methodology with MACs as it did with Carriers/DMERCs/FIs. This methodology includes:

- CERT randomly selecting a sample of 133,333 claims submitted to Carriers/DMERCs/FIs during the reporting period.
- HPMP randomly selecting a sample of 41,399 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.

Both programs are designed to be a measurement of improper payments. Any claim that was paid when it should not have been is an improper payment. This includes claims that may have been fraudulent.

Neither program can be considered a measure of fraud. Since both programs use random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent; however, one scenario of potential fraud that the CERT program is able to identify occurs when the CERT documentation contractor is unable to locate a provider or supplier when requesting medical record documentation. This lack of provider or supplier response results in no documentation errors. For more information about the impact of this form of potential fraud on the no documentation error rate, see the "No Documentation Errors" section in the body of this report.

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.

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
November 2007	Claims submitted in the 12 month period ending March 31, 2007	Discharges occurring in the 12 month period ending December 31, 2006

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 3.9% 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.

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$74.9B	$3.4B	4.5%	$0.2B	0.2%	$3.6B	4.8%
DMERC	$9.9B	$1.0B	10.2%	$0.0B	0.0%	$1.0B	10.3%
FI	$89.4B	$1.2B	1.3%	$0.1B	0.2%	$1.3B	1.5%
QIOs	$102.0B	$4.3B	4.2%	$0.7B	0.7%	$4.9B	4.8%
All Medicare FFS	**$276.2B**	**$9.8B**	**3.6%**	**$1.0B**	**0.4%**	**$10.8B**	**3.9%**

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	Palmetto Region C	17.7%	$770.0 M	First Coast Service Options FL, Carrier	$783.5 M	10.0%
Error Rates by Service Type	Suction Pump	53.1%	$14.5 M	Hospital visit - subsequent	$566.2 M	11.3%
Error Rates by Provider Type	Unknown Supplier/Provider	51.1%	$48.3 M	Internal Medicine	$650.9 M	8.0%

Goals

One of the performance goals for CMS is the reduction of improper payments made under the FFS program to 4.3% or less by the November 2007 reporting period. The findings in this report indicate that CMS has met its November 2007 goals.

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.
8. CMS is working with each Carrier, DMERC, and 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 expects that many of the listed corrective actions will apply to MACs as they transition.

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.
    - Publishing a quarterly 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.
    - 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) 2006, 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 $381.8 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: Medicare Administrative Contractors (MACs), Carriers, Durable Medical Equipment Regional Carriers (DMERCs), Fiscal Intermediaries (FIs), and Quality Improvement Organizations (QIOs).

The primary goal of each contractor 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, contractors must also determine how best to educate providers about Medicare rules and implement the most effective methods for accurately answering coverage and coding questions. As part of 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.

Both programs are designed to be a measurement of improper payments. Any claim that was paid when it should not have been is an improper payment. This includes claims that may have been fraudulent.

Neither program can be considered a measure of fraud. Since both programs use random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent; however, one scenario of potential fraud that the CERT program is able to identify occurs when the CERT documentation contractor is unable to locate a provider or supplier when requesting medical record documentation. This lack of provider or supplier response results in no documentation errors. For more information about the impact of this form of potential fraud on the no documentation error rate, see the "No Documentation Errors" section.

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

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 contractors in the CERT program for this reporting period was 133,333 paid and denied claims. The sample size for error rates concerning QIOs for the reporting period was 41,399 discharges.

Types of Error Rates Produced

To better measure the performance of its contractors 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. 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.

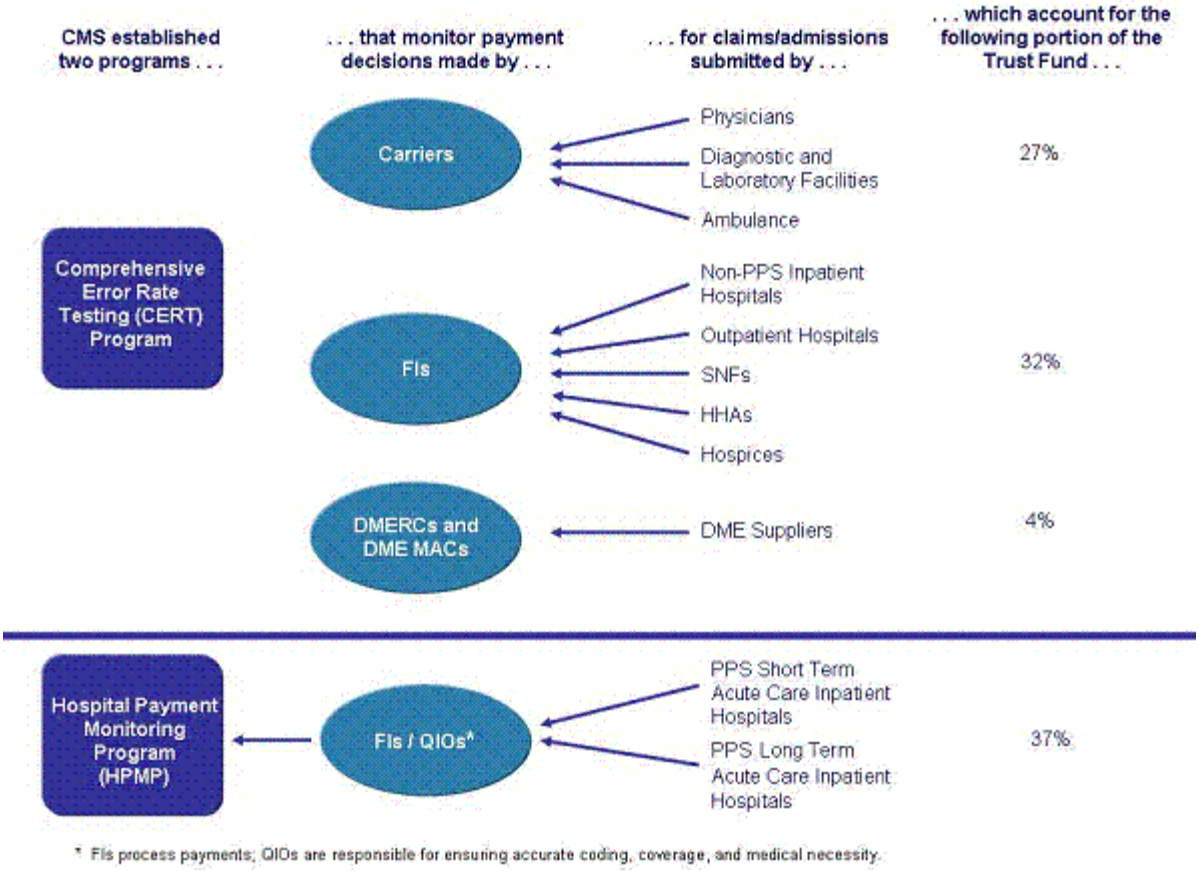
Provider Compliance Error Rate

This rate is based on how the claims looked when they first arrived at the Carrier, DMERC, or Durable Medical Equipment MAC (DME MAC) – before the contractor 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, and the new MACs. The main objective of the CERT program is to measure the degree to which CMS and contractors 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 133,333 claims from Carriers, DMERCs, FIs, and MACs. The CERT Contractor randomly selected about 174 claims each month from each contractor. 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 75 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 75th 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 contractor's 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 contractors in the CERT program 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 2006 to March 2007 while CMS payment data is reported for the 2006 calendar year. Therefore, the CERT program used payment data from calendar year 2006 to generate the projected improper payments in this report. For November 2007, the target sample size was approximately 2,000 reviewable claims per cluster. The portions of the new Medicare Administrative Contractors (MACs) that process Part A and Part B claims were assigned to separate clusters. Thus, CERT attempted to sample 2,000 reviewable claims from the Part A portion of each MAC and 2,000 reviewable claims from the Part B portion of each MAC. Since the newly formed MACs have not been in place for a complete sample period, their sample size for this report is substantially lower than 2,000 claims. In addition, contractors that transferred their work to MACs during the sampling period will experience a reduced sample since they no longer process claims in jurisdictions for which the MACs took control.

As a result of undersampling issues experienced for the November 2006 report, CERT determined an over-sampling of claims needed to be performed for the November 2007 report to reach the desired sample size of 124,000 claims. Instead of changing the sampling scheme to obtain 2,000 claims for every cluster, the “extra” claims were distributed among those clusters which historically have had trouble meeting the IPIA precision requirements. This method

increases precision for historically poor performing clusters but also results in some clusters with less than 2,000 claims sampled and some clusters with more than 2,000 claims sampled. A constant weight was assigned for every claim in the cluster for the given year. Historically, there has been little if any seasonality in the occurrence of errors in claims.

Naming Conventions

From time to time, a contractor 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.

Currently, CMS is in the midst of implementing contracting reform as laid out in section 911 of the Medicare Modernization Act. CMS awarded some of the competitive contracts for Medicare FFS processing work during the sampling period for this report. More information on MACs and Medicare contracting reform can be found at:
http://www.cms.hhs.gov/MedicareContractingReform

The following jurisdictions transitioned contractors during the reporting period:

DME Region A: July 1, 2006 National Heritage Insurance Company (NHIC) officially took over for HealthNow New York. The DME PSC is TriCenturion.

DME Region B: July 1, 2006 National Government Services (NGS) officially took over for Adminastar Federal. The DME PSC is TriCenturion.

DME Region C: June 1, 2007 CIGNA officially took over for Palmetto GBA. The DME PSC is Trust Solutions.

DME Region D: September 30, 2006 Noridian Administrative Services officially took over for CIGNA. The DME PSC is Integriguard.

MAC J3: Noridian Administrative Services officially took over claims processing in:

PART A

Arizona on October 1, 2006 for BCBS AZ
Montana on December 1, 2006 for BCBS MT
North Dakota on December 1, 2006 for Noridian MN/ND
South Dakota on March 1, 2007 for Cahaba IA/SD
Utah on December 1, 2006 for Noridian ID/OR/UT
Wyoming on November 1, 2006for BCBS WY

PART B

Arizona on December 1, 2006 for Noridian AK/AZ/AS/CNMI/GU/HI/NV/OR/WA
Montana on December 1, 2006 for BCBS MT
North Dakota on December 1, 2006 for Noridian ND/CO/WY/IA/SD
South Dakota on December 1, 2006 for Noridian ND/CO/WY/IA/SD

Utah on December 1, 2006 for Noridian UT
Wyoming on December 1, 2006 for Noridian ND/CO/WY/IA/SD

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 41,399 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 contractor's 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 cannot 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, contractors are notified of detected overpayments so that they can implement the necessary adjustments. They are also notified of underpayments, but they are not currently required to make payments to providers for underpayments identified in the CERT program. Contractors 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 $343.7 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 $883,291 in actual overpayments and, as of the final cut-off date for this report, contractors had collected $592,286 of those overpayments. The HPMP identified $15,083,413 in overpayments and, as of the final cutoff date for this report, the FIs had processed $12,542,875 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 contractor 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 2007, reduce the percent of improper payments under Medicare FFS to 4.3%.
  Status: This goal was met. The national paid claims error rate for the November 2007 reporting period was 3.9%
- By November 2008, reduce the percent of improper payments under Medicare FFS to 3.8%.
- By November 2009, reduce the percent of improper payments under Medicare FFS to 3.7%.

2. Reduce the Contractor-Specific Paid Claim Error Rate

- 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.
  Status: This goal was met. During the November 2007 reporting period 78.7% of Medicare claims were processed by contractors with a paid claims error rate less than or equal to the national paid claims error rate of 4.4% for November 2006.

- By November 2008, 85% Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for November 2007.
- By November 2009, 90% Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for November 2008.

3. Decrease the Provider Compliance Error Rate

- This goal is developmental for 2007.
  Status: This goal was not met and will be discontinued in future reports. CMS will continue to report and monitor the provider compliance error rate, but it will not be included as a GPRA goal.
- In November 2008, this goal will be discontinued.

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, and MACs 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 3.9% (which equates to $10.8 B). The 95% confidence interval for Medicare FFS program paid claims error rate was 3.7% - 4.1%. The 90% confidence interval (required to be reported by IPIA) was 3.8% - 4.1%.

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[2]

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$74.9B	$3.4B	4.5%	$0.2B	0.2%	$3.6B	4.8%
DMERC	$9.9B	$1.0B	10.2%	$0.0B	0.0%	$1.0B	10.3%
FI	$89.4B	$1.2B	1.3%	$0.1B	0.2%	$1.3B	1.5%
QIOs	$102.0B	$4.3B	4.2%	$0.7B	0.7%	$4.9B	4.8%
All Medicare FFS	**$276.2B**	**$9.8B**	**3.6%**	**$1.0B**	**0.4%**	**$10.8B**	**3.9%**

[2] Some columns and/or rows may not sum correctly due to rounding.

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

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

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%
2006	$246.8 B	$9.8 B	4.0%	$1.0 B	0.4%	$10.8 B	4.4%
2007	$276.2 B	$9.8 B	3.6%	$1.0 B	0.4%	$10.8 B	3.9%

[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%.

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[4]

Type Of Error	1996 Net	1997 Net	1998 Net	1999 Net	2000 Net	2001 Net	2002 Net	2003 Net	2004 Gross	2005 Gross	2006 Gross	2007 Gross
No Documentation Errors	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%	0.6%
Insufficient Documentation Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%	0.4%
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%	1.3%
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%	1.5%
Other Errors	1.1%	0.5%	0.7%	0.9%	0.4%	-0.2%	0.0%	0.1%	0.2%	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%**	**3.9%**
CORRECT PAYMENTS	86.2%	88.6%	92.9%	92.0%	93.2%	93.7%	93.7%	90.2%	89.9%	94.8%	95.6%	96.1%

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

Table 3d: Type of Error Comparison for 2006 and 2007[5]

Type of Error	Nov 2006 Report	November 2007 Report				
	Total	Total	Carrier	DMERC	FI	QIO
No Documentation Errors	0.6%	0.6%	0.3%	0.2%	0.0%	0.1%
Insufficient Documentation Errors	0.6%	0.4%	0.3%	0.0%	0.1%	0.0%
Medically Unnecessary Errors	1.4%	1.3%	0.0%	0.1%	0.1%	1.0%
Incorrect Coding Errors	1.6%	1.5%	0.7%	0.0%	0.2%	0.6%
Other Errors	0.2%	0.2%	0.0%	0.0%	0.0%	0.1%
Improper Payments	4.4%	3.9%	1.3%	0.4%	0.5%	1.8%

[4] 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%.

[5] Some columns and/or rows 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.[6] 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:[7]

Carrier	DMERC	FI	QIO	Total
0.3%	0.2%	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 (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	No Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Neg press wound therapy pump (E2402)	45.0%	$86,444,132	21.2% - 68.8%
Budesonide non-comp unit (J7626)	23.6%	$51,254,280	7.3% - 39.9%
EF spec metabolic noninherit (B4154)	28.4%	$44,683,314	5.2% - 51.7%
Subsequent hospital care (99232)	1.6%	$40,805,994	0.4% - 2.8%
Levalbuterol non-comp unit (J7614)	10.1%	$36,280,922	(1.0%) - 21.3%
Methylprednisolone 80 MG inj (J1040)	76.3%	$35,478,476	50.7% -101.9%
Powered pres-redu air mattrs (E0277)	24.3%	$33,546,963	7.7% - 40.8%
EXT OR PROC UNREL TO PRINC DIAG (468)	2.1%	$25,784,514	(2.0%) - 6.2%
WND DEBR & SKN GRFT EXC HAND, MUSCSKEL & CON TIS DIS (217)	9.9%	$25,557,636	(9.4%) - 29.3%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$23,524,563	0.0% - 0.1%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	2.0%	$18,910,027	(0.1%) - 4.2%
Enteral feed supp pump per d (B4035)	11.1%	$18,607,701	0.2% - 21.9%
Office/outpatient visit, est (99213)	0.4%	$18,398,567	0.2% - 0.7%
SKN GRFT &/ DEBR - SKN ULCER/CELLU W CC (263)	6.2%	$14,403,457	(5.9%) - 18.3%
G.I. HEMORR W CC (174)	1.0%	$12,693,170	(0.4%) - 2.3%
MAJ JNT REPLACE/REATTACH - LO	0.3%	$12,424,318	(0.1%) - 0.6%

[6] Due to the extremely low insufficient documentation error rate for QIOs, any insufficient documentation errors have been added to the no documentation rate rather than the insufficient documentation category.
[7] Some columns and/or rows may not sum correctly due to rounding.

EXTREM (544)			
Albuterol ipratrop non-comp (J7620)	5.6%	$11,289,116	0.3% - 10.9%
Clinic-CORF (75)	6.6%	$10,975,557	(0.4%) - 13.6%
Heart image (3d), multiple (78465)	1.1%	$9,807,789	(1.0%) - 3.3%
HEART FAILURE & SHOCK (127)	0.3%	$9,581,644	(0.2%) - 0.8%
Overall	**0.6%**	**$1,603,325,203**	**0.4% - 0.7%**

The following are examples of No Documentation errors:

- A Fiscal Intermediary (FI) paid $144.80 for an Outpatient Clinic Visit. After multiple attempts to obtain supporting documentation, the provider sent the following statement: "Last documented visit on file 08/05. No records for date requested". As a result, the CERT Contractor counted the entire payment as an error.
- A Carrier paid $446.16 for an office visit and an injection of Epoetin. After multiple attempts to obtain documentation, no documentation was ever received from provider. As a result, the CERT Contractor counted the entire payment as an 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.

An unusual number of the claims sampled in Florida resulted in no documentation errors during the November report period. The no documentation errors in Florida accounted for 63.5% of the 0.6% national no documentation error rate. About three quarters of the claims with no documentation errors were submitted by DME suppliers while the remaining quarter was submitted by Part B providers.

For most of the DMERC claims scored as no documentation errors, the DME supplier was unreachable after their claims were sampled for the CERT program. This is attributable, at least in part, to the continued efforts of CMS and contractors finding and disabling or revoking provider numbers for providers not in compliance with CMS policies. Most of the providers who did not respond during the November report period were associated with provider numbers that were revoked some time during the sampling process.

A smaller number of Carrier claims in the sample resulted in no documentation errors due, in part, to ongoing fraud fighting efforts. In several cases, these claims were associated with provider numbers revoked in direct response to ongoing CMS efforts in Florida.

