Improper Medicare Fee-For-Service Payments Report - May 2008

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 129,875 claims submitted to Carriers/DMERCs/FIs during the reporting period.
- HPMP randomly selecting a sample of 39,841 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
May 2008	Claims submitted in the 12 month period ending September 30, 2007	Discharges occurring in the 12 month period ending June 30, 2007

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.
The IPIA also requires the inclusion of denied claims in the sample. The CERT program includes denied claims in its sample for both the May and November reports. The HPMP samples denied claims only for the November report. Therefore, the HPMP denied claims data from the November 2007 report was used to make calculations for this May report. For more information please see "Two Measurement Programs: CERT and HPMP".

Summary of Findings

National Error Rate

This report shows that 3.7% of the dollars paid nationally did not comply with one or more Medicare coverage, coding, billing, and payment rules. Projected overpayments were $9.3 B and the underpayments were $0.9 B. Thus, gross improper payments were projected as $10.2 B (i.e., $9.3 B **plus** $0.9 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	$3.2B	4.2%	$0.2B	0.3%	$3.4B	4.5%
DMERC	$9.9B	$0.9B	8.9%	$0B	0.1%	$0.9B	9.0%
FI	$89.4B	$1.2B	1.3%	$0.1B	0.2%	$1.3B	1.5%
QIOs	$102B	$4B	4.0%	$0.5B	0.5%	$4.6B	4.5%
All Medicare FFS	**$276.2B**	**$9.3B**	**3.4%**	**$0.9B**	**0.3%**	**$10.2B**	**3.7%**

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	12.3%	$345.4 M	First Coast Service Options FL, Carrier	$422.8 M	5.4%
Error Rates by Service Type	Suction Pump	73.4%	$29.0 M	Office visits - established	$622.5 M	6.0%
Error Rates by Provider Type	Occupational Therapist in Private Practice	21.2%	$18.0 M	Internal Medicine	$710.3 M	8.5%

Goals

One of the performance goals for CMS is the reduction of improper payments made under the FFS program to 3.8% or less by the November 2008 reporting period.

Corrective Actions Taken to Date

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

1. Using the First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) that generates state-specific hospital billing reports to help QIOs analyze administrative claims data and target interventions with hospitals,
2. Continuing one-on-one educational contacts with providers with indicators of high levels of payment errors,
3. Developing projects with the QIOs addressing state-specific admissions necessity, coding, and billing concerns,
4. Distributing FATHOM generated hospital-specific reports,
5. Developing and distributing QIO-specific payment error cause analyses,
6. Conducting national training on the use of FATHOM reports in compliance efforts, and
7. Providing monthly updates to QIO-specific and national error rates.

CMS requires each **Carrier, DMERC, FI, and MAC** 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 worked 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 129,875 paid and denied claims. The sample size for error rates concerning QIOs for the reporting period was 39,841 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.

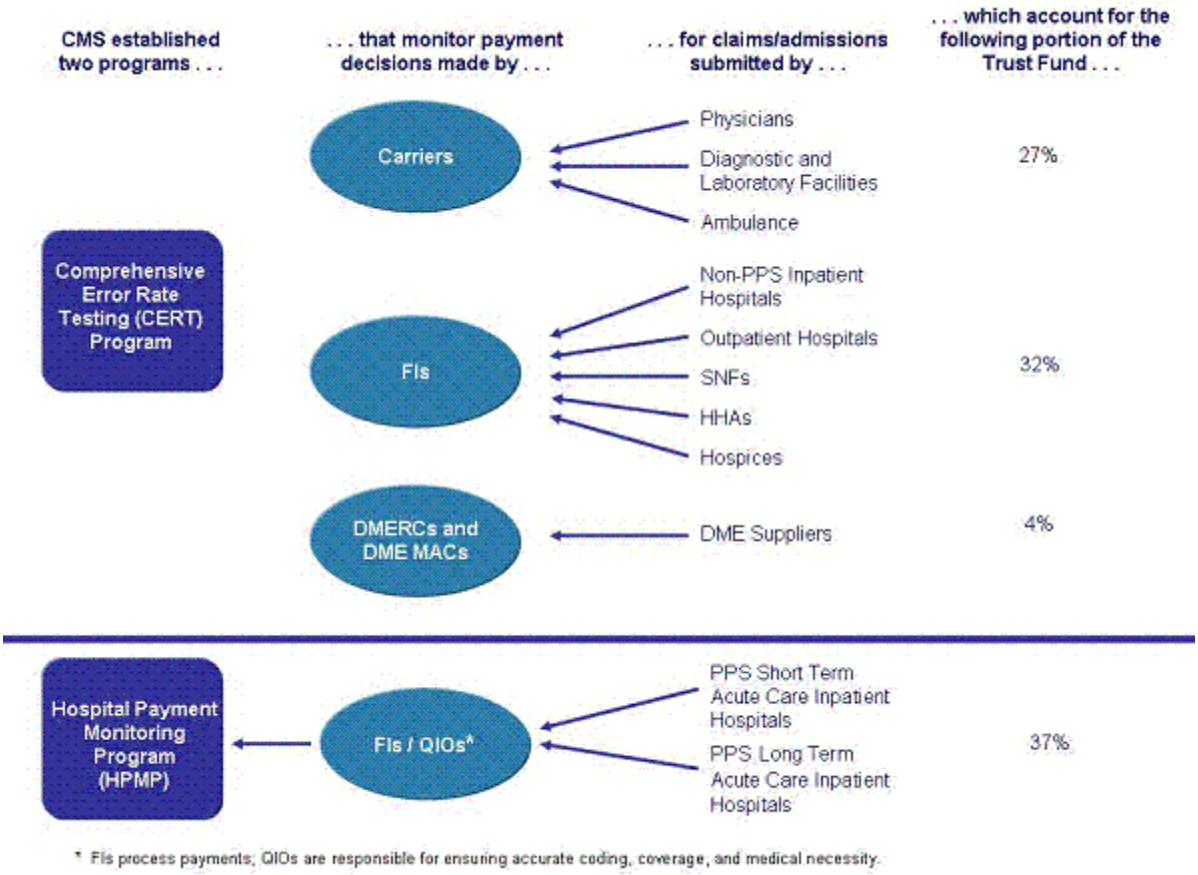
Provider Compliance Error Rate

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 129,875 claims from Carriers, DMERCs, FIs, and MACs. The CERT Contractor randomly selected about 172 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

The CERT program used payment data from calendar year 2006 to generate the projected improper payments in this report. For May 2008, 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.