Based on findings in this report and observations from other monitoring activities, CMS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments. During this report period, CMS issued regulations that clarify and strengthen provider enrollment requirements and standards and increased efforts to deactivate or, when necessary, revoke billing privileges for providers and suppliers that are inactive or do not meet program requirements. Additionally, CMS has initiated three demonstration projects that target fraudulent business practices. The demonstrations focus on billing by suppliers of durable medical equipment, prosthetics, orthotics and supplies in south Florida and southern California,

home health agencies in the greater Los Angeles and Houston areas and infusion therapy providers in south Florida.

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.[8]
Insufficient documentation errors accounted for 0.4% of the total dollars allowed during the reporting period. This data breaks down as follows:[9]

Carrier	DMERC	FI	QIO	Total
0.3%	0.0%	0.1%	0.0%	0.4%

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 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.

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

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/MACs

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)	0.7%	$174,767,859	0.5% - 0.9%
Subsequent hospital care (99232)	3.6%	$94,476,515	2.7% - 4.5%
Clinic-hospital based or independent renal dialysis facility (72)	0.8%	$52,383,076	(0.1%) - 1.6%
Subsequent hospital care (99233)	3.1%	$40,170,148	1.9% - 4.4%
SNF-inpatient (including Part A) (21)	0.2%	$39,043,101	(0.0%) - 0.4%
Subsequent hospital care (99231)	7.1%	$35,308,892	3.1% - 11.0%
Therapeutic exercises (97110)	5.3%	$33,972,936	3.4% - 7.1%
Inpatient consultation (99255)	5.9%	$28,456,732	1.4% - 10.4%
Office/outpatient visit, est (99214)	0.7%	$26,903,868	0.3% - 1.1%
Hospital-inpatient or home health visits (Part B only) (12)	6.1%	$22,850,022	(1.0%) - 13.1%
Office/outpatient visit, est (99213)	0.5%	$21,759,655	0.3% - 0.7%
Office/outpatient visit, est (99211)	12.3%	$19,165,055	8.9% - 15.6%
SNF-inpatient or home health visits (Part B only) (22)	1.3%	$17,357,179	0.3% - 2.2%
Initial hospital care (99223)	2.3%	$16,810,848	0.4% - 4.1%
Manual therapy (97140)	7.8%	$16,571,551	4.5% - 11.1%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.6%	$16,187,169	0.3% - 1.0%
HHA-inpatient or home health visits (Part B only) (32)	0.2%	$15,790,823	(0.2%) - 0.5%
Radiation treatment aid(s) (77334)	21.5%	$15,245,164	(11.9%) - 55.0%
Critical care, first hour (99291)	2.0%	$14,291,569	(0.7%) - 4.6%
Chiropractic manipulation (98941)	4.2%	$13,735,291	1.9% - 6.6%
All Other Codes	0.5%	$495,286,838	0.4% - 0.6%
Overall	**0.7%**	**$1,210,534,289**	**0.6% - 0.8%**

The following are examples of insufficient documentation errors:

- An FI paid $1,120.20 for Physical Therapy, in a skilled nursing facility SNF), Part B stay. The nurse reviewer was missing the documentation for the physician's order, therapy evaluation and plan of care, certified by the ordering physician. After multiple attempts to obtain the documentation, the CERT reviewer determined there was insufficient

documentation to support the services billed and the CERT Contractor counted the entire payment as an error.

- A Carrier paid $139.69 for an inpatient consultation. Multiple attempts were made to obtain the documentation. Documentation received consisted of multiple copies of the discharge summary only. As a result, the CERT Contractor counted the claim line in error and recouped the entire amount.

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 1.3% of the total dollars allowed during the reporting period. This data breaks down as follows:[10]

Carrier	DMERC	FI	QIO	Total
0.0%	0.1%	0.1%	1.0%	1.3%

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

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

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

Table 4c: Top 20 Medically Unnecessary Services: All Contractors

Service Billed to Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	Medically Unnecessary Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	11.9%	$164,182,142	8.8% - 15.0%
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	8.0%	$145,493,621	1.2% - 14.9%
CHEST PAIN (143)	20.1%	$118,194,148	15.6% - 24.6%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	10.7%	$99,252,860	7.2% - 14.2%
HHA-inpatient or home health visits (Part B only) (32)	1.0%	$87,615,724	0.1% - 2.0%
RENAL FAILURE (316)	4.9%	$82,828,870	2.7% - 7.1%
Blood glucose/reagent strips (A4253)	7.9%	$80,823,935	6.3% - 9.4%
MEDICAL BACK PROB (243)	15.5%	$58,879,136	9.6% - 21.5%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	1.2%	$55,085,636	0.4% - 2.0%
OTH VAS PROC W CC W/O MAJ CV DX (554)	5.5%	$51,440,246	(0.0%) - 11.0%
HEART FAILURE & SHOCK (127)	1.4%	$47,473,236	0.7% - 2.0%
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	9.8%	$45,758,977	4.2% - 15.4%
SNF-inpatient or home health visits (Part B only) (22)	3.3%	$44,616,705	2.2% - 4.4%
OTH CIRC SYS OR PROC (120)	9.6%	$42,310,159	0.8% - 18.5%
KIDNEY & URIN TRACT INFECT AGE >17 W CC (320)	4.1%	$42,156,470	2.1% - 6.2%
Special facility or ASC surgery-hospice (non-hospital based) (81)	0.5%	$40,197,740	(0.0%) - 1.0%
SYNCOPE & COLLAPSE W CC (141)	8.1%	$39,879,723	3.8% - 12.4%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.2%	$39,165,227	0.0% - 0.3%
EXT OR PROC UNREL TO PRINC DIAG (468)	3.2%	$39,051,720	(2.6%) - 9.0%
DIABETES AGE >35 (294)	9.2%	$35,996,770	4.2% - 14.1%
Overall	**1.3%**	**$3,553,336,758**	**1.2% - 1.4%**

The following are examples of medically unnecessary services:

- An FI paid $91.56 for daily glucose monitor checks in a SNF, Part B stay. After review of the documentation, the nurse reviewer determined that there was no medical necessity

for the daily testing. The CERT contractor counted the claim in error and the entire amount was recouped.

- An FI denied a CAT scan of the thorax with contrast as not medically necessary, based on their local coverage determination (LCD). The nurse reviewer determined that as a result of the FI denial, the low Osmolar contrast billed which paid $109.20 should also have been denied as not medically necessary. The money was recouped.
- 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 1.5% percentage of the total dollars allowed during the reporting period. This data breaks down as follows:[11]

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

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.

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

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: All Contractors

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	**Incorrect Coding Errors**		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
SNF-inpatient (including Part A) (21)	1.1%	$230,829,737	0.5% - 1.7%
Office/outpatient visit, est (99214)	5.7%	$230,221,581	5.2% - 6.3%
Subsequent hospital care (99233)	15.8%	$201,812,776	13.4% - 18.3%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.6%	$156,040,424	0.4% - 0.8%
Office consultation (99244)	16.6%	$115,451,305	13.5% - 19.8%
Office/outpatient visit, est (99215)	16.0%	$112,823,175	13.7% - 18.4%
Inpatient consultation (99254)	14.3%	$105,362,727	11.8% - 16.9%
Initial hospital care (99223)	13.0%	$97,268,646	10.2% - 15.9%
Inpatient consultation (99255)	18.9%	$91,290,030	14.6% - 23.1%
Subsequent hospital care (99232)	3.2%	$82,373,354	2.4% - 3.9%
Office consultation (99245)	18.8%	$81,704,677	14.5% - 23.2%
Office/outpatient visit, new (99204)	21.2%	$70,693,512	17.0% - 25.5%
Office/outpatient visit, est (99213)	1.6%	$67,488,605	1.3% - 1.8%
SEPTICEMIA AGE >17 (416)	2.6%	$60,965,185	1.3% - 4.0%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	5.0%	$46,407,417	0.3% - 9.8%
Office/outpatient visit, new (99203)	9.9%	$44,074,005	7.5% - 12.3%
Office consultation (99243)	9.1%	$42,425,964	6.8% - 11.4%
RENAL FAILURE (316)	2.5%	$41,971,743	1.2% - 3.7%
CIRC DISOR EXC AMI, W CAR CATH & COMPL DIAG (124)	4.6%	$39,782,666	(2.2%) - 11.5%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	1.6%	$39,754,559	(0.1%) - 3.2%
Overall	**1.5%**	**$4,030,196,197**	**1.4% - 1.6%**

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

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%	$67,934,202	0.1% - 0.4%
Office/outpatient visit, est (99213)	0.7%	$29,172,251	0.5% - 0.9%
Office/outpatient visit, est (99212)	3.4%	$21,633,366	2.5% - 4.3%
SNF-inpatient (including Part A) (21)	0.1%	$15,247,258	(0.0%) - 0.1%
HHA-inpatient or home health visits (Part B only) (32)	0.1%	$12,800,989	0.0% - 0.3%
Darbepoetin alfa, non-ESRD (J0881)	1.3%	$11,721,979	0.9% - 1.7%
HHA-outpatient (HHA-A also) (33)	0.2%	$11,701,399	(0.0%) - 0.4%
Subsequent hospital care (99231)	2.1%	$10,582,963	1.1% - 3.1%
Office/outpatient visit, est (99211)	3.0%	$4,649,056	1.4% - 4.6%
Clinic-hospital based or independent renal dialysis facility (72)	0.1%	$4,416,597	0.0% - 0.1%
Emergency dept visit (99283)	2.1%	$4,407,027	0.0% - 4.1%
Chiropractic manipulation (98940)	3.3%	$4,300,134	1.0% - 5.7%
Ground mileage (A0425)	0.7%	$3,884,281	(0.4%) - 1.7%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.1%	$3,377,263	(0.0%) - 0.3%
Subsequent hospital care (99232)	0.1%	$2,709,199	0.0% - 0.2%
Epoetin alfa, non-ESRD(J0885)	0.7%	$2,702,757	(0.6%) - 1.9%
Nursing fac care, subseq (99307)	2.7%	$2,687,956	0.5% - 4.8%
ESRD related svs 2-3 mo 20+y (G0318)	1.9%	$2,092,034	1.4% - 2.3%
Eye exam established pat (92012)	0.5%	$1,793,781	(0.0%) - 1.0%
Drain/inject, joint/bursa (20610)	0.6%	$1,658,182	(0.3%) - 1.5%
All Other Codes	0.0%	$39,595,161	0.0% - 0.1%
Overall	**0.1%**	**$259,067,836**	**0.1% - 0.2%**

The following are examples of coding errors:

- An FI paid $324.44 to a provider for three injections of Iron Sucrose. The provider had billed J1756, Iron sucrose, 1mg, 40 units. The nurse reviewer determined that the actual amount of the drug injected was 200 mg, thus 200 units. This coding error resulted in an underpayment to the provider of an additional $203.52.
- A Carrier paid $200.88 to a provider for an inpatient consult CPT code 99255 which requires 3 of 3 key components: a comprehensive history, a comprehensive exam, and high complexity medical decision making (MDM). Upon review it was determined that documentation supported downcode to CPT 99252 by meeting/ exceeding 3 of 3 components with detailed history, expanded problem focused (EPF) exam, and moderate complexity MDM. The overpayment collected was $126.10.

- 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
Subsequent hospital care (99233)	17.4%	$353,688,093	12.4% - 22.4%
Office/outpatient visit, est (99214)	5.0%	$201,852,904	4.5% - 5.5%
Subsequent hospital care (99232)	4.0%	$106,983,044	2.5% - 5.4%
Office/outpatient visit, est (99213)	1.5%	$62,945,624	1.2% - 1.7%
Office/outpatient visit, est (99215)	8.5%	$60,046,630	7.0% - 10.1%
Inpatient consultation (99254)	7.3%	$53,518,550	5.6% - 9.0%
Emergency dept visit (99285)	3.9%	$32,242,941	2.6% - 5.2%
Office/outpatient visit, new (99203)	6.5%	$29,110,409	4.9% - 8.1%
Office consultation (99244)	3.9%	$27,339,020	2.7% - 5.2%
Office/outpatient visit, new (99204)	7.3%	$24,436,639	5.2% - 9.5%
Nursing fac care, subseq (99309)	8.1%	$23,732,570	5.9% - 10.3%
Office consultation (99243)	4.2%	$19,727,859	3.0% - 5.5%
Initial hospital care (99222)	6.2%	$19,534,920	4.3% - 8.2%
Office/outpatient visit, est (99212)	2.8%	$17,599,049	2.0% - 3.5%
Initial hospital care (99223)	1.6%	$11,900,426	0.7% - 2.5%
Subsequent hospital care (99231)	2.1%	$10,755,678	1.0% - 3.3%

Inpatient consultation (99253)	4.3%	$10,228,368	2.3% - 6.3%
Office consultation (99245)	2.3%	$10,018,566	1.0% - 3.6%
Emergency dept visit (99283)	2.1%	$4,519,651	0.5% - 3.7%
Nursing fac care, subseq (99308)	1.4%	$4,143,207	0.6% - 2.1%
All Other Codes	0.1%	$37,880,486	0.1% - 0.1%
Overall	**1.5%**	**$1,122,204,634**	**1.2% - 1.8%**

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 billing requirements such as those for not covered or unallowable services and duplicate claim submissions.

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:[12]

Carrier	DMERC	FI	QIO	Total
0.0%	0.0%	0.0%	0.1%	0.2%

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

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

Table 4g: Top 20 Other Errors: All Contractors

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	Other Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	2.0%	$36,058,520	(1.3%) - 5.3%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$32,826,092	0.0% - 0.2%
OTH KIDNEY & URIN TRACT PROC (315)	4.4%	$19,886,376	(3.9%) - 12.7%
Special facility or ASC surgery-hospice (non-hospital based) (81)	0.2%	$17,989,620	(0.1%) - 0.5%
HEART FAILURE & SHOCK (127)	0.4%	$15,454,241	(0.1%) - 1.0%
Subsequent hospital care (99232)	0.5%	$13,338,792	(0.1%) - 1.1%
CIRRHOSIS & ALC HEPATITIS (202)	5.4%	$11,390,106	(3.8%) - 14.6%
OTH VAS PROC W/O CC (479)	5.1%	$11,266,211	(2.8%) - 13.0%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	0.8%	$10,932,132	0.2% - 1.4%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	1.1%	$10,320,202	(0.7%) - 3.0%
OTH EAR, NOSE, MTH & THRT DIAG AGE >17 (073)	17.3%	$7,595,274	(16.4%) - 51.1%
Initial hospital care (99223)	0.9%	$6,660,850	(0.3%) - 2.1%
DIABETES AGE >35 (294)	1.4%	$5,457,947	(0.5%) - 3.3%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W/O MAJ CV DX (558)	0.2%	$5,242,282	(0.1%) - 0.5%
CAR ARRHYTHMIA & CONDUCTION DISOR W CC (138)	0.6%	$4,940,844	(0.3%) - 1.4%
Subsequent hospital care (99233)	0.4%	$4,721,191	(0.2%) - 0.9%
PERCU CARVAS PROC W NON-DRUG-ELUT STENT W/O MAJ CV DX (556)	2.1%	$4,686,855	(1.1%) - 5.2%
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	1.0%	$4,590,429	(0.8%) - 2.8%
SYNCOPE & COLLAPSE W CC (141)	0.9%	$4,467,090	(0.5%) - 2.3%
NON-EXT OR PROC UNREL TO PRINC DIAG (477)	1.3%	$4,305,102	(1.2%) - 3.9%
Overall	**0.2%**	**$425,069,191**	**0.1% - 0.2%**

The following are examples of other errors:

- **Not Covered or Unallowable Service error:** An FI paid $19.97 to a provider for Revenue Center Code 0250. Review of the medical record determined that the charge was actually for 3 Phenergan tablets administered in the Emergency Room. Oral

medication administered meets the criteria for self-administered drugs and is statutorily excluded for payment by Medicare. The $19.97 was recouped from provider.

- **Duplicate Payment error:** An FI paid $102.84 to a provider for an emergency room visit and application of a short leg splint. Upon review of the Common Working File (CWF), the reviewer discovered that a claim identical to this claim had been paid 4 days prior. The entire claim amount was recouped.
- **Other error:** A Regional Home Health Intermediary (RHHI) paid $1554.88 for a Home Health episode of care. Upon review, the CERT nurse reviewer discovered that only 4 skilled nursing visits were performed and acknowledged as performed by the Home Health agency. It was determined that this claim should have fallen under a low utilization payment adjustment (LUPA) payment. The RHHI recouped $1,223.96 in overpayment to the provider.
- **Billing error:** 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
1.3%	0.4%	0.5%	1.8%	3.9%

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

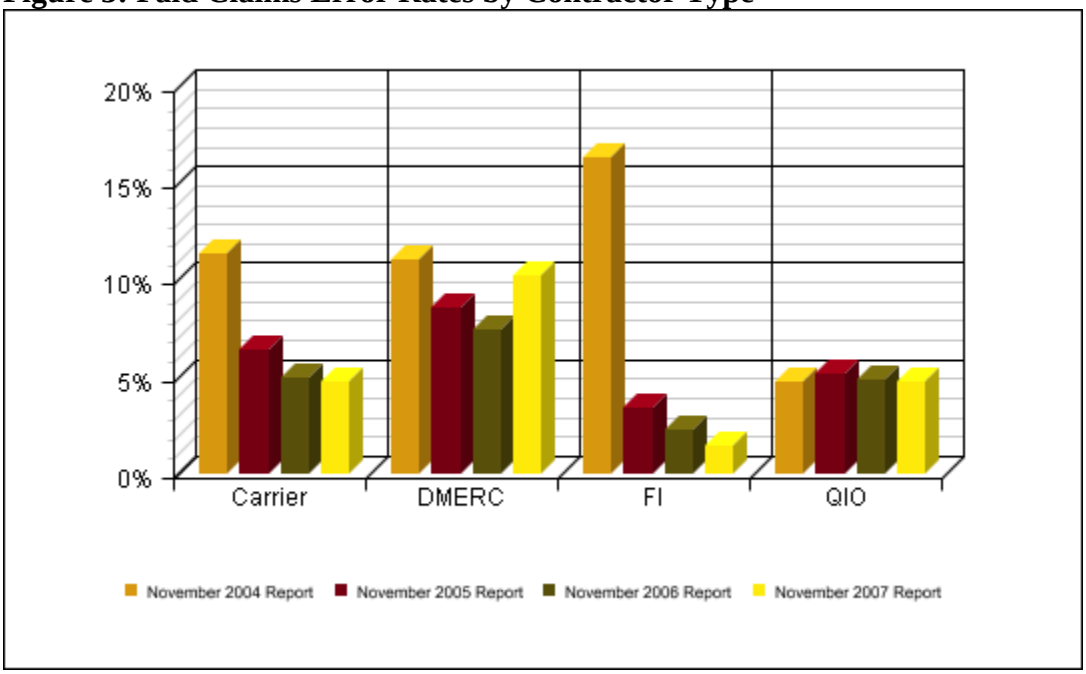
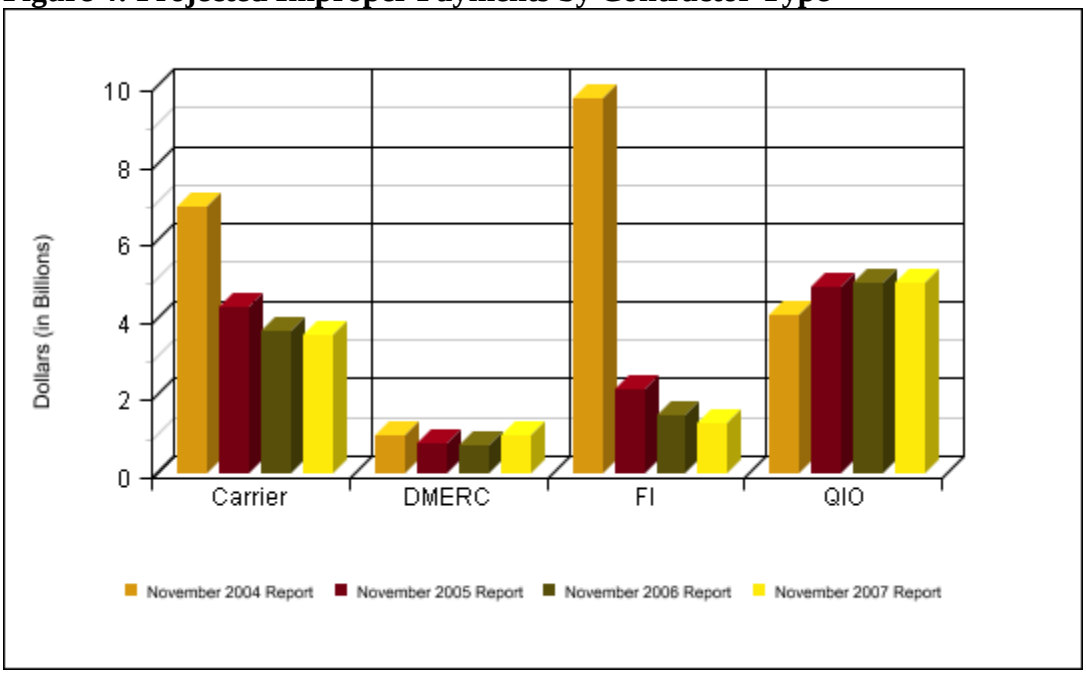


Figure 4: Projected Improper Payments by Contractor Type



Contractor-Specific Error Rates

Beginning with the November 2007 Report, clusters are listed for each contractor that adjudicated claims during the sampling period. There may be some contractors listed that no longer process claims for Medicare FFS. In addition, MACs which began their contracts during the sampling period are listed, but may have less than a full year of data.

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 and MACs

Carrier	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval	
First Coast Service Options FL 00590	10.0%	$783,464,966	1.9%	6.2% - 13.8%	21.2%
Triple S, Inc. PR/VI 00973/00974	9.7%	$39,988,868	0.8%	8.1% - 11.2%	24.5%
Empire NJ 00805	7.0%	$234,545,967	0.8%	5.5% - 8.6%	29.2%
Empire NY 00803	6.5%	$255,243,467	0.7%	5.1% - 7.8%	16.3%
Noridian MAC Region 3 03002	5.5%	$10,531,313	0.9%	3.8% - 7.3%	19.3%
Average=	4.8%				
GHI NY 14330	4.7%	$17,403,719	0.5%	3.8% - 5.7%	22.9%
CIGNA NC 05535	4.5%	$107,659,193	0.8%	3.0% - 6.0%	11.8%
NHIC CA 31140/31146	4.4%	$302,121,034	0.4%	3.6% - 5.3%	12.5%
Cahaba AL/GA/MS 00510/00511/00512	4.4%	$180,088,478	0.5%	3.4% - 5.4%	17.3%
Palmetto SC 00880	4.0%	$43,489,882	0.5%	3.0% - 5.0%	15.7%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	3.9%	$134,257,765	0.5%	3.0% - 4.9%	14.1%
Palmetto OH/WV 00883/00884	3.9%	$126,273,284	0.5%	3.0% - 4.8%	10.8%
BCBS AR RI 00524	3.9%	$8,584,513	0.5%	3.0% - 4.8%	15.4%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/ 00836	3.9%	$140,126,116	0.8%	2.3% - 5.5%	13.8%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	3.9%	$167,430,205	0.5%	2.9% - 4.8%	12.6%
Trailblazer TX 00900	3.8%	$195,827,556	0.4%	3.0% - 4.6%	14.8%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	3.7%	$62,127,673	0.9%	2.0% - 5.4%	9.4%
WPS WI/IL/MI/MN 00951/00952/00953/00954	3.6%	$294,175,659	0.4%	2.8% - 4.4%	14.1%
HealthNow NY 00801	3.5%	$43,447,746	0.4%	2.6% - 4.3%	10.9%
BCBS KS/NE/W MO 00650/00655/00651	3.3%	$48,961,686	0.4%	2.5% - 4.2%	10.1%
Noridian UT 00823	3.3%	$10,273,321	0.5%	2.3% - 4.2%	16.3%

First Coast Service Options CT 00591	3.2%	$37,486,143	0.4%	2.5% - 3.9%	7.7%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.2%	$74,467,507	0.5%	2.2% - 4.1%	10.1%
AdminaStar IN/KY 00630/00660	3.1%	$84,990,497	0.5%	2.1% - 4.1%	11.1%
HGSA PA 00865	3.0%	$93,647,474	0.6%	2.0% - 4.1%	10.7%
CIGNA TN 05440	3.0%	$53,940,509	0.4%	2.2% - 3.8%	12.6%
CIGNA ID 05130	2.1%	$4,492,925	0.3%	1.6% - 2.6%	14.2%
BCBS MT 00751	1.9%	$3,304,593	0.4%	1.2% - 2.6%	7.7%
Combined	**4.8%**	**$3,558,352,057**	**0.2%**	**4.3% - 5.2%**	**14.9%**

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

DMERC and DME MAC Error Rates

Table 6 contains error rates and improper payment amounts for both DMERC and DME MAC contractors. It is sorted in descending order by error rate.

Table 6: Error Rates and Improper Payments: DMERCs and DME MACs

DMERCs and DME MACs	**Paid Claims Error Rate**				**Provider Compliance Error Rate**
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval	
Palmetto Region C 00885	17.7%	$770,026,748	2.5%	12.8% - 22.5%	27.1%
Noridian Administrative Services MAC Region D 19003	11.9%	$59,853,831	2.8%	6.3% - 17.5%	19.3%
Average=	10.3%				
NHIC MAC Region A 16003	4.2%	$32,691,723	0.7%	2.9% - 5.6%	11.9%
National Government Services MAC Region B 17003	4.0%	$46,543,790	0.5%	2.9% - 5.1%	10.4%
AdminaStar Region B 00635	3.9%	$38,978,608	0.9%	2.2% - 5.5%	11.7%
Tricenturion Region A 77011	3.7%	$27,101,350	1.2%	1.3% - 6.1%	8.9%
CIGNA Region D 05655	3.0%	$40,436,437	0.8%	1.3% - 4.6%	11.4%
Combined	10.3%	$1,015,632,486	1.1%	8.1% - 12.5%	19.2%

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 and MACs

FIs	Paid Claims Error Rate			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Anthem NH/VT 00270	6.2%	$27,633,859	4.7%	(3.0%) - 15.5%
UGS AS/CA/GU/HI/NV/NMI 00454	3.4%	$222,156,308	1.0%	1.4% - 5.4%
Trispan LA/MO/MS 00230	2.9%	$49,203,890	0.9%	1.1% - 4.6%
Noridian ID/OR/UT 00323/00325	2.2%	$20,287,872	1.0%	0.2% - 4.2%
COSVI PR/VI 57400	2.2%	$1,572,998	0.7%	0.9% - 3.5%
Palmetto NC 00382	2.0%	$32,113,273	0.7%	0.8% - 3.3%
Highmark Medicare Services DC/MD 00366	1.9%	$99,025,111	0.4%	1.1% - 2.6%
Anthem ME/MA 00180/00181	1.9%	$50,638,337	0.6%	0.6% - 3.1%
Noridian MAC Region 3 03001	1.6%	$4,550,179	0.4%	0.8% - 2.4%
Trailblazer CO/NM/TX 00400	1.6%	$71,209,287	0.4%	0.8% - 2.4%
Riverbend NJ/TN 00390	1.5%	$53,356,738	0.6%	0.4% - 2.6%
First Coast Service Options FL 00090	1.5%	$41,036,972	0.3%	0.9% - 2.1%
Average=	1.5%			
BCBS WY WY 00460	1.4%	$541,300	0.5%	0.5% - 2.4%
Mutual of Omaha (all states) 52280	1.4%	$132,139,337	0.3%	0.8% - 2.0%
Palmetto SC 00380	1.3%	$188,488,528	0.3%	0.8% - 1.8%
BCBS AR RI 00021	1.3%	$1,972,464	0.4%	0.5% - 2.0%
BCBS AR AR 00020	1.2%	$5,051,634	0.3%	0.7% - 1.8%
UGS WI/MI 00450/00452	1.2%	$89,186,173	0.6%	0.1% - 2.3%
Noridian MN/ND 00320/00321	1.2%	$12,382,711	0.5%	0.3% - 2.1%
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	1.1%	$85,539,881	0.2%	0.6% - 1.6%
Noridian AK/WA 00322	1.1%	$7,049,521	0.4%	0.4% - 1.8%
UGS VA/WV 00453	1.1%	$16,951,731	0.2%	0.6% - 1.6%
BCBS AZ AZ 00030	1.0%	$2,252,775	0.3%	0.4% - 1.6%
BCBS KS KS 00150	0.9%	$4,474,264	0.4%	0.1% - 1.7%
BCBS NE NE 00260	0.9%	$2,282,710	0.4%	0.1% - 1.7%
Empire CT/DE/NY 00308	0.9%	$39,747,571	0.2%	0.4% - 1.3%
Cahaba AL 00010	0.8%	$4,795,699	0.3%	0.3% - 1.4%
Veritus PA 00363	0.7%	$14,828,224	0.2%	0.3% - 1.1%
BCBS GA GA 00101	0.6%	$14,558,467	0.1%	0.4% - 0.9%
BCBS MT 00250	0.5%	$859,165	0.1%	0.2% - 0.7%
Chisholm OK 00340	0.4%	$1,292,964	0.1%	0.2% - 0.7%
Cahaba IA/SD 00011	0.3%	$12,683,181	0.1%	0.1% - 0.5%
Combined	1.5%	$1,309,863,123	0.1%	1.2% - 1.7%

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[13]

QIOs	Paid Claims Error Rate			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Alaska	1.1%	$1,555,525	0.3%	0.6% - 1.7%
Alabama	6.4%	$113,180,285	1.7%	2.9% - 9.8%
Arkansas	3.6%	$36,681,340	0.6%	2.5% - 4.6%
Arizona	5.7%	$79,086,760	0.8%	4.1% - 7.3%
California	4.6%	$383,130,721	0.7%	3.2% - 6.0%
Colorado	4.6%	$41,239,170	0.8%	3.2% - 6.1%
Connecticut	3.7%	$56,019,396	0.6%	2.7% - 4.8%
District of Columbia	3.8%	$17,639,168	0.6%	2.6% - 4.9%
Delaware	4.3%	$15,393,467	0.5%	3.3% - 5.3%
Florida	6.6%	$426,475,682	1.1%	4.5% - 8.7%
Georgia	4.1%	$109,368,411	0.6%	2.9% - 5.4%
Hawaii	3.6%	$9,187,289	0.4%	2.9% - 4.4%
Iowa	3.8%	$34,260,668	0.7%	2.5% - 5.2%
Idaho	2.9%	$7,627,689	0.5%	2.0% - 3.8%
Illinois	5.8%	$266,554,200	0.9%	4.1% - 7.6%
Indiana	4.5%	$96,649,457	0.7%	3.2% - 5.8%
Kansas	3.1%	$25,383,483	0.5%	2.1% - 4.2%
Kentucky	6.7%	$119,396,349	0.9%	5.0% - 8.5%
Louisiana	3.4%	$48,349,801	0.6%	2.2% - 4.5%
Massachusetts	7.1%	$180,022,304	0.8%	5.5% - 8.6%
Maryland	4.7%	$132,077,986	0.9%	2.8% - 6.5%
Maine	4.7%	$22,615,472	0.5%	3.7% - 5.8%
Michigan	5.2%	$219,271,223	0.7%	3.8% - 6.6%
Minnesota	3.9%	$59,035,653	0.6%	2.8% - 5.0%
Missouri	3.4%	$76,517,487	0.9%	1.7% - 5.0%
Mississippi	5.8%	$63,029,683	0.9%	4.1% - 7.5%
Montana	1.2%	$3,182,913	0.4%	0.5% - 1.9%
North Carolina	1.5%	$47,994,129	0.3%	0.9% - 2.2%
North Dakota	2.4%	$5,607,761	0.4%	1.6% - 3.3%
Nebraska	1.2%	$7,179,214	0.3%	0.6% - 1.9%
New Hampshire	3.8%	$14,269,816	0.5%	2.8% - 4.8%
New Jersey	5.0%	$180,625,800	0.8%	3.6% - 6.5%
New Mexico	7.6%	$29,023,271	0.9%	5.9% - 9.3%
Nevada	7.5%	$39,926,290	1.0%	5.5% - 9.6%

[13]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.

New York	5.0%	$385,389,445	0.9%	3.4% - 6.7%
Ohio	3.0%	$128,403,620	0.5%	2.0% - 4.1%
Oklahoma	2.9%	$34,608,449	0.5%	1.9% - 3.9%
Oregon	5.0%	$36,363,263	0.7%	3.7% - 6.3%
Pennsylvania	6.0%	$265,240,669	0.9%	4.3% - 7.7%
Puerto Rico	7.9%	$18,205,034	1.4%	5.2% - 10.6%
Rhode Island	3.8%	$12,417,826	0.5%	2.9% - 4.8%
South Carolina	5.2%	$82,399,798	0.8%	3.6% - 6.8%
South Dakota	3.6%	$9,456,541	0.5%	2.6% - 4.5%
Tennessee	2.4%	$58,568,540	0.5%	1.5% - 3.3%
Texas	6.8%	$449,730,615	1.2%	4.5% - 9.2%
Utah	4.7%	$20,542,823	0.6%	3.5% - 5.9%
Virginia	5.9%	$131,726,778	0.9%	4.1% - 7.7%
Vermont	4.6%	$7,577,893	0.6%	3.4% - 5.7%
Washington	2.1%	$33,203,651	0.4%	1.4% - 2.9%
Wisconsin	2.6%	$43,258,693	0.6%	1.5% - 3.8%
West Virginia	6.3%	$50,469,416	1.0%	4.3% - 8.2%
Wyoming	0.9%	$986,220	0.2%	0.6% - 1.3%
Short-term Acute Paid Claims	**4.8%**	**$4,736,107,139**	**0.2%**	**4.5% - 5.2%**
Long-term Acute Paid Claims	**4.8%**	**$202,506,834**	**0.5%**	**3.8% - 5.7%**
Denied Claims	**N/A**	**$9,241,619**	**N/A**	**N/A**
Total	**4.8%**	**$4,947,855,592**	**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 and MACs

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
Hospital visit - subsequent	$566,165,319	11.3%	10.0% - 12.7%	9.5%	33.0%	0.1%	53.6%	3.7%
Office visits - established	$560,692,977	5.7%	5.3% - 6.1%	6.3%	13.8%	1.3%	78.2%	0.4%
Consultations	$526,846,262	16.2%	14.7% - 17.7%	1.5%	10.3%	0.6%	86.9%	0.7%
Other drugs	$419,233,745	8.1%	2.7% - 13.5%	91.8%	3.0%	0.3%	4.9%	0.0%
All Other Codes	$346,383,361	1.2%	0.9% - 1.4%	25.1%	44.9%	4.2%	22.6%	3.3%
Minor procedures - other (Medicare fee schedule)	$181,008,293	7.0%	5.4% - 8.6%	10.2%	64.4%	13.4%	8.2%	3.8%
Hospital visit - initial	$166,663,414	14.5%	11.9% - 17.0%	5.4%	15.3%	0.0%	75.3%	4.0%
Office visits - new	$156,907,935	14.5%	12.3% - 16.6%	0.0%	2.3%	0.2%	96.9%	0.5%
Nursing home visit	$132,513,058	12.5%	10.6% - 14.3%	13.9%	16.3%	0.8%	68.9%	0.0%
Ambulance	$71,766,323	1.9%	1.0% - 2.8%	15.7%	31.0%	31.3%	21.5%	0.5%
Emergency room visit	$65,347,361	4.5%	3.2% - 5.8%	11.6%	15.7%	0.0%	72.0%	0.7%
Hospital visit - critical care	$59,111,799	7.8%	2.5% - 13.1%	10.2%	27.7%	0.0%	62.0%	0.0%
Chiropractic	$57,704,328	10.6%	7.8% - 13.3%	1.6%	50.8%	27.0%	19.1%	1.4%
Other tests - other	$49,321,081	3.8%	1.5% - 6.0%	25.2%	65.4%	0.0%	7.5%	1.9%
Ambulatory procedures - other	$48,253,791	5.7%	0.7% - 10.8%	72.8%	3.8%	1.1%	21.6%	0.7%
Lab tests - other (non-Medicare fee schedule)	$36,402,299	1.8%	1.0% - 2.6%	27.2%	34.6%	11.4%	20.5%	6.3%
Standard imaging - nuclear medicine	$25,870,344	1.5%	(0.9%) - 3.8%	83.0%	8.4%	0.0%	8.6%	0.0%
Oncology - radiation therapy	$25,327,359	1.9%	(0.4%) - 4.3%	0.0%	89.5%	0.0%	10.5%	0.0%
Specialist - ophthalmology	$24,910,618	1.2%	0.6% - 1.8%	27.5%	53.3%	0.0%	19.2%	0.0%
Specialist - other	$19,926,260	12.3%	5.3% - 19.3%	1.4%	31.9%	3.8%	63.0%	0.0%
Imaging/procedure - other	$17,996,131	4.9%	1.2% - 8.6%	44.8%	14.8%	17.1%	23.2%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$3,558,352,057**	**4.8%**	**4.3% - 5.2%**	**20.7%**	**23.2%**	**2.8%**	**51.7%**	**1.6%**