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. Responsibility for the DME MAC error rate for each region is shared between two contractors: the DME MAC and the DME Program Safeguard Contractor (PSC).

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, 2006 for 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 39,841 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 can not be compared to previously published estimates for contractor-specific, service-type, or provider-type calculations. However, since error rate estimates are unaffected, they can be compared across all reports.

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

Table 2: Summary of Inclusion vs. Exclusion

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

Outcome of Sampled Claims

In the CERT program, 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 $297.9M 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 $875,005 in actual overpayments and, as of the final cut-off date for this report, contractors had collected $650,418 of those overpayments. The HPMP identified $14,520,437 in overpayments and, as of the final cutoff date for this report, the FIs had processed $11,877,776 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 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 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.

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 3.7% (which equates to $10.2 B). The 95% confidence interval for Medicare FFS program paid claims error rate was 3.5% - 3.9%. The 90% confidence interval (required to be reported by IPIA) was 3.6% - 3.8%.

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	$3.2B	4.2%	$0.2B	0.3%	$3.4B	4.5%
DMERC	$9.9B	$0.9B	8.9%	$0B	0.1%	$0.9B	9.0%
FI	$89.4B	$1.2B	1.3%	$0.1B	0.2%	$1.3B	1.5%
QIOs	$102B	$4B	4.0%	$0.5B	0.5%	$4.6B	4.5%
All Medicare FFS	**$276.2B**	**$9.3B**	**3.4%**	**$0.9B**	**0.3%**	**$10.2B**	**3.7%**

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%
May 2008	$276.2 B	$9.3 B	3.4%	$0.9 B	0.3%	$10.2 B	3.7%

[2] Some columns and/or rows may not sum correctly due to rounding.
[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	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	May 2008
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross	Gross	Gross
No Doc	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%	0.6%	0.3%
Insufficient Doc Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%	0.4%	0.5%
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%	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%	1.4%
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%	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%**	**3.7%**
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%	96.3%

[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%.

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

Table 3d: Type of Error Comparison for 2007 and 2008[5]

Type of Error	Nov 2007 Report	May 2008 Report				
	Total	Total	Carrier	DMERC	FI	QIO
No Doc Errors	0.6%	0.3%	0.1%	0.1%	0.0%	0.0%
Insufficient Doc Errors	0.4%	0.5%	0.3%	0.0%	0.2%	0.0%
Medically Unnecessary Errors	1.3%	1.3%	0.0%	0.2%	0.1%	1.0%
Incorrect Coding Errors	1.5%	1.4%	0.7%	0.0%	0.2%	0.5%
Other Errors	0.2%	0.2%	0.0%	0.0%	0.0%	0.1%
Improper Payments	3.9%	3.7%	1.2%	0.3%	0.5%	1.7%

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 0.3% 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
0.1%	0.1%	0.0%	0.0%	0.3%

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: All Contractors

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	No Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Subsequent hospital care (99232)	1.5%	$38,930,814	0.3% - 2.7%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$36,503,050	0.1% - 0.2%
Budesonide non-comp unit (J7626)	6.6%	$17,559,234	(2.8%) - 16.0%
Heart image (3d), multiple (78465)	1.8%	$15,204,651	(1.6%) - 5.2%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	0.3%	$14,838,365	(0.0%) - 0.7%

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

Powered pres-redu air mattrs (E0277)	10.3%	$13,908,914	(3.0%) - 23.6%
Office/outpatient visit, est (99213)	0.3%	$13,438,947	0.1% - 0.5%
bls (A0428)	1.4%	$13,002,788	(0.6%) - 3.5%
Office/outpatient visit, est (99214)	0.2%	$8,909,713	0.0% - 0.4%
Levalbuterol non-comp unit (J7614)	3.6%	$8,404,420	(3.3%) - 10.5%
Subsequent hospital care (99231)	1.7%	$7,846,191	0.6% - 2.8%
Tc99m sestamibi (A9500)	3.7%	$7,827,125	(3.3%) - 10.7%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W MAJ CV DX (557)	0.4%	$7,546,550	(0.2%) - 0.9%
Special facility or ASC surgery-hospice (hospital based) (82)	0.6%	$7,529,901	(0.6%) - 1.8%
Nursing fac care, subseq (99309)	2.4%	$7,381,448	0.4% - 4.3%
SHLD,ELBFOREARM PROC,EXC MAJ JNT PROC, W/O CC (224)	22.1%	$7,304,823	(20.9%) - 65.1%
INFECTIOUS & PARASITIC DISS W OR PROC (578)	2.4%	$7,243,919	(2.2%) - 6.9%
Albuterol ipratrop non-comp (J7620)	3.7%	$7,101,206	(0.9%) - 8.4%
Inpatient consultation (99254)	1.0%	$6,813,512	(0.1%) - 2.1%
Emergency dept visit (99284)	1.6%	$6,432,935	(0.8%) - 3.9%
Overall	**0.3%**	**$785,401,846**	**0.2% - 0.3%**

The following are examples of No Documentation errors:

- A Durable Medical Equipment MAC (DME MAC) contractor paid $264.04 for diabetic shoe inserts. We received a letter from the provider stating: "We have no file on this patient." CERT determined there was no documentation to support the services billed and the entire amount was counted as an error.
- A Fiscal Intermediary (FI) paid $339.10 for professional services for the provision of an antigen. 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.