Table 9b: Top 20 Service Types with Highest Improper Payments: DMERCs and DME MACs

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
All Policy Groups with Less than 30 Claims	$228,032,498	15.4%	4.6% - 26.1%	54.2%	0.0%	44.2%	1.6%	0.0%
Nebulizers & Related Drugs	$167,572,569	15.3%	8.2% - 22.5%	60.5%	0.5%	23.5%	15.4%	0.1%
Negative Pressure Wound Therapy	$125,678,545	50.4%	27.5% - 73.3%	100.0 %	0.0%	0.0%	0.0%	0.0%
Glucose Monitor	$114,464,254	9.5%	7.9% - 11.0%	10.2%	2.0%	76.2%	10.7%	1.0%
Enteral Nutrition	$109,383,911	18.9%	7.7% - 30.0%	77.3%	0.0%	15.6%	7.2%	0.0%
Support Surfaces	$33,855,619	20.1%	6.2% - 34.0%	99.8%	0.0%	0.2%	0.0%	0.0%
CPAP	$31,149,480	7.7%	4.1% - 11.3%	24.0%	20.3%	52.7%	1.3%	1.7%
Lower Limb Orthoses	$28,829,394	13.3%	0.4% - 26.2%	96.0%	0.0%	4.0%	0.0%	0.0%
Oxygen Supplies/Equipment	$27,376,887	1.3%	0.8% - 1.8%	25.6%	0.0%	59.2%	12.4%	2.7%
Wheelchairs Options/ Accessories	$27,314,967	12.0%	(3.9%) - 27.9%	5.7%	0.5%	31.3%	0.4%	62.1%
All Other Codes	$22,024,283	3.0%	1.6% - 4.3%	32.3%	0.6%	55.2%	4.8%	7.1%
Wheelchairs Manual	$15,274,364	6.2%	3.9% - 8.4%	1.7%	3.2%	63.5%	23.5%	8.1%
Suction Pump	$14,458,892	53.1%	10.8% - 95.5%	87.5%	0.0%	12.5%	0.0%	0.0%
Immunosuppressive Drugs	$12,740,563	3.0%	0.4% - 5.6%	0.0%	0.0%	78.1%	0.0%	21.9%
Ostomy Supplies	$11,453,618	7.8%	0.5% - 15.0%	21.6%	0.0%	74.0%	4.4%	0.0%
Spinal Orthoses	$9,908,724	13.3%	(2.3%) - 28.9%	98.7%	0.0%	1.3%	0.0%	0.0%
Surgical Dressings	$9,827,558	10.8%	(1.7%) - 23.4%	89.3%	0.3%	10.4%	0.0%	0.0%
Diabetic Shoes	$8,198,843	4.9%	0.8% - 9.0%	10.9%	13.4%	52.6%	23.2%	0.0%
Respiratory Assist Device	$6,283,663	7.1%	0.5% - 13.7%	77.8%	0.0%	22.2%	0.0%	0.0%
Lenses	$5,909,435	8.7%	2.2% - 15.1%	5.6%	21.9%	68.5%	4.1%	0.0%
Upper Limb Orthoses	$5,894,418	14.2%	0.5% - 28.0%	93.4%	0.0%	6.6%	0.0%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$1,015,632,486**	**10.3%**	**8.1% - 12.5%**	**56.8%**	**1.2%**	**33.5%**	**6.0%**	**2.5%**

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

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)	$421,368,707	1.7%	1.4% - 2.0%	5.6%	45.9%	9.3%	32.6%	6.6%
SNF	$363,049,661	1.6%	1.0% - 2.2%	2.3%	17.9%	12.7%	66.2%	0.9%
HHA	$203,642,462	1.4%	0.7% - 2.1%	0.0%	7.8%	55.8%	36.4%	0.0%
Other FI Service Types	$102,605,352	1.9%	1.0% - 2.9%	15.4%	23.6%	8.7%	49.3%	2.9%
Hospice	$90,422,892	1.0%	0.4% - 1.6%	9.1%	7.3%	44.5%	19.3%	19.9%
ESRD	$82,764,933	1.2%	0.3% - 2.1%	0.0%	63.3%	0.5%	36.1%	0.1%
Non-PPS Hospital In-patient	$35,359,132	0.7%	0.3% - 1.1%	2.4%	20.7%	0.4%	60.1%	16.5%
FQHC	$6,550,678	1.5%	0.5% - 2.5%	29.8%	70.2%	0.0%	0.0%	0.0%
RHCs	$3,310,678	0.6%	0.3% - 0.9%	31.6%	54.8%	0.0%	0.0%	13.6%
Free Standing Ambulatory Surgery	$788,627	0.2%	(0.1%) - 0.4%	0.0%	87.9%	0.0%	12.1%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$1,309,863,123**	**1.5%**	**1.2% - 1.7%**	**4.6%**	**28.4%**	**19.0%**	**43.6%**	**4.4%**

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 Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	$204,177,351	11.3%	3.5% - 19.1%	0.0%	N/A	71.3%	11.1%	17.7%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	$187,866,936	13.6%	10.4% - 16.8%	0.0%	N/A	87.4%	6.8%	5.8%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	$140,453,656	15.1%	10.7% - 19.6%	13.5%	N/A	70.7%	14.6%	1.3%
CHEST PAIN (143)	$131,369,679	22.3%	17.4% - 27.2%	3.9%	N/A	90.0%	3.9%	2.2%
RENAL FAILURE (316)	$130,481,892	7.7%	5.1% - 10.2%	1.4%	N/A	63.5%	32.2%	2.9%
EXT OR PROC UNREL TO PRINC DIAG (468)	$100,766,418	8.2%	0.7% - 15.6%	25.6%	N/A	38.8%	35.7%	0.0%
HEART FAILURE & SHOCK (127)	$89,539,751	2.6%	1.5% - 3.6%	10.7%	N/A	53.0%	19.0%	17.3%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	$85,870,116	9.3%	3.4% - 15.3%	5.9%	N/A	38.4%	54.0%	1.7%
SEPTICEMIA AGE >17 (416)	$73,456,343	3.2%	1.7% - 4.7%	7.2%	N/A	9.2%	83.0%	0.7%
MEDICAL BACK PROB (243)	$71,958,957	19.0%	12.4% - 25.6%	6.1%	N/A	81.8%	10.3%	1.8%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	$70,029,794	1.5%	0.6% - 2.4%	17.7%	N/A	78.7%	1.1%	2.5%
KIDNEY & URIN TRACT INFECT AGE >17 W CC (320)	$66,733,368	6.5%	3.5% - 9.6%	0.3%	N/A	63.2%	33.7%	2.9%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	$66,527,926	7.3%	2.6% - 12.1%	0.0%	N/A	49.6%	34.9%	15.5%
OTH VAS PROC W CC W/O MAJ CV DX (554)	$64,803,227	6.9%	1.3% - 12.6%	0.0%	N/A	79.4%	18.7%	1.9%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W/O MAJ CV DX (558)	$64,660,050	3.0%	1.3% - 4.7%	2.6%	N/A	51.6%	37.7%	8.1%
CIRC DISOR EXC AMI, W CAR CATH & COMPL DIAG (124)	$59,347,270	6.9%	(0.2%) - 14.0%	0.0%	N/A	28.4%	67.0%	4.6%

OTH KIDNEY & URIN TRACT PROC (315)	$58,984,717	13.1%	1.5% - 24.7%	0.0%	N/A	30.2%	36.1%	33.7%
CHRON OBSTRUCTIVE PULM DIS (088)	$57,928,635	3.4%	2.0% - 4.9%	6.4%	N/A	56.1%	32.7%	4.8%
SIMP PNEUM & PLEURISY AGE >17 W CC (089)	$54,467,501	2.2%	1.0% - 3.4%	17.3%	N/A	8.8%	72.0%	2.0%
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	$54,361,687	11.6%	5.7% - 17.6%	0.6%	N/A	84.2%	6.8%	8.4%
All HPMP	**$4,947,855,592**	**4.8%**	**4.5% - 5.2%**	**4.7%**	**N/A**	**58.0%**	**31.5%**	**5.8%**

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 and MACs

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	8.0%	$650,913,480	0.7%	6.7% - 9.4%	18.6%
Cardiology	4.6%	$292,056,119	0.5%	3.6% - 5.5%	19.5%
Family Practice	6.8%	$276,763,500	0.5%	5.8% - 7.8%	17.4%
General Practice	27.3%	$239,798,804	6.4%	14.8% - 39.8%	41.7%
Orthopedic Surgery	5.4%	$163,421,204	1.0%	3.4% - 7.4%	15.3%
Obstetrics/Gynecology	23.6%	$161,999,147	14.6%	(5.1%) - 52.3%	28.7%
Gastroenterology	8.4%	$118,560,416	1.1%	6.1% - 10.6%	17.3%
General Surgery	6.3%	$113,738,940	1.2%	4.0% - 8.6%	22.7%
Pulmonary Disease	7.1%	$107,941,782	0.9%	5.3% - 8.9%	15.7%
Neurology	8.8%	$92,896,999	1.3%	6.3% - 11.4%	26.6%
Hematology/Oncology	2.1%	$81,950,560	0.4%	1.2% - 2.9%	8.8%
Nephrology	5.8%	$77,958,485	0.9%	4.1% - 7.5%	14.9%
Urology	3.8%	$74,654,876	0.8%	2.2% - 5.5%	9.9%
Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)	1.9%	$71,766,323	0.5%	1.0% - 2.8%	9.8%
Ophthalmology	1.6%	$70,602,966	0.4%	0.9% - 2.4%	9.8%
Psychiatry	8.9%	$70,413,523	1.6%	5.7% - 12.1%	18.8%
Physical Therapist in Private Practice	6.2%	$63,633,089	1.1%	4.2% - 8.3%	15.5%
Chiropractic	10.4%	$60,348,512	1.3%	7.8% - 13.1%	27.9%
Emergency Medicine	4.1%	$60,201,610	0.7%	2.8% - 5.4%	13.4%
Diagnostic Radiology	1.3%	$56,228,728	0.3%	0.6% - 2.0%	9.5%
Physical Medicine and Rehabilitation	7.7%	$53,337,061	1.6%	4.6% - 10.9%	16.1%
Clinical Laboratory (Billing Independently)	1.4%	$39,319,877	0.3%	0.8% - 2.1%	8.1%
Infectious Disease	11.0%	$38,063,145	2.1%	6.8% - 15.1%	27.0%
Podiatry	3.0%	$36,695,863	0.5%	2.1% - 3.8%	16.2%
Nurse Practitioner	6.4%	$36,334,958	1.5%	3.5% - 9.3%	15.4%
Otolaryngology	5.0%	$35,492,764	0.8%	3.3% - 6.6%	13.9%

Radiation Oncology	2.6%	$34,754,227	1.3%	(0.0%) - 5.2%	9.9%
Neurosurgery	9.5%	$32,679,218	4.3%	1.1% - 17.9%	17.6%
Thoracic Surgery	9.9%	$29,733,199	8.0%	(5.7%) - 25.6%	10.7%
Rheumatology	4.0%	$26,485,248	1.1%	1.8% - 6.2%	9.4%
Endocrinology	8.3%	$24,966,266	1.9%	4.5% - 12.2%	13.4%
Anesthesiology	1.7%	$21,651,417	0.6%	0.5% - 2.9%	10.1%
Dermatology	1.3%	$21,301,200	0.3%	0.7% - 1.9%	7.6%
Geriatric Medicine	14.8%	$20,900,776	5.2%	4.6% - 24.9%	20.5%
Hematology	11.0%	$18,810,115	8.7%	(6.0%) - 27.9%	15.4%
Optometry	3.3%	$18,713,784	0.9%	1.4% - 5.1%	14.8%
Vascular Surgery	4.8%	$17,353,366	1.8%	1.2% - 8.4%	15.1%
Occupational Therapist in Private Practice	19.4%	$15,201,952	5.2%	9.2% - 29.6%	28.6%
Medical Oncology	1.0%	$15,126,484	0.3%	0.4% - 1.7%	9.1%
Allergy/Immunology	11.0%	$13,251,138	4.5%	2.2% - 19.7%	24.5%
Critical Care (Intensivists)	7.3%	$13,130,857	2.6%	2.3% - 12.4%	24.9%
All Provider Types With Less Than 30 Claims	2.0%	$11,986,201	1.0%	0.0% - 4.0%	4.6%
Physician Assistant	3.1%	$11,904,616	0.8%	1.6% - 4.7%	13.6%
Plastic and Reconstructive Surgery	6.3%	$11,635,795	1.7%	3.0% - 9.6%	13.5%
Independent Diagnostic Testing Facility (IDTF)	0.9%	$9,794,111	0.5%	(0.1%) - 1.8%	14.3%
Pathology	1.1%	$9,308,693	0.5%	0.1% - 2.1%	13.7%
Colorectal Surgery (formerly proctology)	5.0%	$6,537,647	1.6%	1.7% - 8.2%	12.3%
Cardiac Surgery	1.9%	$6,429,696	0.8%	0.5% - 3.4%	13.0%
Pain Management	4.5%	$6,403,957	1.7%	1.2% - 7.9%	28.4%
Clinical Psychologist	2.3%	$5,425,419	0.7%	1.0% - 3.7%	19.7%
Pediatric Medicine	8.6%	$4,174,792	6.0%	(3.2%) - 20.4%	21.3%
Interventional Pain Management	3.2%	$2,615,181	2.0%	(0.8%) - 7.2%	17.1%
Nuclear Medicine	1.0%	$1,175,630	0.5%	0.0% - 2.1%	2.4%
Osteopathic Manipulative Therapy	2.7%	$990,090	1.0%	0.8% - 4.7%	12.5%
Portable X-Ray Supplier (Billing Independently)	0.2%	$450,229	0.2%	(0.2%) - 0.6%	10.0%
Clinical Social Worker	0.2%	$252,318	0.1%	(0.1%) - 0.4%	9.2%
Multispecialty Clinic or Group Practice	0.5%	$86,742	0.6%	(0.6%) - 1.6%	4.8%
Clinical Nurse Specialist	0.1%	$28,961	0.1%	(0.1%) - 0.3%	36.9%
Ambulatory Surgical Center	0.0%	$0	0.0%	0.0% - 0.0%	17.7%
Certified Registered Nurse Anesthetist (CRNA)	0.0%	$0	0.0%	0.0% - 0.0%	6.3%
Interventional Radiology	0.0%	$0	0.0%	0.0% - 0.0%	4.3%

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%	9.3%
Public Health or Welfare Agencies (Federal, State, and local)	0.0%	$0	0.0%	0.0% - 0.0%	6.2%
All Provider Types	**4.8%**	**$3,558,352,057**	**0.2%**	**4.3% - 5.2%**	**14.9%**

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

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	13.4%	$534,238,701	2.0%	9.5% - 17.3%	23.7%
Pharmacy	9.1%	$354,689,730	1.5%	6.1% - 12.0%	17.9%
Unknown Supplier/Provider	51.1%	$48,289,228	22.0%	7.9% - 94.3%	49.5%
All Provider Types With Less Than 30 Claims	19.5%	$42,315,763	8.7%	2.5% - 36.5%	22.0%
Medical Supply Company with Respiratory Therapist	2.9%	$25,017,017	0.6%	1.7% - 4.2%	9.6%
Medical supply company with orthotic personnel certified by an accrediting organization	1.5%	$4,226,468	1.3%	(1.1%) - 4.1%	5.5%
Podiatry	2.2%	$1,991,027	1.6%	(1.0%) - 5.4%	12.2%
Individual orthotic personnel certified by an accrediting organization	1.1%	$1,898,139	1.2%	(1.2%) - 3.5%	6.7%
Individual prosthetic personnel certified by an accrediting organization	0.9%	$1,202,387	0.7%	(0.4%) - 2.2%	4.5%
Ophthalmology	3.3%	$779,456	2.4%	(1.4%) - 8.1%	18.3%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	0.6%	$467,317	0.5%	(0.4%) - 1.7%	12.6%
Orthopedic Surgery	1.1%	$276,990	1.1%	(1.1%) - 3.3%	2.8%
Optometry	1.2%	$240,262	1.2%	(1.2%) - 3.6%	8.8%
All Provider Types	**10.3%**	**$1,015,632,486**	**1.1%**	**8.1% - 12.5%**	**19.2%**

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

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)	1.7%	421,368,707	0.2%	1.4% - 2.0%
SNF	1.6%	363,049,661	0.3%	1.0% - 2.2%
HHA	1.4%	203,642,462	0.4%	0.7% - 2.1%
Other FI Service Types	1.9%	102,605,352	0.5%	1.0% - 2.9%
Hospice	1.0%	90,422,892	0.3%	0.4% - 1.6%
ESRD	1.2%	82,764,933	0.4%	0.3% - 2.1%
Non-PPS Hospital In-patient	0.7%	35,359,132	0.2%	0.3% - 1.1%
FQHC	1.5%	6,550,678	0.5%	0.5% - 2.5%
RHCs	0.6%	3,310,678	0.2%	0.3% - 0.9%
Free Standing Ambulatory Surgery	0.2%	788,627	0.1%	(0.1%) - 0.4%
Overall	**1.5%**	**1,309,863,123**	**0.1%**	**1.2% - 1.7%**

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%	$4,736,107,139	0.2%	4.5% - 5.2%
Long-term Acute Paid Claims	4.8%	$202,506,834	0.5%	3.8% - 5.7%
Denied Claims	N/A	$9,241,619	N/A	N/A
Total	**4.8%**	**$4,947,855,592**	**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.
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.

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

5. Contacting third party providers to request documentation when the billing provider indicated that medical records were possessed by a third party.

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

1. 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.
2. 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:
    1. A Medicare FI can realize efficiencies in their medical review program and lower their error rate by accepting computerized and imaged medical records, and
    2. It would be feasible for the CERT program to accept computerized or imaged medical records from providers using claim attachment records.
3. Based on findings in this report and observations from other monitoring activities, CMS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments. During this report period, CMS issued regulations that clarify and strengthen provider enrollment requirements and standards and increased efforts to deactivate or, when necessary, revoke billing privileges for providers and suppliers that are inactive or do not meet program requirements. Additionally, CMS has initiated three demonstration projects that target fraudulent business practices. The demonstrations focus on billing by suppliers of durable medical equipment, prosthetics, orthotics and supplies in south Florida and southern California, home health agencies in the greater Los Angeles and Houston areas and infusion therapy providers in south Florida.