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. 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. The initial results from these demonstration projects should appear in the period sampled by the November 2008 report.

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 0.5% 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%	0.2%	0.0%	0.5%

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.

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)	0.8%	$186,333,455	0.6% - 0.9%
Subsequent hospital care (99232)	4.1%	$105,492,610	3.0% - 5.1%
Subsequent hospital care (99233)	4.2%	$55,400,040	2.7% - 5.7%
SNF-inpatient (including Part A) (21)	0.3%	$53,646,699	0.1% - 0.5%
Therapeutic exercises (97110)	6.3%	$43,787,560	4.1% - 8.4%
Clinic-hospital based or independent renal dialysis facility (72)	0.6%	$40,040,922	0.1% - 1.1%
Initial hospital care (99223)	4.6%	$38,362,998	1.5% - 7.6%
Subsequent hospital care (99231)	6.5%	$30,061,084	3.1% - 9.9%
Office/outpatient visit, est (99214)	0.6%	$27,618,993	0.2% - 1.0%
HHA-outpatient (HHA-A also) (33)	0.4%	$24,546,493	(0.4%) - 1.2%
Office/outpatient visit, est (99213)	0.5%	$24,473,898	0.3% - 0.8%

[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.

SNF-inpatient or home health visits (Part B only) (22)	1.8%	$24,241,974	0.2% - 3.3%
Office/outpatient visit, est (99211)	15.3%	$24,044,936	11.5% - 19.1%
Manual therapy (97140)	9.9%	$20,941,788	5.8% - 14.0%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.7%	$17,356,687	0.4% - 1.1%
HHA-inpatient or home health visits (Part B only) (32)	0.2%	$16,704,959	(0.2%) - 0.6%
Hospital-inpatient or home health visits (Part B only) (12)	5.0%	$16,697,652	(0.8%) - 10.7%
Inpatient consultation (99253)	6.6%	$16,696,967	2.6% - 10.5%
Chiropractic manipulation (98941)	5.2%	$16,648,199	2.9% - 7.6%
Inpatient consultation (99255)	3.7%	$15,573,132	0.8% - 6.5%
All Other Codes	0.6%	$544,611,922	0.5% - 0.7%
Overall	**0.8%**	**$1,343,282,970**	**0.7% - 0.9%**

The following are examples of insufficient documentation errors:

- An FI paid $324.62 to a provider for destruction of a localized lesion of the retina. The nurse reviewer determined that the procedure note was missing the date that the procedure was performed. 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 $744.57 for a Myocardial Perfusion imaging (SPECT) scan. Multiple attempts were made to obtain the documentation. Documentation received consisted of an EKG and a cardiolyte stress test 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%	0.2%	0.1%	1.0%	1.3%

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

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.

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
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	9.2%	$166,151,680	2.4% - 16.0%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	10.3%	$142,309,960	7.6% - 13.0%
CHEST PAIN (143)	17.9%	$105,582,836	14.0% - 21.9%
Blood glucose/reagent strips (A4253)	10.1%	$102,669,585	8.3% - 11.9%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	10.3%	$95,379,335	7.0% - 13.6%
HHA-inpatient or home health visits (Part B only) (32)	0.8%	$71,261,700	(0.0%) - 1.7%
MEDICAL BACK PROB (243)	17.0%	$64,414,331	11.0% - 23.0%
RENAL FAILURE (316)	3.6%	$61,056,159	2.1% - 5.1%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W/O MAJ CV DX (558)	2.5%	$52,663,503	0.7% - 4.2%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	5.4%	$49,220,222	0.9% - 10.0%
OTH DIG SYS DX AGE >17 W CC (188)	8.7%	$49,036,845	4.5% - 12.8%
CHRON OBSTRUCTIVE PULM DIS (088)	2.8%	$47,450,900	1.2% - 4.4%
CAR ARRHYTHMIA & CONDUCTION DISOR W CC (138)	5.1%	$45,571,751	2.6% - 7.6%
HEART FAILURE & SHOCK (127)	1.2%	$41,043,108	0.6% - 1.8%
G.I. HEMORR W CC (174)	3.1%	$40,852,716	1.2% - 4.9%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	0.9%	$39,670,499	0.1% - 1.6%
KIDNEY & URIN TRACT INFECT AGE >17 W CC (320)	3.9%	$39,520,122	1.9% - 5.8%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.2%	$37,854,810	0.0% - 0.3%
DIABETES AGE >35 (294)	9.4%	$37,025,889	3.8% - 15.1%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	3.9%	$35,575,188	(0.5%) - 8.2%
Overall	**1.3%**	**$3,702,347,910**	**1.2% - 1.4%**

The following are examples of medically unnecessary services:

- An FI paid $408.54 for Hyperbaric Oxygen under pressure, full body chamber, 4 units. The reviewer determined that the documentation did not support medical necessity per the National Coverage Determination (NCD). The CERT contractor counted the claim in error and the entire amount was recouped.
- A DME MAC paid $824.39 for a power wheelchair component. The reviewer requested additional documentation from the provider. The Certificate of Medical Necessity created

in 2004 stated that the equipment would be required for 24 months and that the time spent in the chair was 0-3 hours. The reviewer determined that the equipment was not medically necessary, based on the local coverage determination (LCD). 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 1.4% 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%	0.5%	1.4%

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

Table 4d lists the services with the highest paid claims error rates due to incorrect coding for Carriers/DMERCs/FIs/QIOs. Table 4e includes only undercoding errors for Carriers/DMERCs/FIs.

Table 4d: Top 20 Services with Incorrect Coding Errors: 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
Office/outpatient visit, est (99214)	5.5%	$244,047,384	5.0% - 6.1%
SNF-inpatient (including Part A) (21)	1.1%	$231,568,336	0.5% - 1.6%
Subsequent hospital care (99233)	16.8%	$220,483,945	14.7% - 18.9%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.6%	$149,077,042	0.4% - 0.8%
Office/outpatient visit, est (99215)	18.6%	$128,689,331	16.1% - 21.1%
Office consultation (99244)	17.5%	$120,385,360	14.2% - 20.8%
Initial hospital care (99223)	12.7%	$106,820,039	10.0% - 15.4%
Inpatient consultation (99254)	15.5%	$106,671,540	12.8% - 18.3%

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

Subsequent hospital care (99232)	3.5%	$91,410,988	2.8% - 4.3%
Office/outpatient visit, est (99213)	1.7%	$75,715,227	1.4% - 1.9%
Inpatient consultation (99255)	17.7%	$75,543,920	13.1% - 22.3%
Office/outpatient visit, new (99204)	20.8%	$66,046,693	16.8% - 24.8%
Office consultation (99245)	19.1%	$65,230,754	14.3% - 23.9%
Office consultation (99243)	9.6%	$48,749,995	7.4% - 11.9%
Emergency dept visit (99285)	5.4%	$47,404,916	3.9% - 6.9%
HHA-inpatient or home health visits (Part B only) (32)	0.5%	$44,834,494	0.2% - 0.8%
Office/outpatient visit, new (99203)	10.4%	$42,348,998	7.9% - 12.9%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	4.5%	$41,428,669	(0.1%) - 9.0%
ECMO/TRAH W MV 96+ HR/PDX EXC FCE MTH & NCK W MAJ OR (541)	1.3%	$38,134,963	(1.2%) - 3.8%
EXT OR PROC UNREL TO PRINC DIAG (468)	3.1%	$37,800,101	1.1% - 5.1%
Overall	**1.4%**	**$3,866,320,182**	**1.3% - 1.5%**

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)	0.2%	$54,172,301	0.1% - 0.3%
Office/outpatient visit, est (99212)	5.6%	$33,330,715	4.3% - 6.8%
Office/outpatient visit, est (99213)	0.6%	$28,360,087	0.5% - 0.8%
Nursing fac care, subseq (99307)	17.6%	$23,190,725	(2.1%) - 37.3%
SNF-inpatient (including Part A) (21)	0.1%	$19,361,864	0.0% - 0.2%
HHA-outpatient (HHA-A also) (33)	0.3%	$17,394,106	(0.0%) - 0.6%
HHA-inpatient or home health visits (Part B only) (32)	0.2%	$15,651,794	0.1% - 0.3%
Subsequent hospital care (99231)	3.0%	$13,809,074	1.3% - 4.7%
Office/outpatient visit, est (99211)	6.3%	$9,832,148	3.4% - 9.1%
Emergency dept visit (99283)	2.3%	$5,009,414	0.3% - 4.3%
Subsequent hospital care (99232)	0.2%	$4,037,321	(0.0%) - 0.4%
Clinic-hospital based or independent renal dialysis facility (72)	0.1%	$3,996,561	0.0% - 0.1%
Ground mileage (A0425)	0.6%	$3,963,950	(0.4%) - 1.6%
Chiropractic manipulation (98940)	2.3%	$3,117,869	0.2% - 4.4%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.1%	$2,635,460	(0.0%) - 0.3%
Epoetin alfa, non-esrd (J0885)	0.7%	$2,407,190	(0.6%) - 1.9%
Emergency dept visit (99282)	11.8%	$2,311,892	3.3% - 20.3%
Als 1 (A0426)	3.6%	$2,259,996	2.6% - 4.6%
SNF-inpatient or home health visits (Part B only) (22)	0.2%	$2,213,724	0.0% - 0.3%

Inpatient consultation (99252)	3.3%	$2,033,224	(0.8%) - 7.3%
All Other Codes	0.1%	$52,417,136	0.0% - 0.1%
Overall	**0.2%**	**$301,506,552**	**0.1% - 0.2%**

The following are examples of coding errors:

- An FI paid $3857.60 for a Skilled Nursing Facility (SNF) stay. The provider had billed a Resource Utilization Group (RUG) code of Rehabilitation Ultra High (RUB). The nurse reviewer requested documentation of the therapy minutes provided. No documentation was received. Based on the MDS QC Review, the code was changed to Clinically Complex hierarchy (CB). This coding error resulted in an overpayment to the provider of $2022.96, which was recouped by the contractor.
- A Carrier paid $164.28 to a provider for an inpatient consult CPT code 99254 which requires 3 of 3 key components: a comprehensive history, a comprehensive exam, and moderate complexity medical decision making (MDM). Upon review it was determined that documentation supported a downcode to CPT 99252 by meeting/ exceeding 3 of 3 components with a detailed history, expanded problem focused (EPF) exam, and moderate complexity MDM. The overpayment collected was $86.69.
- A hospital submitted an inpatient admission claim coded for aspiration pneumonia and hypernatremia. The correct code for admission was dehydration and hypernatremia as the patient aspirated after admission; the payment difference between the two DRGs was $3,595.40.

The OIG and CMS have noted problems with certain procedure codes for the past several years. These problematic codes include CPT codes 99214 (office or other outpatient visit), 99232 (subsequent hospital care level 2) and 99233 (subsequent hospital care level 3). See Appendix E for more information on problematic codes.
Table 4f provides information on the impact of 1 level disagreement between Carriers and providers when coding evaluation and management codes.