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 both contractors 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 contractors 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 contractors 60 days prior to the due date of an improper payment report. Carriers, DMERCs, FIs, and MACs 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.
3. CMS requires the Carriers, DMERCs, FIs, and MACs 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, and MAC with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.
8. CMS requires the Carriers, DMERCs, FIs, and MACs 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, and MAC with developing an Error Rate Reduction Plan (ERRP) that targets incorrect coding errors in their jurisdiction.
4. CMS requires the contractors 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 contractors 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 75.
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.
4.

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 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. In March 2005 CMS began a demonstration project using RACs in the states of California, New York and Florida. In FY 2008 CMS will begin to expand the use of RACs (as required by Section 302 of the Tax Relief and Health Care Act of 2006). For more information about the demonstration or expansion, see www.cms.hhs.gov/rac. CMS will closely monitor provider compliance error rates and paid claim error rates in states where a RAC is operational to see if providers in RAC states improve their provider compliance error rate faster than those in non-RAC states. In 2008 and beyond, 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. 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.
11. CMS provided Carriers/DMERCs/FIs more detailed reports and information to enable them to better identify problem areas and target corrective actions.
12. 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 revised the CERT sampling schedule to allow additional time for provider adjustments or corrections.

SUPPLEMENTAL INFORMATION

Error Rates by Type of Service

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

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
Consultations	16.2%	14.7% - 17.7%	1.5%	10.3%	0.6%	86.9%	0.7%
Hospital visit - initial	14.5%	11.9% - 17.0%	5.4%	15.3%	0.0%	75.3%	4.0%
Office visits - new	14.5%	12.3% - 16.6%	0.0%	2.3%	0.2%	96.9%	0.5%
Nursing home visit	12.5%	10.6% - 14.3%	13.9%	16.3%	0.8%	68.9%	0.0%
Specialist - other	12.3%	5.3% - 19.3%	1.4%	31.9%	3.8%	63.0%	0.0%
Hospital visit - subsequent	11.3%	10.0% - 12.7%	9.5%	33.0%	0.1%	53.6%	3.7%
Chiropractic	10.6%	7.8% - 13.3%	1.6%	50.8%	27.0%	19.1%	1.4%
Other drugs	8.1%	2.7% - 13.5%	91.8%	3.0%	0.3%	4.9%	0.0%
Hospital visit - critical care	7.8%	2.5% - 13.1%	10.2%	27.7%	0.0%	62.0%	0.0%
Minor procedures - other (Medicare fee schedule)	7.0%	5.4% - 8.6%	10.2%	64.4%	13.4%	8.2%	3.8%
Ambulatory procedures - other	5.7%	0.7% - 10.8%	72.8%	3.8%	1.1%	21.6%	0.7%
Office visits - established	5.7%	5.3% - 6.1%	6.3%	13.8%	1.3%	78.2%	0.4%
Imaging/procedure - other	4.9%	1.2% - 8.6%	44.8%	14.8%	17.1%	23.2%	0.0%
Emergency room visit	4.5%	3.2% - 5.8%	11.6%	15.7%	0.0%	72.0%	0.7%
Other tests - other	3.8%	1.5% - 6.0%	25.2%	65.4%	0.0%	7.5%	1.9%
Oncology - radiation therapy	1.9%	(0.4%) - 4.3%	0.0%	89.5%	0.0%	10.5%	0.0%
Ambulance	1.9%	1.0% - 2.8%	15.7%	31.0%	31.3%	21.5%	0.5%
Lab tests - other (non-Medicare fee schedule)	1.8%	1.0% - 2.6%	27.2%	34.6%	11.4%	20.5%	6.3%
Standard imaging - nuclear medicine	1.5%	(0.9%) - 3.8%	83.0%	8.4%	0.0%	8.6%	0.0%
Specialist - ophthalmology	1.2%	0.6% - 1.8%	27.5%	53.3%	0.0%	19.2%	0.0%
All Other Codes	1.2%	0.9% - 1.4%	25.1%	44.9%	4.2%	22.6%	3.3%
All Types of Services	**4.8%**	**4.3% - 5.2%**	**20.7%**	**23.2%**	**2.8%**	**51.7%**	**1.6%**

Table 11b: Top 20 Service Type Error Rates: DMERCs and DME MACs

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
Suction Pump	53.1%	10.8% - 95.5%	87.5%	0.0%	12.5%	0.0%	0.0%
Negative Pressure Wound Therapy	50.4%	27.5% - 73.3%	100.0%	0.0%	0.0%	0.0%	0.0%
Support Surfaces	20.1%	6.2% - 34.0%	99.8%	0.0%	0.2%	0.0%	0.0%
Enteral Nutrition	18.9%	7.7% - 30.0%	77.3%	0.0%	15.6%	7.2%	0.0%
All Policy Groups with Less than 30 Claims	15.4%	4.6% - 26.1%	54.2%	0.0%	44.2%	1.6%	0.0%
Nebulizers & Related Drugs	15.3%	8.2% - 22.5%	60.5%	0.5%	23.5%	15.4%	0.1%
Upper Limb Orthoses	14.2%	0.5% - 28.0%	93.4%	0.0%	6.6%	0.0%	0.0%
Lower Limb Orthoses	13.3%	0.4% - 26.2%	96.0%	0.0%	4.0%	0.0%	0.0%
Spinal Orthoses	13.3%	(2.3%) - 28.9%	98.7%	0.0%	1.3%	0.0%	0.0%
Wheelchairs Options/Accessories	12.0%	(3.9%) - 27.9%	5.7%	0.5%	31.3%	0.4%	62.1%
Surgical Dressings	10.8%	(1.7%) - 23.4%	89.3%	0.3%	10.4%	0.0%	0.0%
Glucose Monitor	9.5%	7.9% - 11.0%	10.2%	2.0%	76.2%	10.7%	1.0%
Lenses	8.7%	2.2% - 15.1%	5.6%	21.9%	68.5%	4.1%	0.0%
Ostomy Supplies	7.8%	0.5% - 15.0%	21.6%	0.0%	74.0%	4.4%	0.0%
CPAP	7.7%	4.1% - 11.3%	24.0%	20.3%	52.7%	1.3%	1.7%
Respiratory Assist Device	7.1%	0.5% - 13.7%	77.8%	0.0%	22.2%	0.0%	0.0%
Wheelchairs Manual	6.2%	3.9% - 8.4%	1.7%	3.2%	63.5%	23.5%	8.1%
Diabetic Shoes	4.9%	0.8% - 9.0%	10.9%	13.4%	52.6%	23.2%	0.0%
Immunosuppressive Drugs	3.0%	0.4% - 5.6%	0.0%	0.0%	78.1%	0.0%	21.9%
All Other Codes	3.0%	1.6% - 4.3%	32.3%	0.6%	55.2%	4.8%	7.1%
Oxygen Supplies/Equipment	1.3%	0.8% - 1.8%	25.6%	0.0%	59.2%	12.4%	2.7%
All Types of Services	**10.3%**	**8.1% - 12.5%**	**56.8%**	**1.2%**	**33.5%**	**6.0%**	**2.5%**

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

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
Other FI Service Types	1.9%	1.0% - 2.9%	15.4%	23.6%	8.7%	49.3%	2.9%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	1.7%	1.4% - 2.0%	5.6%	45.9%	9.3%	32.6%	6.6%
SNF	1.6%	1.0% - 2.2%	2.3%	17.9%	12.7%	66.2%	0.9%
FQHC	1.5%	0.5% - 2.5%	29.8%	70.2%	0.0%	0.0%	0.0%
HHA	1.4%	0.7% - 2.1%	0.0%	7.8%	55.8%	36.4%	0.0%
ESRD	1.2%	0.3% - 2.1%	0.0%	63.3%	0.5%	36.1%	0.1%
Hospice	1.0%	0.4% - 1.6%	9.1%	7.3%	44.5%	19.3%	19.9%
Non-PPS Hospital In-patient	0.7%	0.3% - 1.1%	2.4%	20.7%	0.4%	60.1%	16.5%
RHCs	0.6%	0.3% - 0.9%	31.6%	54.8%	0.0%	0.0%	13.6%
Free Standing Ambulatory Surgery	0.2%	(0.1%) - 0.4%	0.0%	87.9%	0.0%	12.1%	0.0%
All Types of Services	**1.5%**	**1.2% - 1.7%**	**4.6%**	**28.4%**	**19.0%**	**43.6%**	**4.4%**

Table 11d: Top 20 Service Type Error Rates: QIOs[14]

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
FX, SPR, STR & DISL - UPARM,LOLEG EX FT AGE >17 W/O CC (254)	65.7%	18.9% -112.5%	0.0%	N/A	98.0%	0.2%	1.8%
CRANIAL & PERIPHERAL NERVE DISOR W/O CC (019)	42.8%	4.8% - 80.9%	0.0%	N/A	91.6%	8.4%	0.0%
OTH EAR, NOSE, MTH & THRT DIAG AGE >17 (073)	34.9%	(5.0%) - 74.8%	0.0%	N/A	45.7%	4.6%	49.6%
OTH DISOR - NERV SYS W/O CC (035)	34.2%	6.1% - 62.4%	0.0%	N/A	92.5%	7.5%	0.0%
DYSEQUILIBRIUM (065)	25.8%	12.0% - 39.6%	0.0%	N/A	90.2%	5.8%	4.1%

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

SIGNS & SYMP W CC (463)	25.1%	13.2% - 36.9%	12.1%	N/A	59.6%	27.1%	1.2%
ANGINA PECTORIS (140)	23.4%	6.2% - 40.6%	0.0%	N/A	81.8%	12.0%	6.2%
G.I. HEMORR W/O CC (175)	23.0%	6.7% - 39.4%	0.0%	N/A	83.0%	17.0%	0.0%
CHEST PAIN (143)	22.3%	17.4% - 27.2%	3.9%	N/A	90.0%	3.9%	2.2%
MIN SKIN DISOR W CC (283)	22.3%	0.4% - 44.2%	0.0%	N/A	92.0%	2.4%	5.6%
EPISTAXIS (066)	21.7%	(1.3%) - 44.7%	0.0%	N/A	100.0%	0.0%	0.0%
PERIPHERAL VAS DISOR W/O CC (131)	21.2%	(1.0%) - 43.3%	0.0%	N/A	92.6%	7.1%	0.4%
SKN GRFT &/ DEBR - SKN ULCER/CELLU W CC (263)	20.8%	3.3% - 38.3%	29.9%	N/A	20.3%	48.7%	1.1%
TRAUMA - SKIN, SUBCU TISS & BREAST AGE >17 W CC (280)	20.4%	6.2% - 34.6%	0.0%	N/A	96.1%	3.9%	0.0%
ALC/DRUG ABUSE/DEP W/O REHAB THERAPY W/O CC (523)	19.4%	1.1% - 37.6%	32.8%	N/A	63.4%	0.0%	3.9%
MEDICAL BACK PROB (243)	19.0%	12.4% - 25.6%	6.1%	N/A	81.8%	10.3%	1.8%
SIGNS & SYMP - MUS-SKEL SYS & CON TIS (247)	18.9%	7.6% - 30.2%	0.0%	N/A	82.5%	11.2%	6.3%
KIDNEY & URIN TRACT INFECT AGE >17 W/O CC (321)	18.7%	2.4% - 34.9%	0.0%	N/A	72.7%	27.3%	0.0%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W/O CC (183)	18.4%	11.4% - 25.5%	3.6%	N/A	79.1%	8.4%	8.9%
OTH DIG SYS DX AGE >17 W/O CC (189)	18.4%	(1.1%) - 37.9%	0.0%	N/A	98.0%	2.0%	0.0%
All HPMP	**4.8%**	**4.5% - 5.2%**	**4.7%**	**N/A**	**58.0%**	**31.5%**	**5.8%**

Error Rates by Type of Error

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

Carriers	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
First Coast Service Options FL 00590	10.0%	6.3%	1.1%	0.1%	2.5%	0.0%
Triple S, Inc. PR/VI 00973/00974	9.7%	0.7%	2.1%	1.6%	5.2%	0.0%
Empire NJ 00805	7.0%	0.2%	1.8%	0.2%	4.7%	0.1%
Empire NY 00803	6.5%	0.6%	2.4%	0.3%	3.1%	0.0%
Noridian MAC Region 3 03002	5.5%	0.4%	2.2%	0.0%	2.8%	0.0%
GHI NY 14330	4.7%	0.3%	1.3%	0.1%	2.9%	0.1%
CIGNA NC 05535	4.5%	0.6%	1.3%	0.0%	2.1%	0.4%
NHIC CA 31140/31146	4.4%	0.3%	0.6%	0.2%	3.4%	0.1%
Cahaba AL/GA/MS 00510/00511/00512	4.4%	0.3%	1.7%	0.1%	2.2%	0.1%
Palmetto SC 00880	4.0%	0.5%	1.3%	0.4%	1.7%	0.1%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	3.9%	0.5%	1.0%	0.1%	2.3%	0.0%
Palmetto OH/WV 00883/00884	3.9%	0.3%	1.2%	0.0%	2.3%	0.1%
BCBS AR RI 00524	3.9%	0.1%	1.2%	0.2%	2.2%	0.2%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/00836	3.9%	0.5%	1.5%	0.2%	1.6%	0.0%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	3.9%	0.1%	1.0%	0.1%	2.3%	0.4%
Trailblazer TX 00900	3.8%	0.4%	0.9%	0.1%	2.4%	0.0%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	3.7%	0.2%	1.6%	0.4%	1.5%	0.0%
WPS WI/IL/MI/MN 00951/00952/00953/00954	3.6%	0.5%	0.9%	0.0%	2.2%	0.0%
HealthNow NY 00801	3.5%	0.2%	1.0%	0.0%	2.2%	0.0%
BCBS KS/NE/W MO 00650/00655/00651	3.3%	0.3%	1.0%	0.2%	1.8%	0.1%
Noridian UT 00823	3.3%	0.0%	1.7%	0.0%	1.5%	0.0%
First Coast Service Options CT 00591	3.2%	0.4%	0.7%	0.1%	2.1%	0.0%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.2%	0.2%	0.6%	0.0%	2.1%	0.3%

AdminaStar IN/KY 00630/00660	3.1%	0.1%	0.4%	0.1%	2.5%	0.0%
HGSA PA 00865	3.0%	0.5%	0.6%	0.0%	1.8%	0.1%
CIGNA TN 05440	3.0%	0.3%	0.3%	0.5%	1.8%	0.0%
CIGNA ID 05130	2.1%	0.1%	0.4%	0.2%	1.4%	0.0%
BCBS MT 00751	1.9%	0.1%	0.8%	0.0%	1.1%	0.0%
Combined	**4.8%**	**1.0%**	**1.1%**	**0.1%**	**2.5%**	**0.1%**

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

DMERC	**Paid Claims Error Rate**	**Type of Error**				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Palmetto Region C 00885	17.7%	12.0%	0.2%	4.2%	0.8%	0.5%
Noridian Administrative Services MAC Region D 19003	11.9%	6.4%	0.0%	4.3%	0.2%	1.0%
NHIC MAC Region A 16003	4.2%	0.5%	0.2%	3.0%	0.6%	0.0%
National Government Services MAC Region B 17003	4.0%	0.6%	0.1%	3.1%	0.3%	0.0%
AdminaStar Region B 00635	3.9%	0.4%	0.0%	2.5%	1.0%	0.0%
Tricenturion Region A 77011	3.7%	0.0%	0.0%	3.4%	0.3%	0.0%
CIGNA Region D 05655	3.0%	0.5%	0.0%	2.0%	0.3%	0.0%
Combined	**10.3%**	**5.8%**	**0.1%**	**3.4%**	**0.6%**	**0.3%**

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

FI	Paid Claims Error Rate	Type of Error				
		No Documentation	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
Anthem NH/VT 00270	6.2%	0.1%	0.3%	0.0%	5.5%	0.3%
UGS AS/CA/GU/HI/NV/NMI 00454	3.4%	0.2%	1.4%	0.4%	1.4%	0.0%
Trispan LA/MO/MS 00230	2.9%	0.1%	0.4%	0.1%	2.3%	0.0%
Noridian ID/OR/UT 00323/00325	2.2%	0.0%	0.5%	0.1%	1.1%	0.5%
COSVI PR/VI 57400	2.2%	0.2%	1.2%	0.0%	0.8%	0.0%
Palmetto NC 00382	2.0%	0.0%	0.6%	0.4%	1.0%	0.1%
Highmark Medicare Services DC/MD 00366	1.9%	0.0%	0.7%	0.1%	0.9%	0.1%
Anthem ME/MA 00180/00181	1.9%	0.1%	0.2%	0.6%	0.9%	0.1%
Noridian MAC Region 3 03001	1.6%	0.1%	0.8%	0.1%	0.6%	0.0%
Trailblazer CO/NM/TX 00400	1.6%	0.0%	0.5%	0.2%	0.8%	0.1%
Riverbend NJ/TN 00390	1.5%	0.1%	0.3%	0.1%	1.0%	0.0%
First Coast Service Options FL 00090	1.5%	0.4%	0.5%	0.0%	0.6%	0.0%
BCBS WY 00460	1.4%	0.3%	0.6%	0.1%	0.4%	0.0%
Mutual of Omaha (all states) 52280	1.4%	0.0%	0.7%	0.0%	0.5%	0.1%
Palmetto SC 00380	1.3%	0.0%	0.1%	0.7%	0.3%	0.1%
BCBS AR RI 00021	1.3%	0.3%	0.3%	0.0%	0.7%	0.0%
BCBS AR 00020	1.2%	0.1%	0.3%	0.0%	0.7%	0.1%
UGS WI/MI 00450/00452	1.2%	0.0%	0.1%	0.7%	0.4%	0.0%
Noridian MN/ND 00320/00321	1.2%	0.0%	0.6%	0.0%	0.5%	0.0%
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	1.1%	0.2%	0.3%	0.1%	0.5%	0.0%
Noridian AK/WA 00322	1.1%	0.0%	0.4%	0.0%	0.6%	0.0%
UGS VA/WV 00453	1.1%	0.0%	0.4%	0.2%	0.4%	0.0%
BCBS AZ 00030	1.0%	0.2%	0.3%	0.0%	0.5%	0.0%
BCBS KS 00150	0.9%	0.1%	0.5%	0.0%	0.3%	0.0%
BCBS NE 00260	0.9%	0.0%	0.2%	0.0%	0.7%	0.0%
Empire CT/DE/NY 00308	0.9%	0.0%	0.4%	0.1%	0.3%	0.0%
Cahaba AL 00010	0.8%	0.0%	0.2%	0.0%	0.6%	0.0%
Veritus PA 00363	0.7%	0.0%	0.1%	0.2%	0.3%	0.0%
BCBS GA 00101	0.6%	0.0%	0.3%	0.0%	0.3%	0.0%
BCBS MT 00250	0.5%	0.0%	0.1%	0.1%	0.2%	0.0%
Chisholm OK 00340	0.4%	0.0%	0.1%	0.0%	0.3%	0.0%
Cahaba IA/SD 00011	0.3%	0.0%	0.0%	0.1%	0.2%	0.0%
Combined	**1.5%**	**0.1%**	**0.4%**	**0.3%**	**0.6%**	**0.1%**

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
ALABAMA	6.4%	0.0%	N/A	2.2%	4.1%	0.1%
ALASKA	1.1%	0.0%	N/A	0.4%	0.2%	0.5%
ARIZONA	5.7%	0.5%	N/A	2.4%	2.5%	0.3%
ARKANSAS	3.6%	0.0%	N/A	2.2%	0.9%	0.4%
CALIFORNIA	4.6%	0.7%	N/A	2.1%	1.0%	0.8%
COLORADO	4.6%	0.8%	N/A	0.5%	2.2%	1.2%
CONNECTICUT	3.7%	0.0%	N/A	2.0%	1.7%	0.1%
DELAWARE	4.3%	0.0%	N/A	2.9%	1.2%	0.2%
DISTRICT OF COLUMBIA	3.8%	0.4%	N/A	2.5%	0.9%	0.0%
FLORIDA	6.6%	0.1%	N/A	3.9%	2.6%	0.0%
GEORGIA	4.1%	0.1%	N/A	1.7%	2.2%	0.1%
HAWAII	3.6%	0.1%	N/A	1.5%	1.9%	0.2%
IDAHO	2.9%	0.0%	N/A	1.6%	0.6%	0.7%
ILLINOIS	5.8%	0.9%	N/A	3.3%	1.5%	0.1%
INDIANA	4.5%	0.7%	N/A	3.5%	0.3%	0.0%
IOWA	3.8%	0.0%	N/A	1.9%	1.9%	0.0%
KANSAS	3.1%	0.1%	N/A	0.9%	2.0%	0.1%
KENTUCKY	6.7%	0.6%	N/A	5.8%	0.3%	0.1%
LOUISIANA	3.4%	0.2%	N/A	1.3%	1.4%	0.4%
MAINE	4.7%	0.0%	N/A	4.0%	0.4%	0.4%
MARYLAND	4.7%	0.0%	N/A	4.7%	0.0%	0.0%
MASSACHUSETTS	7.1%	0.0%	N/A	6.8%	0.2%	0.1%
MICHIGAN	5.2%	0.0%	N/A	3.2%	1.3%	0.7%
MINNESOTA	3.9%	0.2%	N/A	2.3%	1.0%	0.4%
MISSISSIPPI	5.8%	0.4%	N/A	3.0%	1.5%	0.8%
MISSOURI	3.4%	0.0%	N/A	1.8%	1.3%	0.3%
MONTANA	1.2%	0.0%	N/A	0.4%	0.5%	0.4%
NEBRASKA	1.2%	0.0%	N/A	0.5%	0.5%	0.3%
NEVADA	7.5%	0.2%	N/A	5.2%	1.6%	0.6%
NEW HAMPSHIRE	3.8%	0.1%	N/A	2.9%	0.6%	0.3%
NEW JERSEY	5.0%	0.2%	N/A	3.0%	1.7%	0.1%
NEW MEXICO	7.6%	0.0%	N/A	3.7%	3.0%	0.8%
NEW YORK	5.0%	0.3%	N/A	2.3%	2.3%	0.0%
NORTH CAROLINA	1.5%	0.0%	N/A	1.2%	0.4%	0.0%
NORTH DAKOTA	2.4%	0.1%	N/A	1.4%	1.0%	0.0%
OHIO	3.0%	0.0%	N/A	2.7%	0.2%	0.2%
OKLAHOMA	2.9%	0.2%	N/A	1.3%	1.1%	0.4%
OREGON	5.0%	0.0%	N/A	3.4%	0.7%	0.9%
PENNSYLVANIA	6.0%	0.4%	N/A	2.5%	3.1%	0.0%

PUERTO RICO	7.9%	0.4%	N/A	3.8%	3.7%	0.0%
RHODE ISLAND	3.8%	0.0%	N/A	3.4%	0.3%	0.1%
SOUTH CAROLINA	5.2%	0.5%	N/A	3.8%	0.8%	0.0%
SOUTH DAKOTA	3.6%	0.5%	N/A	2.4%	0.0%	0.7%
TENNESSEE	2.4%	0.0%	N/A	1.0%	1.1%	0.2%
TEXAS	6.8%	0.0%	N/A	3.5%	2.6%	0.7%
UTAH	4.7%	0.2%	N/A	2.1%	1.6%	0.9%
VERMONT	4.6%	0.0%	N/A	3.4%	0.6%	0.6%
VIRGINIA	5.9%	0.0%	N/A	4.9%	0.8%	0.2%
WASHINGTON	2.1%	0.0%	N/A	1.3%	0.3%	0.5%
WEST VIRGINIA	6.3%	0.3%	N/A	3.7%	2.1%	0.1%
WISCONSIN	2.6%	0.0%	N/A	0.9%	1.6%	0.1%
WYOMING	0.9%	0.1%	N/A	0.2%	0.4%	0.3%
Short-term Acute Paid Claims	**4.8%**	**0.2%**	**N/A**	**2.8%**	**1.5%**	**0.3%**
Long-term Acute Paid Claims	**4.8%**	**0.1%**	**N/A**	**2.6%**	**1.8%**	**0.2%**
Denied Claims	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**4.8%**	**0.2%**	**N/A**	**2.8%**	**1.5%**	**0.3%**

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 and MACs

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
Hospital visit - subsequent	11.3%	5,943	$566,165,319	0.7%	10.0% - 12.7%
Office visits - established	5.7%	14,976	$560,692,977	0.2%	5.3% - 6.1%
Consultations	16.2%	1,954	$526,846,262	0.8%	14.7% - 17.7%
Other drugs	8.1%	2,216	$419,233,745	2.8%	2.7% - 13.5%
Minor procedures - other (Medicare fee schedule)	7.0%	6,185	$181,008,293	0.8%	5.4% - 8.6%
Hospital visit - initial	14.5%	751	$166,663,414	1.3%	11.9% - 17.0%
Office visits - new	14.5%	1,108	$156,907,935	1.1%	12.3% - 16.6%
Nursing home visit	12.5%	1,535	$132,513,058	1.0%	10.6% - 14.3%
Ambulance	1.9%	2,272	$71,766,323	0.5%	1.0% - 2.8%
Emergency room visit	4.5%	1,255	$65,347,361	0.7%	3.2% - 5.8%
Hospital visit - critical care	7.8%	322	$59,111,799	2.7%	2.5% - 13.1%
Chiropractic	10.6%	1,714	$57,704,328	1.4%	7.8% - 13.3%
Other tests - other	3.8%	1,757	$49,321,081	1.1%	1.5% - 6.0%
Ambulatory procedures - other	5.7%	634	$48,253,791	2.6%	0.7% - 10.8%
Lab tests - other (non-Medicare fee schedule)	1.8%	11,741	$36,402,299	0.4%	1.0% - 2.6%
All Codes With Less Than 30 Claims	1.5%	368	$29,250,193	1.3%	(1.2%) - 4.1%
Standard imaging - nuclear medicine	1.5%	1,052	$25,870,344	1.2%	(0.9%) - 3.8%
Oncology - radiation therapy	1.9%	580	$25,327,359	1.2%	(0.4%) - 4.3%
Specialist - ophthalmology	1.2%	2,964	$24,910,618	0.3%	0.6% - 1.8%
Specialist - other	12.3%	278	$19,926,260	3.6%	5.3% - 19.3%
Imaging/procedure - other	4.9%	448	$17,996,131	1.9%	1.2% - 8.6%
Specialist - psychiatry	2.1%	1,532	$17,366,281	0.8%	0.6% - 3.6%
Standard imaging - musculoskeletal	2.4%	2,405	$16,421,678	0.7%	1.1% - 3.7%
Other - Medicare fee schedule	12.4%	278	$16,412,733	3.7%	5.2% - 19.7%
Home visit	11.5%	153	$16,213,894	4.2%	3.2% - 19.8%
Echography - other	3.1%	528	$15,307,388	1.5%	0.3% - 6.0%
Eye procedure - other	3.4%	163	$14,894,233	3.0%	(2.5%) - 9.4%
Other tests - electrocardiograms	3.6%	2,382	$14,689,491	0.6%	2.5% - 4.8%
Chemotherapy	1.0%	241	$14,055,680	0.8%	(0.5%) - 2.5%
Lab tests - other (Medicare fee schedule)	0.9%	1,549	$13,779,146	0.4%	0.1% - 1.6%
Minor procedures - musculoskeletal	1.3%	955	$13,393,757	0.4%	0.6% - 2.0%
Advanced imaging - CAT: other	1.0%	1,108	$13,318,018	0.5%	(0.1%) - 2.0%

Echography - heart	0.9%	1,661	$12,918,792	0.4%	0.2% - 1.7%
Dialysis services (Non MFS)	1.8%	221	$11,464,465	0.6%	0.6% - 3.0%
Minor procedures - skin	0.9%	1,374	$9,927,107	0.4%	0.2% - 1.6%
Ambulatory procedures - skin	0.6%	1,456	$7,418,115	0.2%	0.1% - 1.1%
Standard imaging - chest	1.8%	2,511	$7,247,951	0.5%	0.9% - 2.8%
Oncology - other	1.7%	676	$6,958,331	1.1%	(0.4%) - 3.8%
Anesthesia	0.6%	812	$6,783,123	0.3%	(0.1%) - 1.2%
Echography - eye	6.0%	172	$6,628,124	1.6%	2.9% - 9.1%
Major procedure, cardiovascular-Other	0.7%	281	$6,267,211	0.6%	(0.4%) - 1.8%
Other tests - cardiovascular stress tests	1.8%	423	$6,065,362	0.9%	0.1% - 3.5%
Standard imaging - other	1.8%	691	$5,730,252	0.6%	0.6% - 3.0%
Echography - carotid arteries	1.8%	199	$5,320,246	1.8%	(1.7%) - 5.4%
Dialysis services	5.2%	116	$5,247,611	3.1%	(0.9%) - 11.2%
Endoscopy - upper gastrointestinal	1.3%	205	$5,154,114	0.1%	1.0% - 1.5%
Other tests - EKG monitoring	4.8%	108	$4,779,724	0.9%	3.0% - 6.5%
Immunizations/Vaccinations	1.4%	1,977	$4,708,991	0.5%	0.5% - 2.4%
Major procedure, orthopedic - other	1.1%	115	$4,506,182	1.1%	(1.1%) - 3.3%
Advanced imaging - MRI: brain	0.7%	202	$3,764,804	0.5%	(0.3%) - 1.8%
Lab tests - routine venipuncture (non Medicare fee schedule)	2.4%	4,528	$3,714,823	0.5%	1.4% - 3.4%
Ambulatory procedures - musculoskeletal	0.8%	118	$3,343,895	0.4%	(0.0%) - 1.5%
Lab tests - blood counts	1.1%	2,427	$3,186,169	0.3%	0.6% - 1.6%
Lab tests - automated general profiles	0.9%	2,392	$2,860,630	0.3%	0.4% - 1.5%
Advanced imaging - MRI: other	0.2%	399	$2,568,799	0.1%	(0.0%) - 0.3%
Lab tests - urinalysis	3.9%	1,386	$2,369,139	0.7%	2.6% - 5.2%
Major procedure, orthopedic - Knee replacement	0.4%	31	$1,775,861	0.1%	0.3% - 0.6%
Endoscopy - cystoscopy	0.6%	119	$1,650,024	0.1%	0.4% - 0.7%
Standard imaging - breast	0.3%	781	$1,293,075	0.2%	(0.1%) - 0.8%
Lab tests - bacterial cultures	1.4%	571	$1,177,294	0.6%	0.3% - 2.5%
Standard imaging - contrast gastrointestinal	1.4%	108	$1,063,830	1.2%	(1.1%) - 3.8%
Echography - abdomen/pelvis	0.5%	369	$1,055,650	0.3%	(0.2%) - 1.1%
Medical/surgical supplies	25.9%	72	$898,198	7.3%	11.5% - 40.2%
Endoscopy - colonoscopy	0.1%	285	$895,402	0.1%	(0.1%) - 0.3%
Advanced imaging - CAT: head	0.2%	421	$821,170	0.1%	(0.0%) - 0.5%
Major procedure - Other	0.1%	201	$770,584	0.1%	(0.0%) - 0.2%
Lab tests - glucose	3.0%	479	$689,794	1.3%	0.4% - 5.6%
Other - non-Medicare fee schedule	0.8%	436	$256,026	0.7%	(0.5%) - 2.1%
Echography - prostate, transrectal	0.0%	36	N/A	N/A	N/A
Endoscopy - arthroscopy	0.0%	43	N/A	N/A	N/A
Endoscopy - laryngoscopy	0.0%	32	N/A	N/A	N/A
Endoscopy - other	0.0%	75	N/A	N/A	N/A

Eye procedure - cataract removal/lens insertion	0.0%	248	N/A	N/A	N/A
Imaging/procedure - heart including cardiac catheter	0.0%	334	N/A	N/A	N/A
No Service Code	0.0%	36	N/A	N/A	N/A
Orthotic devices	0.0%	91	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**4.8%**	**100,565**	**$3,558,352,057**	**0.2%**	**4.3% - 5.2%**

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

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
All Policy Groups with Less than 30 Claims	15.4%	473	$228,032,498	5.5%	4.6% - 26.1%
Nebulizers & Related Drugs	15.3%	3,137	$167,572,569	3.6%	8.2% - 22.5%
Negative Pressure Wound Therapy	50.4%	63	$125,678,545	11.7%	27.5% - 73.3%
Glucose Monitor	9.5%	3,696	$114,464,254	0.8%	7.9% - 11.0%
Enteral Nutrition	18.9%	473	$109,383,911	5.7%	7.7% - 30.0%
Support Surfaces	20.1%	116	$33,855,619	7.1%	6.2% - 34.0%
CPAP	7.7%	1,120	$31,149,480	1.8%	4.1% - 11.3%
Lower Limb Orthoses	13.3%	184	$28,829,394	6.6%	0.4% - 26.2%
Oxygen Supplies/Equipment	1.3%	3,173	$27,376,887	0.3%	0.8% - 1.8%
Wheelchairs Options/Accessories	12.0%	493	$27,314,967	8.1%	(3.9%) - 27.9%
Wheelchairs Manual	6.2%	793	$15,274,364	1.1%	3.9% - 8.4%
Suction Pump	53.1%	75	$14,458,892	21.6%	10.8% - 95.5%
Immunosuppressive Drugs	3.0%	376	$12,740,563	1.3%	0.4% - 5.6%
Ostomy Supplies	7.8%	394	$11,453,618	3.7%	0.5% - 15.0%
Spinal Orthoses	13.3%	47	$9,908,724	7.9%	(2.3%) - 28.9%
Surgical Dressings	10.8%	193	$9,827,558	6.4%	(1.7%) - 23.4%
Diabetic Shoes	4.9%	250	$8,198,843	2.1%	0.8% - 9.0%
Respiratory Assist Device	7.1%	74	$6,283,663	3.4%	0.5% - 13.7%
Lenses	8.7%	389	$5,909,435	3.3%	2.2% - 15.1%
Upper Limb Orthoses	14.2%	82	$5,894,418	7.0%	0.5% - 28.0%
Hospital Beds/Accessories	1.7%	514	$4,925,464	0.7%	0.4% - 3.1%
TENS	14.8%	64	$4,748,501	9.4%	(3.7%) - 33.2%
Walkers	3.1%	208	$2,739,022	1.8%	(0.4%) - 6.6%
Repairs/DME	22.9%	31	$2,602,734	13.3%	(3.3%) - 49.1%
Commodes/Bed Pans/Urinals	5.7%	120	$2,393,791	3.4%	(0.9%) - 12.3%
Urological Supplies	4.2%	248	$2,142,249	2.0%	0.4% - 8.0%
Heat/Cold Application	4.8%	40	$1,009,336	4.1%	(3.1%) - 12.8%
Patient Lift	3.0%	54	$703,962	2.1%	(1.2%) - 7.1%
Orthopedic Footwear	9.3%	41	$398,410	9.1%	(8.5%) - 27.0%
Canes/Crutches	2.8%	42	$223,844	2.1%	(1.3%) - 6.9%
Infusion Pumps & Related Drugs	0.1%	230	$136,970	0.1%	(0.0%) - 0.2%

Wheelchairs Seating	0.0%	40	N/A	N/A	N/A
Routinely Denied Items	N/A	103	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**10.3%**	**17,336**	**$1,015,632,486**	**1.1%**	**8.1% - 12.5%**

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

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)	1.7%	41,919	$421,368,707	0.2%	1.4% - 2.0%
SNF	1.6%	2,593	$363,049,661	0.3%	1.0% - 2.2%
HHA	1.4%	1,969	$203,642,462	0.4%	0.7% - 2.1%
Other FI Service Types	1.9%	6,979	$102,605,352	0.5%	1.0% - 2.9%
Hospice	1.0%	990	$90,422,892	0.3%	0.4% - 1.6%
ESRD	1.2%	1,264	$82,764,933	0.4%	0.3% - 2.1%
Non-PPS Hospital In-patient	0.7%	2,648	$35,359,132	0.2%	0.3% - 1.1%
FQHC	1.5%	572	$6,550,678	0.5%	0.5% - 2.5%
RHCs	0.6%	3,262	$3,310,678	0.2%	0.3% - 0.9%
Free Standing Ambulatory Surgery	0.2%	84	$788,627	0.1%	(0.1%) - 0.4%
All Type of Services (Incl. Codes Not Listed)	**1.5%**	**62,280**	**$1,309,863,123**	**0.1%**	**1.2% - 1.7%**

Table 13d: Paid Claims Error Rates by Service Type: QIOs[15]