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

Final E&M Code	**Incorrect Coding Errors**		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Office/outpatient visit, est (99214)	5.0%	$220,880,955	4.5% - 5.5%
Subsequent hospital care (99233)	12.8%	$168,226,345	11.1% - 14.5%
Subsequent hospital care (99232)	3.3%	$85,702,480	2.6% - 4.0%
Office/outpatient visit, est (99213)	1.6%	$71,980,640	1.4% - 1.9%
Office/outpatient visit, est (99215)	9.4%	$65,134,620	7.9% - 10.9%
Inpatient consultation (99254)	8.0%	$54,785,105	6.2% - 9.8%
Emergency dept visit (99285)	4.9%	$42,601,181	3.5% - 6.3%
Office/outpatient visit, est (99212)	4.8%	$28,451,777	3.7% - 5.9%

Office/outpatient visit, new (99204)	8.9%	$28,299,570	6.3% - 11.5%
Office consultation (99244)	4.1%	$28,179,950	2.8% - 5.4%
Office/outpatient visit, new (99203)	6.9%	$28,099,040	5.2% - 8.6%
Office consultation (99243)	4.7%	$23,554,867	3.3% - 6.1%
Nursing fac care, subseq (99307)	17.6%	$23,190,725	(2.1%) - 37.4%
Initial hospital care (99222)	8.2%	$21,517,670	5.7% - 10.8%
Nursing fac care, subseq (99309)	6.9%	$21,271,179	5.0% - 8.7%
Initial hospital care (99223)	1.8%	$15,550,702	1.0% - 2.7%
Subsequent hospital care (99231)	2.6%	$12,018,450	1.2% - 4.0%
Inpatient consultation (99253)	4.6%	$11,645,768	2.7% - 6.5%
Inpatient consultation (99255)	2.3%	$9,956,137	0.9% - 3.8%
Emergency dept visit (99283)	3.4%	$7,220,378	1.3% - 5.5%
All Other Codes	0.1%	$58,439,542	0.1% - 0.1%
Overall	**1.4%**	**$1,026,707,082**	**1.3% - 1.5%**

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
SNF-inpatient (including Part A) (21)	0.4%	$81,661,570	(0.0%) - 0.8%
HEART FAILURE & SHOCK (127)	0.6%	$20,389,576	(0.1%) - 1.2%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$15,440,618	0.0% - 0.1%
CHEST PAIN (143)	2.3%	$13,445,902	0.7% - 3.9%
CIRC DISOR EXC AMI, W CAR CATH & COMPL DIAG (124)	1.3%	$11,538,679	(0.8%) - 3.5%
OTH VAS PROC W/O CC (479)	5.1%	$11,266,211	(2.8%) - 13.0%
OTH CIRC SYS OR PROC (120)	2.5%	$10,886,891	(2.4%) - 7.3%
Special facility or ASC surgery-hospice (non-hospital based) (81)	0.1%	$10,479,984	(0.1%) - 0.4%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	1.1%	$9,739,932	(0.8%) - 2.9%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	1.0%	$9,175,257	(0.6%) - 2.6%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	0.6%	$8,774,701	(0.1%) - 1.4%
DIABETES AGE >35 (294)	2.2%	$8,548,901	(0.4%) - 4.7%
OTH EAR, NOSE, MTH & THRT DIAG AGE >17 (073)	17.3%	$7,595,274	(16.4%) - 51.1%
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	0.4%	$7,200,384	(0.2%) - 0.9%
Initial hospital care (99223)	0.7%	$6,276,816	(0.3%) - 1.8%
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	1.2%	$5,647,255	(0.7%) - 3.1%
CAR ARRHYTHMIA & CONDUCTION DISOR W CC (138)	0.5%	$4,789,364	(0.3%) - 1.4%
BRONCHITIS & ASTHMA AGE >17 W/O CC (097)	9.6%	$4,770,126	(8.6%) - 27.8%
OTH VAS PROC W CC W/O MAJ CV DX (554)	0.5%	$4,639,267	(0.3%) - 1.3%
Subsequent hospital care (99232)	0.2%	$4,556,448	(0.1%) - 0.4%
Overall	**0.2%**	**$476,105,544**	**0.1% - 0.2%**

The following are examples of other errors:

- **Not Covered or Unallowable Service error:** An FI paid $1572.04 to a provider for extraction of multiple dental caries and insertion of prepared dentures. Review of the medical record determined that the charge was for routine dental care which is not covered under the Medicare program. The entire amount was recouped from the provider.

- **Duplicate Payment error:** A Carrier paid $40.60 to a provider for an office visit. 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.
- **Unbundling error:** A Carrier paid $125.00 to a provider for a conductive gel paste used during an Extracranial Duplex scan. Per the Physician Fee Schedule 2007, payment for this code is incident to, or bundled into the payment made for the Duplex scan and is not paid separately. The AC recouped the full amount.
- **Other error:** A DME MAC paid $12.50 for ostomy supplies. Upon review of the Common Working File (CWF), the CERT nurse reviewer discovered that the beneficiary had Group Health Coverage. It was determined that this claim should have been billed to the other insurance carrier. The DME MAC recouped the full amount.
- **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
1.2%	0.3%	0.5%	1.7%	3.7%

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

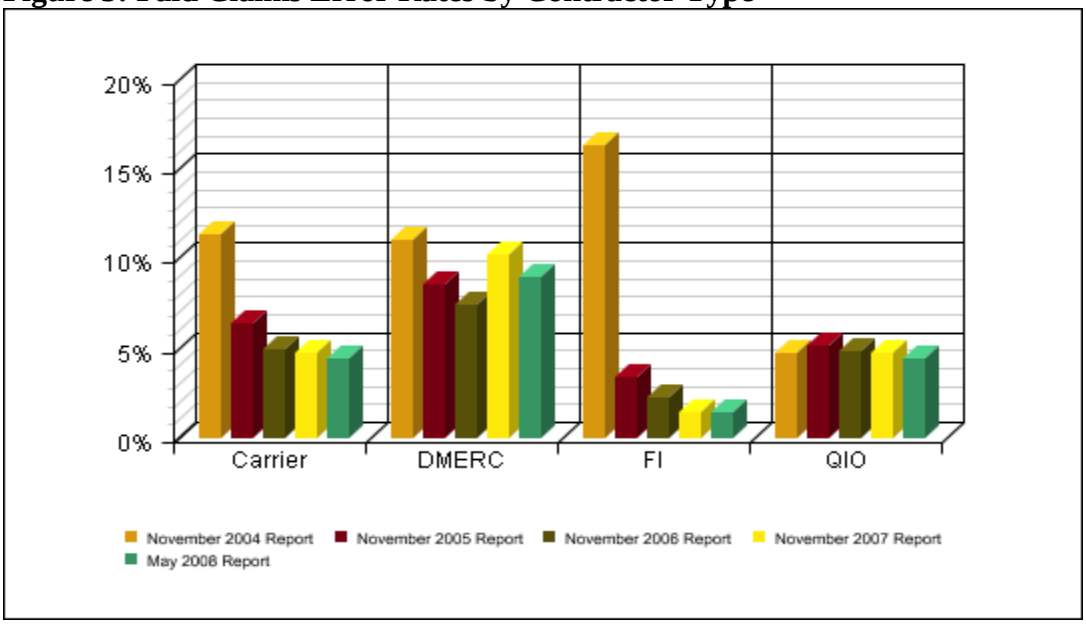
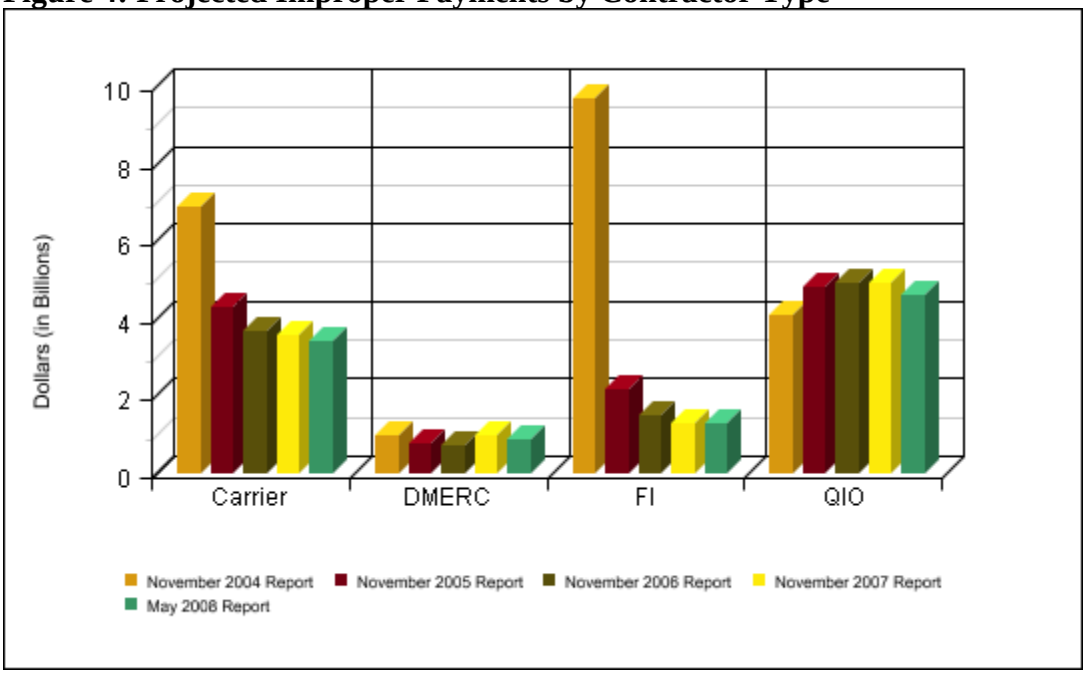


Figure 4: Projected Improper Payments by Contractor Type



Contractor-Specific Error Rates

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	
Triple S, Inc. PR/VI 00973/00974	11.1%	$45,924,849	1.2%	8.8% - 13.4%	24.8%
Empire NJ 00805	7.3%	$241,410,095	1.2%	4.9% - 9.6%	19.6%
Empire NY 00803	6.8%	$270,721,647	0.7%	5.6% - 8.1%	20.6%
GHI NY 14330	6.2%	$23,013,194	0.9%	4.4% - 8.0%	22.0%
First Coast Service Options FL 00590	5.4%	$422,818,134	0.7%	3.9% - 6.8%	19.2%
Cahaba AL/GA/MS 00510/00511/00512	5.1%	$210,566,867	0.5%	4.1% - 6.2%	18.5%
BCBS AR RI 00524	4.9%	$10,897,655	0.6%	3.7% - 6.2%	17.0%
BCBS KS/NE/W MO 00650/00655/00651	4.8%	$69,881,012	0.7%	3.3% - 6.2%	9.9%
Trailblazer TX 00900	4.5%	$231,812,618	0.5%	3.5% - 5.6%	17.7%
Average=	**4.5%**				
Palmetto SC 00880	4.5%	$48,972,079	0.6%	3.4% - 5.6%	18.8%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	4.3%	$189,039,321	0.5%	3.3% - 5.4%	14.1%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	4.3%	$145,775,915	0.4%	3.4% - 5.1%	15.5%
NHIC CA 31140/31146	4.2%	$288,393,710	0.4%	3.5% - 4.9%	13.8%
WPS WI/IL/MI/MN 00951/00952/00953/00954	4.1%	$333,884,655	0.5%	3.2% - 5.1%	15.0%
CIGNA NC 05535	3.8%	$91,607,712	0.7%	2.5% - 5.2%	11.5%
HGSA PA 00865	3.8%	$117,885,973	0.6%	2.6% - 5.0%	12.3%
CIGNA TN 05440	3.8%	$68,416,227	0.5%	2.8% - 4.7%	14.6%
Noridian MAC Region 3 03002	3.8%	$71,934,410	0.4%	2.9% - 4.6%	20.6%
HealthNow NY 00801	3.7%	$46,755,784	0.5%	2.8% - 4.7%	14.5%
Palmetto OH/WV 00883/00884	3.6%	$115,858,248	0.4%	2.8% - 4.4%	11.1%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.3%	$76,940,669	0.5%	2.3% - 4.2%	9.4%
Noridian UT 00823	3.2%	$2,020,816	0.7%	1.7% - 4.6%	18.8%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	3.1%	$52,949,636	0.4%	2.3% - 4.0%	9.8%
AdminaStar IN/KY 00630/00660	3.1%	$84,180,115	0.4%	2.3% - 3.8%	11.8%