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
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	11.3%	176	$204,177,351	4.0%	3.5% - 19.1%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	13.6%	1035	$187,866,936	1.6%	10.4% - 16.8%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	15.1%	731	$140,453,656	2.3%	10.7% - 19.6%
CHEST PAIN (143)	22.3%	689	$131,369,679	2.5%	17.4% - 27.2%
RENAL FAILURE (316)	7.7%	754	$130,481,892	1.3%	5.1% - 10.2%
EXT OR PROC UNREL TO PRINC DIAG (468)	8.2%	153	$100,766,418	3.8%	0.7% - 15.6%
HEART FAILURE & SHOCK (127)	2.6%	1957	$89,539,751	0.5%	1.5% - 3.6%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	9.3%	174	$85,870,116	3.0%	3.4% - 15.3%
SEPTICEMIA AGE >17 (416)	3.2%	696	$73,456,343	0.8%	1.7% - 4.7%
MEDICAL BACK PROB (243)	19.0%	292	$71,958,957	3.4%	12.4% - 25.6%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	1.5%	1577	$70,029,794	0.5%	0.6% - 2.4%

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

KIDNEY & URIN TRACT INFECT AGE >17 W CC (320)	6.5%	701	$66,733,368	1.5%	3.5% - 9.6%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	7.3%	264	$66,527,926	2.4%	2.6% - 12.1%
OTH VAS PROC W CC W/O MAJ CV DX (554)	6.9%	258	$64,803,227	2.9%	1.3% - 12.6%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W/O MAJ CV DX (558)	3.0%	562	$64,660,050	0.9%	1.3% - 4.7%
CIRC DISOR EXC AMI, W CAR CATH & COMPL DIAG (124)	6.9%	362	$59,347,270	3.6%	(0.2%) - 14.0%
OTH KIDNEY & URIN TRACT PROC (315)	13.1%	102	$58,984,717	5.9%	1.5% - 24.7%
CHRON OBSTRUCTIVE PULM DIS (088)	3.4%	1199	$57,928,635	0.7%	2.0% - 4.9%
SIMP PNEUM & PLEURISY AGE >17 W CC (089)	2.2%	1545	$54,467,501	0.6%	1.0% - 3.4%
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	11.6%	261	$54,361,687	3.0%	5.7% - 17.6%
G.I. HEMORR W CC (174)	3.8%	840	$50,127,984	1.0%	1.9% - 5.6%
SKN GRFT &/ DEBR - SKN ULCER/CELLU W CC (263)	20.8%	73	$48,114,957	8.9%	3.3% - 38.3%
UNKNOWN (475)	2.3%	349	$47,098,473	1.3%	(0.2%) - 4.8%
SYNCOPE & COLLAPSE W CC (141)	9.4%	366	$46,286,000	2.3%	4.9% - 13.9%
INTRACRANIAL HEMORR/CEREB INFARCT (014)	2.7%	849	$45,996,877	0.7%	1.4% - 4.0%
RESP NEOPS (082)	9.7%	220	$45,499,961	3.1%	3.6% - 15.8%
WND DEBR & SKN GRFT EXC HAND, MUSCSKEL & CON TIS DIS (217)	17.3%	42	$44,479,001	10.7%	(3.8%) - 38.3%
OTH CIRC SYS OR PROC (120)	10.1%	97	$44,390,001	4.5%	1.3% - 19.0%
DIABETES AGE >35 (294)	11.3%	287	$44,237,327	2.7%	5.9% - 16.6%
OTH CIRC SYS DIAG W CC (144)	5.4%	331	$43,214,365	1.5%	2.4% - 8.4%
CELLULITIS AGE >17 W CC (277)	7.7%	370	$42,405,446	2.2%	3.5% - 12.0%
DEGEN NERV SYS DISOR (012)	14.5%	177	$38,797,411	3.2%	8.1% - 20.8%
ECMO/TRAH W MV 96+ HR/PDX EXC FCE MTH & NCK W MAJ OR (541)	1.3%	89	$38,179,241	1.3%	(1.2%) - 3.8%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W/O CC (183)	18.4%	286	$36,485,703	3.6%	11.4% - 25.5%
DISOR - LIVER EXC MALIG,CIRR,ALC HEPA W CC (205)	15.3%	98	$34,907,905	12.3%	(8.8%) - 39.4%
RESP INFECT & INFLAM AGE >17 W CC (079)	2.6%	521	$34,188,238	0.7%	1.1% - 4.0%
PERIPHERAL VAS DISOR W CC (130)	8.0%	265	$33,909,651	2.9%	2.2% - 13.7%
TRANSIENT ISCHEMIA (524)	9.2%	308	$33,862,199	1.9%	5.5% - 12.8%
OTH OR PROC - INJURIES W CC (442)	11.1%	77	$33,360,503	7.8%	(4.3%) - 26.4%
SIGNS & SYMP W CC (463)	25.1%	117	$33,338,796	6.1%	13.2% - 36.9%
OTH KIDNEY & URIN TRACT DIAG AGE >17 W CC (331)	9.5%	185	$33,099,134	3.4%	2.9% - 16.2%
OTH DIG SYS DX AGE >17 W CC (188)	5.6%	307	$31,884,661	1.4%	2.8% - 8.5%
NON-EXT OR PROC UNREL TO PRINC DIAG (477)	10.0%	94	$31,828,391	4.1%	2.0% - 17.9%
CAR ARRHYTHMIA & CONDUCTION DISOR W CC (138)	3.4%	723	$30,291,579	0.9%	1.7% - 5.1%
PERIPH & CRANIAL NERVE & OTH NERV SYST PROC W CC (007)	13.0%	41	$30,026,866	6.9%	(0.5%) - 26.6%

UNKNOWN (154)	5.8%	82	$29,336,828	4.9%	(3.7%) - 15.3%
DYSEQUILIBRIUM (065)	25.8%	131	$29,153,349	7.0%	12.0% - 39.6%
OTH DIG SYS OR PROC W CC (170)	8.9%	63	$28,510,990	5.2%	(1.2%) - 19.1%
PATH FRACT & MUSCSKEL & CON TIS MALIG (239)	12.9%	133	$26,831,538	4.4%	4.2% - 21.5%
OR PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES (415)	2.5%	143	$26,687,013	1.1%	0.3% - 4.7%
OTH VAS PROC W CC W MAJ CV DX (553)	3.2%	127	$26,088,537	1.5%	0.2% - 6.1%
CAR ARRHYTHMIA & CONDUCTION DISOR W/O CC (139)	16.6%	225	$25,627,940	4.1%	8.5% - 24.6%
MAJ SM & LG BOWEL PROC W CC (148)	1.3%	327	$25,276,539	0.5%	0.4% - 2.2%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W MAJ CV DX (557)	1.2%	400	$23,954,957	0.4%	0.3% - 2.0%
COAGULATION DISOR (397)	16.9%	59	$23,457,633	6.4%	4.4% - 29.5%
CHEMOTHAPY W/O ACUTE LEUK SEC DIAG (410)	11.5%	86	$23,003,174	4.4%	2.8% - 20.2%
OTH RESP SYS OR PROC W CC (076)	3.0%	139	$22,717,382	1.8%	(0.6%) - 6.6%
CIRRHOSIS & ALC HEPATITIS (202)	10.8%	81	$22,655,352	5.3%	0.4% - 21.1%
BIOPSIES - MUSCSKEL SYS & CON TIS (216)	11.0%	49	$22,622,615	6.1%	(1.1%) - 23.0%
FRACT - HIP & PELVIS (236)	14.8%	138	$21,717,518	5.8%	3.5% - 26.1%
ATHEROSCLEROSIS W CC (132)	8.2%	277	$20,691,064	2.7%	2.9% - 13.5%
INFECTIOUS & PARASITIC DISS W OR PROC (578)	6.8%	35	$20,648,576	5.4%	(3.8%) - 17.4%
OTH DISOR - NERV SYS W CC (034)	12.6%	88	$20,625,230	3.9%	4.8% - 20.3%
LYMPHOMA & NON-ACUTE LEUK W CC (403)	6.1%	93	$19,784,330	2.0%	2.2% - 10.0%
LAPAROSCOPIC CHOLE W/O C.D.E. W CC (493)	3.2%	195	$19,216,521	1.4%	0.5% - 5.8%
DISOR - BIL TRACT W CC (207)	7.7%	133	$19,212,069	2.9%	2.0% - 13.3%
SEIZURE & HEADACHE AGE >17 W CC (024)	7.3%	145	$18,980,532	3.4%	0.6% - 13.9%
SKN ULCERS (271)	17.3%	69	$18,461,382	9.3%	(0.9%) - 35.5%
UTER & ADNEXA PROC - NON-MALIG W CC (358)	14.8%	71	$17,668,388	8.8%	(2.4%) - 32.0%
EXTRACRANIAL PROC W CC (533)	4.4%	148	$17,199,392	3.8%	(3.1%) - 11.9%
OTH RESP SYS DIAG W CC (101)	15.4%	78	$17,027,921	4.9%	5.7% - 25.1%
POSTOPERATIVE & POST-TRAUM INFECT (418)	9.2%	101	$16,716,966	5.2%	(1.1%) - 19.5%
OTH VAS PROC W/O CC (479)	7.3%	94	$16,254,325	4.2%	(0.9%) - 15.6%
SYNCOPE & COLLAPSE W/O CC (142)	12.9%	134	$15,789,093	3.2%	6.6% - 19.1%
FX, SPR, STR & DISL - UPARM,LOLEG EX FT AGE >17 W CC (253)	15.2%	85	$15,319,272	4.5%	6.3% - 24.1%
OTH EAR, NOSE, MTH & THRT DIAG AGE >17 (073)	34.9%	38	$15,298,883	20.4%	(5.0%) - 74.8%
G.I. OBSTR W CC (180)	3.2%	291	$15,139,762	1.6%	0.1% - 6.4%
MAJ CAR-VAS PROC W/O CC (111)	10.3%	35	$15,135,102	10.3%	(9.8%) -30.5%

RED BLOOD CELL DISOR AGE >17 (395)	3.0%	329	$14,937,704	0.9%	1.2% - 4.9%
G.I. HEMORR W/O CC (175)	23.0%	80	$14,825,927	8.3%	6.7% - 39.4%
NUTR & MISC METAB DISOR AGE >17 W/O CC (297)	17.9%	122	$14,621,371	4.8%	8.4% - 27.3%
KIDNEY & URIN TRACT INFECT AGE >17 W/O CC (321)	18.7%	115	$14,557,748	8.3%	2.4% - 34.9%
CORON BYPASS W CAR CATH W/O MAJ CV DX (548)	2.2%	91	$14,487,288	1.4%	(0.6%) - 5.0%
TRAUMA - SKIN, SUBCU TISS & BREAST AGE >17 W CC (280)	20.4%	57	$14,426,935	7.2%	6.2% - 34.6%
PERCU CARVAS PROC W NON-DRUG-ELUT STENT W/O MAJ CV DX (556)	6.3%	62	$14,098,329	2.8%	0.7% - 11.8%
TRANSURETHRAL PROC W CC (310)	8.6%	78	$13,716,494	3.5%	1.8% - 15.5%
BRONCHITIS & ASTHMA AGE >17 W CC (096)	7.2%	171	$13,451,229	2.9%	1.6% - 12.9%
HYPERTENSION (134)	12.0%	117	$13,380,115	3.7%	4.7% - 19.3%
COMPL - TREATMENT W CC (452)	7.1%	74	$13,206,425	3.6%	(0.0%) - 14.2%
SEPTICEMIA W/O MV 96+ HOURS AGE >17 (576)	1.9%	213	$12,981,795	0.9%	0.2% - 3.6%
ANGINA PECTORIS (140)	23.4%	86	$12,977,652	8.8%	6.2% - 40.6%
NONSPEC CEREBVAS DISOR W CC (016)	8.5%	52	$12,463,459	4.2%	0.2% - 16.8%
CERVICAL SPINAL FUSION W CC (519)	5.9%	43	$12,132,095	4.2%	(2.4%) - 14.2%
BACK & NCK PROC EXC SPINAL FUSION W CC (499)	4.6%	123	$12,075,336	1.8%	1.2% - 8.1%
CRANIAL & PERIPHERAL NERVE DISOR W CC (018)	6.7%	117	$11,913,992	2.3%	2.3% - 11.2%
CIRC DISOR W AMI & MAJ COMP, DISC ALIVE (121)	1.0%	404	$11,704,308	0.4%	0.3% - 1.8%
FX, SPR, STR & DISL - UPARM,LOLEG EX FT AGE >17 W/O CC (254)	65.7%	33	$11,601,306	23.9%	18.9% - 112.5%
SIGNS & SYMP - MUS-SKEL SYS & CON TIS (247)	18.9%	68	$11,583,061	5.8%	7.6% - 30.2%
DISOR - PANCREAS EXC MALIG (204)	2.8%	211	$11,497,222	1.4%	0.2% - 5.5%
CORON BYPASS W/O CAR CATH W MAJ CV DX (549)	2.9%	37	$11,485,293	1.8%	(0.5%) - 6.4%
CRANIAL & PERIPHERAL NERVE DISOR W/O CC (019)	42.8%	30	$11,411,742	19.4%	4.8% - 80.9%
BONE DIS & SPEC ARTHROPATHIES W CC (244)	17.6%	44	$11,400,628	9.9%	(1.7%) - 37.0%
PULM EDEMA & RESP FAILURE (087)	1.4%	371	$11,139,140	0.5%	0.4% - 2.3%
PERIPHERAL VAS DISOR W/O CC (131)	21.2%	65	$11,030,424	11.3%	(1.0%) - 43.3%
HERNIA PROC EXC ING & FEMORAL AGE >17 W CC (159)	7.1%	72	$10,519,919	5.4%	(3.4%) - 17.6%
FEVER - UNKNOWN ORIGIN AGE >17 W CC (419)	12.6%	62	$9,909,145	6.6%	(0.3%) - 25.5%
ORGANIC DISTURBANCES & MENTAL RETARDATION (429)	11.2%	61	$9,758,606	3.3%	4.8% - 17.7%
CORON BYPASS W/O CAR CATH W/O MAJ CV DX (550)	1.6%	122	$9,463,022	1.5%	(1.3%) - 4.5%

MAJ GASTROINTESTINAL DISOR&PERITONEAL INFECT (572)	7.9%	48	$9,459,811	6.7%	(5.3%) - 21.1%
MAJ SHLD/ELBOW PROC,/OTH UP EXTR PROC W CC (223)	13.8%	32	$9,449,382	10.2%	(6.1%) - 33.8%
COMPL PEPTIC ULCER (176)	11.6%	44	$9,281,975	6.0%	(0.2%) - 23.4%
MAJ CHEST PROC (075)	1.1%	164	$9,151,586	0.8%	(0.4%) - 2.6%
NONSPEC CVA & PRECEREB OCCLUS W/O INFARCT (015)	13.7%	46	$9,091,535	9.2%	(4.3%) - 31.7%
OTH MUSCSKEL SYS & CON TIS OR PROC W CC (233)	3.5%	75	$8,728,065	2.1%	(0.7%) - 7.7%
G.I. OBSTR W/O CC (181)	14.6%	73	$8,593,629	12.4%	(9.7%) - 38.9%
TENDONITIS, MYOSITIS & BURSITIS (248)	10.1%	52	$8,232,410	4.3%	1.7% - 18.6%
TRANSURETHRAL PROSTATECT W CC (336)	7.7%	93	$8,196,287	4.2%	(0.4%) - 15.8%
OTH DISOR - NERV SYS W/O CC (035)	34.2%	37	$8,195,063	14.4%	6.1% - 62.4%
INFLAM BOWEL DIS (179)	9.7%	51	$8,156,111	5.1%	(0.4%) - 19.7%
SPINAL FUSION EXC CERVICAL W CC (497)	1.1%	148	$7,722,760	0.8%	(0.5%) - 2.7%
DIG MALIG W CC (172)	2.9%	96	$7,596,505	1.0%	0.9% - 4.9%
HIP & FEM PROC EXC MAJ JNT AGE >17 W CC (210)	0.6%	444	$7,405,563	0.3%	(0.1%) - 1.2%
HERNIA PROC EXC ING & FEMORAL AGE >17 W/O CC (160)	16.9%	48	$7,358,757	8.8%	(0.4%) - 34.2%
CIRC DISOR W AMI, EXPIRED (123)	3.4%	84	$7,294,306	2.1%	(0.6%) - 7.4%
BRONCHITIS & ASTHMA AGE >17 W/O CC (097)	14.4%	58	$7,120,900	6.2%	2.2% - 26.5%
CON TIS DISOR W CC (240)	6.8%	34	$7,107,001	3.4%	0.1% - 13.5%
ALC/DRUG ABUSE/DEP W CC (521)	5.4%	119	$6,925,523	2.3%	0.8% - 10.0%
PNEUMOTHORAX W CC (094)	8.3%	55	$6,896,159	7.0%	(5.4%) - 22.0%
OTH MUSCSKEL SYS & CON TIS OR PROC W/O CC (234)	9.8%	38	$6,885,435	4.9%	0.2% - 19.4%
ANAL & STOMAL PROC W CC (157)	11.1%	42	$6,791,615	6.5%	(1.7%) - 24.0%
OTH DIG SYS DX AGE >17 W/O CC (189)	18.4%	31	$6,514,355	10.0%	(1.1%) - 37.9%
OTITIS MEDIA & URI AGE >17 W CC (068)	14.3%	50	$6,407,143	5.7%	3.2% - 25.5%
OTH SKIN, SUBCU TISS & BREAST PROC W CC (269)	5.4%	33	$6,331,187	3.2%	(1.0%) - 11.7%
SEIZURE AGE >17 W CC (562)	7.6%	50	$6,298,580	5.7%	(3.7%) - 18.8%
LAPAROSCOPIC CHOLE W/O C.D.E. W/O CC (494)	5.5%	68	$6,230,798	2.7%	0.2% - 10.8%
MIN SKIN DISOR W CC (283)	22.3%	32	$6,211,267	11.2%	0.4% - 44.2%
CHOLE EXC BY LAP W/O C.D.E. W CC (197)	2.8%	55	$6,115,008	2.5%	(2.1%) - 7.7%
LO EXTREM & HUMER PROC EXC HIP,FT,FEMUR AGE >17 W/O CC (219)	6.0%	70	$6,113,131	6.0%	(5.7%) - 17.7%

SIMP PNEUM & PLEURISY AGE >17 W/O CC (090)	6.7%	113	$6,112,826	3.1%	0.6% - 12.9%
AFTERCARE, MUSCSKEL SYS & CON TIS (249)	11.3%	54	$6,098,824	5.3%	1.0% - 21.7%
OSTEOMYELITIS (238)	8.2%	31	$6,072,361	7.6%	(6.7%) - 23.1%
KIDNEY&URETER PROC - NON-NEOP W CC (304)	2.9%	56	$6,042,067	2.9%	(2.7%) - 8.6%
CIRC DISOR W AMI W/O MAJ COMP, DISC ALIVE (122)	2.6%	166	$5,746,669	1.3%	(0.0%) - 5.2%
BACK & NCK PROC EXC SPINAL FUSION W/O CC (500)	2.9%	163	$5,723,353	1.6%	(0.2%) - 6.0%
ALC/DRUG ABUSE/DEP W/O REHAB THERAPY W/O CC (523)	19.4%	46	$5,655,444	9.3%	1.1% - 37.6%
RESP SIGNS & SYMP W CC (099)	7.1%	61	$5,472,609	2.6%	2.1% - 12.2%
RETICULOENDOTHELIAL & IMMUN DISOR W CC (398)	4.5%	53	$5,455,206	2.2%	0.2% - 8.8%
CORON BYPASS W CAR CATH W MAJ CV DX (547)	0.5%	102	$5,376,189	0.5%	(0.5%) - 1.5%
CELLULITIS AGE >17 W/O CC (278)	7.1%	113	$5,331,772	6.2%	(5.0%) - 19.2%
CAR VALVE & OTH MAJ CAR-THOR PROC W CAR CATH (104)	0.5%	70	$5,258,562	0.5%	(0.5%) - 1.6%
EPISTAXIS (066)	21.7%	31	$5,181,214	11.7%	(1.3%) - 44.7%
MAJ SM & LG BOWEL PROC W/O CC (149)	3.8%	80	$5,178,625	2.3%	(0.6%) - 8.3%
THYROID PROC (290)	9.1%	41	$5,142,101	9.0%	(8.5%) - 26.6%
HIV W MAJ REL CONDITION (489)	2.7%	34	$4,863,441	1.9%	(1.1%) - 6.4%
PERCU CAR-VAS PROC W/O CORON ART STENT/AMI (518)	1.9%	71	$4,553,897	1.3%	(0.7%) - 4.5%
RESP SYS DIAG W VENTILATOR SUPPORT <96 HOURS (566)	1.6%	62	$4,277,957	1.4%	(1.2%) - 4.5%
MAJ CAR-VAS PROC W CC (110)	0.3%	199	$3,996,606	0.2%	(0.0%) - 0.6%
EXTRACRANIAL PROC W/O CC (534)	2.1%	122	$3,977,541	1.9%	(1.6%) - 5.8%
SEIZURE & HEADACHE AGE >17 W/O CC (025)	6.0%	56	$3,572,900	2.8%	0.4% - 11.5%
LO EXTREM & HUMER PROC EXC HIP,FT,FEMUR AGE >17 W CC (218)	1.2%	97	$3,322,654	0.7%	(0.2%) - 2.5%
INTERSTITIAL LUNG DIS W CC (092)	3.2%	44	$3,307,276	2.1%	(0.9%) - 7.4%
ACUTE ADJUST REACT & PSYCHOSOC DYSFUNCT (425)	9.5%	36	$3,046,444	5.4%	(1.0%) - 20.1%
NERV SYS NEOPS W CC (010)	2.3%	63	$2,987,603	1.3%	(0.3%) - 4.9%
CAR VALVE & OTH MAJ CAR-THOR PROC W/O CAR CATH (105)	0.2%	105	$2,915,583	0.2%	(0.2%) - 0.7%
MAJ SMALL & LARGE BOWEL PROC W CC W/O MAJ GI DX (570)	1.1%	57	$2,834,350	1.0%	(0.8%) - 3.0%
VIRAL ILLNESS AGE >17 (421)	6.2%	37	$2,788,895	5.3%	(4.2%) - 16.7%
NONTRAUM STUPOR & COMA (023)	6.3%	42	$2,717,747	2.5%	1.3% - 11.2%
CERVICAL SPINAL FUSION W/O CC (520)	1.5%	62	$2,352,024	1.2%	(0.8%) - 3.8%

TRAUM STUPOR & COMA, COMA <1 HR AGE >17 W CC (028)	1.4%	77	$2,253,824	1.0%	(0.5%) - 3.3%
HIP & FEM PROC EXC MAJ JNT AGE >17 W/O CC (211)	1.5%	101	$2,184,373	1.3%	(1.0%) - 3.9%
TRACH W MV 96+ HRS/PDX EXC FCE, MTH & NCK W/O MAJ OR (542)	0.1%	58	$2,128,152	0.1%	(0.1%) - 0.4%
SPINAL FUSION EXC CERVICAL W/O CC (498)	0.6%	102	$1,995,358	0.5%	(0.4%) - 1.5%
ENDO DISOR W CC (300)	1.5%	65	$1,970,588	1.3%	(1.1%) - 4.1%
TRANSURETHRAL PROSTATECT W/O CC (337)	4.1%	66	$1,929,005	2.6%	(1.0%) - 9.2%
PSYCHOSES (430)	0.5%	267	$1,624,242	0.3%	(0.0%) - 1.1%
URIN STONES W CC, &/ ESW LITHOTRIPSY (323)	1.9%	61	$1,484,562	1.3%	(0.7%) - 4.5%
PERITONEAL ADHESIOLYSIS W CC (150)	0.4%	95	$1,362,823	0.2%	(0.1%) - 0.8%
MAJ SMALL & LARGE BOWEL PROC W CC W MAJ GI DX (569)	0.3%	53	$1,359,728	0.3%	(0.3%) - 1.0%
KIDNEY&URETER PROC - NEOP (303)	0.4%	98	$1,239,952	0.4%	(0.3%) - 1.1%
POISONING & TOXIC EFFECTS - DRUGS AGE >17 W CC (449)	0.6%	141	$1,222,130	0.4%	(0.1%) - 1.3%
FEMALE REPROD SYS RECONSTR PROC (356)	1.5%	91	$1,059,899	0.7%	0.1% - 2.8%
TOTAL MASTECTOMY - MALIG W/O CC (258)	3.1%	40	$1,041,501	2.9%	(2.6%) - 8.8%
PERCU CARDIOVAS PROC W MAJ CV DX (555)	0.2%	155	$943,364	0.1%	(0.0%) - 0.3%
PLEURAL EFFUSION W CC (085)	0.5%	68	$695,965	0.3%	(0.1%) - 1.0%
LOC EXC & REMOV INT FIX DEV EXC HIP & FEMUR W CC (537)	0.6%	32	$622,054	0.5%	(0.4%) - 1.7%
APPEND W/O COMPLIC PRINC DIAG W CC (166)	1.4%	31	$594,838	0.8%	(0.1%) - 3.0%
MAJ MALE PELVIC PROC W/O CC (335)	0.7%	47	$527,391	0.4%	(0.1%) - 1.5%
MAJ MALE PELVIC PROC W CC (334)	0.7%	39	$469,839	0.7%	(0.6%) - 1.9%
PULM EMBOLISM (078)	0.1%	161	$375,750	0.1%	(0.0%) - 0.3%
AMP - CIRC SYS DISOR EXC UP LIMB & TOE (113)	0.1%	97	$353,975	0.1%	(0.1%) - 0.2%
VAGINA, CERVIX & VULVA PROC (360)	0.5%	38	$323,989	0.4%	(0.2%) - 1.3%
BILATERAL/MULT MAJ JNT PROCS - LO EXTREM (471)	0.1%	67	$165,573	0.0%	(0.0%) - 0.1%
REVIS - HIP/KNEE REPLACE (545)	0.0%	152	$120,460	0.0%	(0.0%) - 0.1%
TOTAL MASTECTOMY - MALIG W CC (257)	0.1%	39	$76,110	0.1%	(0.0%) - 0.3%
UTER & ADNEXA PROC - NON-MALIG W/O CC (359)	0.0%	85	$0	0.0%	0.0% - 0.0%
MAJ JNT & LIMB REATTACH PROC - UP EXTREM (491)	0.0%	102	$0	0.0%	0.0% - 0.0%
CRANIOTOMY AGE >17 W CC (001)	0.0%	84	$0	0.0%	0.0% - 0.0%
CRANIOTOMY AGE >17 W/O CC (002)	0.0%	35	$0	0.0%	0.0% - 0.0%
MALIG - HEPATOBIL SYS/PANCREAS (203)	0.0%	83	$0	0.0%	0.0% - 0.0%
All HPMP	**4.8%**	**N/A**	**$4,947,855,592**	**0.2%**	**4.5% - 5.2%**

Paid Claims Error Rates by Provider Type and Type of Error

Table 14a: Paid Claims Error Rates by Provider Type and Type of Error: Carriers and MACs

Provider Types Billed to Carriers	Paid Claims Error Rate	Number of Claims in Sample	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
General Practice	27.3%	847	79.5%	7.0%	0.1%	13.3%	0.2%
Obstetrics/Gynecology	23.6%	395	81.4%	2.6%	1.0%	14.9%	0.0%
Occupational Therapist in Private Practice	19.4%	66	0.0%	89.0%	0.6%	10.4%	0.0%
Geriatric Medicine	14.8%	119	7.5%	42.9%	0.0%	49.6%	0.0%
Infectious Disease	11.0%	221	11.6%	17.0%	0.0%	71.4%	0.0%
Hematology	11.0%	66	0.0%	0.0%	0.0%	100.0%	0.0%
Allergy/Immunology	11.0%	148	1.1%	29.4%	8.7%	60.8%	0.0%
Chiropractic	10.4%	1,260	2.4%	49.9%	25.8%	20.5%	1.4%
Thoracic Surgery	9.9%	55	83.7%	0.0%	0.0%	16.3%	0.0%
Neurosurgery	9.5%	127	30.9%	30.6%	0.0%	38.5%	0.0%
Psychiatry	8.9%	805	8.6%	24.6%	0.0%	66.9%	0.0%
Neurology	8.8%	599	1.0%	27.5%	0.6%	70.9%	0.0%
Pediatric Medicine	8.6%	50	0.0%	49.5%	0.0%	50.5%	0.0%
Gastroenterology	8.4%	783	11.1%	18.4%	0.0%	69.6%	0.9%
Endocrinology	8.3%	259	19.5%	21.1%	0.0%	59.4%	0.0%
Internal Medicine	8.0%	7,838	22.1%	22.6%	1.0%	53.9%	0.5%
Physical Medicine and Rehabilitation	7.7%	510	5.2%	30.6%	18.3%	45.8%	0.0%
Critical Care (Intensivists)	7.3%	71	24.7%	24.7%	0.0%	50.6%	0.0%
Pulmonary Disease	7.1%	789	2.2%	24.4%	0.9%	68.5%	3.9%
Family Practice	6.8%	4,862	8.0%	21.3%	2.9%	63.1%	4.6%
Nurse Practitioner	6.4%	810	10.3%	19.3%	8.3%	62.2%	0.0%
Plastic and Reconstructive Surgery	6.3%	72	0.0%	7.8%	0.0%	92.2%	0.0%
General Surgery	6.3%	811	2.9%	19.2%	0.1%	71.3%	6.4%
Physical Therapist in Private Practice	6.2%	1,030	1.3%	71.1%	11.5%	12.4%	3.6%
Nephrology	5.8%	647	4.1%	12.3%	0.6%	75.6%	7.4%
Orthopedic Surgery	5.4%	1,285	6.5%	28.3%	0.0%	65.2%	0.0%
Colorectal Surgery (formerly proctology)	5.0%	48	22.2%	12.4%	0.0%	65.4%	0.0%
Otolaryngology	5.0%	507	0.9%	11.8%	2.4%	84.2%	0.8%
Vascular Surgery	4.8%	170	23.0%	17.1%	9.2%	24.4%	26.4%
Cardiology	4.6%	3,842	15.6%	24.0%	0.0%	58.2%	2.1%
Pain Management	4.5%	70	0.0%	14.0%	25.9%	60.0%	0.0%
Emergency Medicine	4.1%	1,142	11.8%	13.2%	0.0%	73.4%	1.7%
Rheumatology	4.0%	356	0.0%	33.4%	0.0%	66.6%	0.0%

Urology	3.8%	957	9.9%	31.2%	0.4%	58.1%	0.4%
Optometry	3.3%	639	0.0%	21.7%	0.0%	78.3%	0.0%
Interventional Pain Management	3.2%	51	0.0%	0.0%	0.0%	100.0%	0.0%
Physician Assistant	3.1%	544	0.7%	47.0%	0.0%	48.8%	3.5%
Podiatry	3.0%	1,587	9.1%	7.3%	9.4%	74.3%	0.0%
Osteopathic Manipulative Therapy	2.7%	43	0.0%	3.6%	0.0%	96.4%	0.0%
Radiation Oncology	2.6%	280	0.0%	57.2%	0.7%	42.1%	0.0%
Clinical Psychologist	2.3%	236	0.0%	0.0%	0.0%	100.0%	0.0%
Hematology/Oncology	2.1%	950	12.8%	21.3%	2.7%	62.9%	0.3%
All Provider Types With Less Than 30 Claims	2.0%	174	0.0%	38.0%	3.5%	52.5%	6.1%
Cardiac Surgery	1.9%	58	0.0%	47.3%	0.0%	52.7%	0.0%
Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)	1.9%	975	15.7%	31.0%	31.3%	21.5%	0.5%
Anesthesiology	1.7%	653	1.6%	36.9%	0.0%	61.5%	0.0%
Ophthalmology	1.6%	2,060	17.5%	41.4%	0.0%	40.0%	1.1%
Clinical Laboratory (Billing Independently)	1.4%	4,949	28.6%	21.2%	15.5%	29.1%	5.7%
Diagnostic Radiology	1.3%	5,377	36.1%	36.3%	2.4%	21.4%	3.8%
Dermatology	1.3%	937	0.0%	7.5%	8.3%	84.3%	0.0%
Pathology	1.1%	728	52.1%	41.6%	0.0%	6.3%	0.0%
Nuclear Medicine	1.0%	67	0.0%	0.0%	0.0%	71.8%	28.2%
Medical Oncology	1.0%	358	24.2%	38.2%	8.0%	29.6%	0.0%
Independent Diagnostic Testing Facility (IDTF)	0.9%	299	50.4%	15.6%	0.0%	34.0%	0.0%
Multispecialty Clinic or Group Practice	0.5%	51	0.0%	100.0%	0.0%	0.0%	0.0%
Portable X-Ray Supplier (Billing Independently)	0.2%	226	0.0%	13.8%	0.0%	86.2%	0.0%
Clinical Social Worker	0.2%	257	0.0%	0.0%	0.0%	100.0%	0.0%
Clinical Nurse Specialist	0.1%	63	0.0%	0.0%	0.0%	100.0%	0.0%
Ambulatory Surgical Center	0.0%	272	N/A	N/A	N/A	N/A	N/A
Certified Registered Nurse Anesthetist (CRNA)	0.0%	311	N/A	N/A	N/A	N/A	N/A
Interventional Radiology	0.0%	143	N/A	N/A	N/A	N/A	N/A

Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)	0.0%	193	N/A	N/A	N/A	N/A	N/A
Public Health or Welfare Agencies (Federal, State, and local)	0.0%	104	N/A	N/A	N/A	N/A	N/A
All Provider Types	**4.8%**	**54,135**	**20.7%**	**23.2%**	**2.8%**	**51.7%**	**1.6%**

Table 14b: Paid Claims Error Rates by Provider Type and Type of Error: DMERCs and DME MACs

Provider Types Billed to DMERCs	Paid Claims Error Rate	Number of Claims in Sample	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Unknown Supplier/Provider	51.1%	68	93.3%	0.0%	6.7%	0.0%	0.0%
All Provider Types With Less Than 30 Claims	19.5%	199	8.4%	0.1%	73.7%	17.8%	0.0%
Medical supply company not included in 51, 52, or 53	13.4%	3,571	76.4%	0.6%	16.8%	2.4%	3.8%
Pharmacy	9.1%	4,715	31.8%	2.3%	54.2%	10.3%	1.4%
Ophthalmology	3.3%	39	42.5%	0.0%	57.5%	0.0%	0.0%
Medical Supply Company with Respiratory Therapist	2.9%	1,188	24.0%	0.0%	71.6%	4.4%	0.0%
Podiatry	2.2%	73	44.9%	55.1%	0.0%	0.0%	0.0%
Medical supply company with orthotic personnel certified by an accrediting organization	1.5%	64	0.0%	0.0%	83.6%	16.4%	0.0%
Optometry	1.2%	43	0.0%	0.0%	0.0%	100.0%	0.0%
Individual orthotic personnel certified by an accrediting organization	1.1%	77	0.0%	0.0%	0.0%	100.0%	0.0%
Orthopedic Surgery	1.1%	52	0.0%	0.0%	100.0%	0.0%	0.0%
Individual prosthetic personnel certified by an accrediting organization	0.9%	42	0.0%	0.0%	100.0%	0.0%	0.0%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	0.6%	61	0.0%	0.0%	100.0%	0.0%	0.0%
All Provider Types	**10.3%**	**10,191**	**56.8%**	**1.2%**	**33.5%**	**6.0%**	**2.5%**

Table 14c: Paid Claims Error Rates by Provider Type and Type of Error: FIs and MACs

Provider Types Billed to FIs	Paid Claims Error Rate	Number of Claims in Sample	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Other FI Service Types	1.9%	6,979	15.4%	23.6%	8.7%	49.3%	2.9%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	1.7%	41,919	5.6%	45.9%	9.3%	32.6%	6.6%
SNF	1.6%	2,593	2.3%	17.9%	12.7%	66.2%	0.9%
FQHC	1.5%	572	29.8%	70.2%	0.0%	0.0%	0.0%
HHA	1.4%	1,969	0.0%	7.8%	55.8%	36.4%	0.0%
ESRD	1.2%	1,264	0.0%	63.3%	0.5%	36.1%	0.1%
Hospice	1.0%	990	9.1%	7.3%	44.5%	19.3%	19.9%
Non-PPS Hospital In-patient	0.7%	2,648	2.4%	20.7%	0.4%	60.1%	16.5%
RHCs	0.6%	3,262	31.6%	54.8%	0.0%	0.0%	13.6%
Free Standing Ambulatory Surgery	0.2%	84	0.0%	87.9%	0.0%	12.1%	0.0%
All Provider Types	**1.5%**	**62,280**	**4.6%**	**28.4%**	**19.0%**	**43.6%**	**4.4%**

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.

CMS Contacts

See www.cms.hhs.gov/cert to obtain additional copies of this report.

CMS CERT Contacts: Jill Nicolaisen (CERT@cms.hhs.gov)
CMS HPMP Contact: Anita Bhatia (anita.bhatia@cms.hhs.gov)
CMS Public Affairs Contact: Jeff Nelligan (jeff.nelligan@cms.hhs.gov)