First Coast Service Options CT 00591	2.9%	$33,939,626	0.4%	2.2% - 3.6%	8.0%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/00836	2.8%	$64,962,588	0.4%	2.1% - 3.6%	14.7%
BCBS MT 00751	2.7%	$842,144	0.8%	1.1% - 4.3%	8.1%
CIGNA ID 05130	2.3%	$5,003,901	0.3%	1.8% - 2.9%	11.3%
Combined	**4.5%**	**$3,366,409,599**	**0.1%**	**4.2% - 4.8%**	**15.5%**

Carriers and Medicare Administrative Contractors (MAC) that were affected by the implementation of the J3 MAC, and thus have less than a 12 month sampling period, are:

Noridan MAC Region 3 03002
Noridian UT 00823
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/00836
BCBS MT 00751

Note that a reduced sampling period does not affect the error rate and improper payment information reported at this level. For paid claim error rates, provider compliance error rates and no resolution rates by contractor and provider type, see Appendix C. For more information on the MAC transitions please see the Overview section of this report.

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. Due to the implementation of the Jurisdiction C DME MAC, both CIGNA Government Services MAC Region C 18003 and Palmetto Region C 00885 included less than a 12 month sampling period.

Note that a reduced sampling period does not affect the error rate and improper payment information reported at this level. For more information on the MAC transitions please see the Overview section of this report.

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	12.3%	$345,414,038	2.7%	7.0% - 17.5%	18.5%
Noridian Administrative Services MAC Region D 19003	11.6%	$222,789,512	2.6%	6.5% - 16.7%	21.8%
Average=	**9.0%**				
CIGNA Government Services MAC Region C 18003	7.7%	$117,403,254	2.4%	3.0% - 12.5%	14.3%
NHIC MAC Region A 16003	5.9%	$83,937,052	0.7%	4.6% - 7.2%	13.5%
National Government Services MAC Region B 17003	5.3%	$117,463,120	1.1%	3.1% - 7.5%	13.1%
Combined	**9.0%**	**$887,006,976**	**1.0%**	**7.0% - 11.0%**	**16.6%**

FI-Specific Error Rates

Table 7 contains error rates and improper payment amounts for FIs. It is sorted in descending order by error rate. Fiscal Intermediaries and Medicare Administrative Contractors (MAC) that were affected by the implementation of the J3 MAC, and thus have less than a 12 month sampling period, are:

Noridan MAC Region 3 03001
BCBS MT 00250
Noridian MN/ND 00320/00321
CahabaIA/SD 00011
Noridian ID/OR/UT 00323/00325
BCBS WY00460

Note that a reduced sampling period does not affect the error rate and improper payment information reported at this level. For more information on the MAC transitions please see the Overview section of this report.

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
UGS AS/CA/GU/HI/NV/NMI 00454	3.5%	$229,592,265	1.0%	1.5% - 5.5%
First Coast Service Options FL 00090	2.8%	$78,604,730	0.9%	1.1% - 4.5%
BCBS AR AR 00020	2.7%	$11,046,521	1.0%	0.8% - 4.6%
Noridian AK/WA 00322	2.5%	$16,154,601	1.4%	(0.3%) - 5.3%
COSVI PR/VI 57400	2.2%	$1,586,058	0.4%	1.4% - 3.1%
Trailblazer CO/NM/TX 00400	2.2%	$98,023,279	0.6%	1.1% - 3.3%
Trispan LA/MO/MS 00230	2.1%	$35,804,714	0.8%	0.5% - 3.7%
UGS VA/WV 00453	1.8%	$27,856,206	0.5%	0.8% - 2.7%
Highmark Medicare Services DC/MD 00366	1.8%	$92,924,004	0.4%	1.0% - 2.5%
Empire CT/DE/NY 00308	1.7%	$76,451,956	0.4%	0.8% - 2.5%
Anthem NH/VT 00270	1.6%	$6,991,957	0.4%	0.9% - 2.3%
Average=	**1.5%**			
Anthem ME/MA 00180/00181	1.5%	$39,858,419	0.6%	0.2% - 2.7%
Noridian MAC Region 3 03001	1.4%	$18,716,806	0.4%	0.7% - 2.1%
Noridian ID/OR/UT 00323/00325	1.4%	$8,169,094	0.4%	0.5% - 2.2%
UGS WI/MI 00450/00452	1.3%	$99,138,477	0.6%	0.2% - 2.4%
Palmetto NC 00382	1.3%	$19,999,131	0.4%	0.5% - 2.0%
Mutual of Omaha (all states) 52280	1.2%	$112,085,860	0.3%	0.7% - 1.7%
Riverbend NJ/TN 00390	1.2%	$42,812,491	0.3%	0.6% - 1.7%
Palmetto SC 00380	1.1%	$158,285,783	0.2%	0.6% - 1.6%
Noridian MN/ND 00320/00321	1.1%	$9,738,456	0.3%	0.5% - 1.7%
Chisholm OK 00340	1.0%	$3,034,635	0.3%	0.5% - 1.5%
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	1.0%	$77,085,853	0.2%	0.5% - 1.5%
BCBS AR RI 00021	1.0%	$1,506,187	0.3%	0.3% - 1.7%
Veritus PA 00363	0.9%	$18,553,177	0.3%	0.3% - 1.5%
BCBS GA GA 00101	0.8%	$18,710,504	0.2%	0.5% - 1.2%
Cahaba AL 00010	0.7%	$4,241,488	0.1%	0.5% - 1.0%
BCBS KS KS 00150	0.7%	$3,625,779	0.2%	0.4% - 1.1%
BCBS NE NE 00260	0.7%	$1,803,574	0.2%	0.3% - 1.1%
BCBS MT MT 00250	0.6%	$190,856	0.3%	(0.0%) - 1.2%
Cahaba IA/SD 00011	0.6%	$26,791,429	0.3%	0.1% - 1.1%
BCBS WY WY 00460	0.5%	$17,063	0.3%	(0.0%) - 1.0%
Combined	**1.5%**	**$1,339,401,351**	**0.1%**	**1.3% - 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	0.6%	$906,421	0.2%	0.2% - 1.1%
Alabama	5.1%	$90,575,862	0.8%	3.5% - 6.6%
Arkansas	3.3%	$33,925,880	0.5%	2.3% - 4.3%
Arizona	7.2%	$100,936,445	1.6%	4.0% - 10.3%
California	4.1%	$345,661,556	0.6%	3.0% - 5.3%
Colorado	4.4%	$39,422,606	0.9%	2.6% - 6.2%
Connecticut	3.9%	$58,258,372	0.6%	2.8% - 5.0%
District of Columbia	3.0%	$13,755,905	0.5%	1.9% - 4.1%
Delaware	4.2%	$15,357,843	0.5%	3.3% - 5.1%
Florida	5.9%	$376,889,809	0.9%	4.1% - 7.8%
Georgia	5.4%	$142,268,176	0.8%	3.9% - 6.9%
Hawaii	3.9%	$9,695,274	0.5%	2.9% - 4.8%
Iowa	3.8%	$33,557,342	0.5%	2.7% - 4.8%
Idaho	3.3%	$8,396,183	0.5%	2.4% - 4.2%
Illinois	5.0%	$229,430,967	0.7%	3.7% - 6.3%
Indiana	3.7%	$80,093,809	0.5%	2.7% - 4.8%
Kansas	2.6%	$21,384,084	0.4%	1.8% - 3.5%
Kentucky	4.9%	$86,193,410	0.7%	3.5% - 6.3%
Louisiana	3.8%	$54,495,861	0.6%	2.7% - 5.0%
Massachusetts	5.8%	$150,671,847	0.7%	4.5% - 7.1%
Maryland	3.5%	$101,391,781	0.4%	2.7% - 4.3%
Maine	5.0%	$24,057,073	0.6%	3.8% - 6.2%
Michigan	4.5%	$185,167,684	0.6%	3.2% - 5.7%
Minnesota	4.3%	$64,866,995	0.6%	3.1% - 5.4%
Missouri	3.3%	$74,809,162	0.6%	2.1% - 4.5%
Mississippi	5.0%	$54,209,142	0.8%	3.4% - 6.7%
Montana	2.3%	$5,997,241	0.6%	1.1% - 3.6%
North Carolina	1.9%	$61,205,029	0.4%	1.2% - 2.7%
North Dakota	2.0%	$4,583,471	0.4%	1.3% - 2.7%
Nebraska	0.7%	$4,080,213	0.2%	0.3% - 1.2%
New Hampshire	5.1%	$19,912,203	0.8%	3.6% - 6.6%
New Jersey	5.8%	$209,498,213	0.9%	4.1% - 7.5%
New Mexico	9.9%	$38,604,315	1.1%	7.7% - 12.1%
Nevada	6.8%	$36,453,073	0.9%	5.0% - 8.6%
New York	3.0%	$228,211,037	0.7%	1.6% - 4.3%
Ohio	3.7%	$155,435,624	0.5%	2.6% - 4.7%
Oklahoma	2.6%	$30,263,040	0.5%	1.6% - 3.5%
Oregon	3.5%	$25,156,123	0.5%	2.5% - 4.4%
Pennsylvania	5.7%	$254,590,811	0.9%	4.1% - 7.4%
Puerto Rico	7.1%	$13,426,730	1.2%	4.7% - 9.5%
Rhode Island	4.3%	$13,751,559	0.5%	3.2% - 5.4%
South Carolina	5.4%	$85,183,137	0.9%	3.7% - 7.1%

[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.

South Dakota	3.5%	$9,164,192	0.5%	2.5% - 4.4%
Tennessee	2.4%	$57,692,251	0.6%	1.1% - 3.6%
Texas	5.4%	$356,672,450	0.9%	3.6% - 7.2%
Utah	5.9%	$25,170,777	0.7%	4.6% - 7.3%
Virginia	8.4%	$184,841,969	1.2%	6.1% - 10.7%
Vermont	3.8%	$6,472,894	0.5%	2.8% - 4.7%
Washington	2.6%	$41,104,060	0.5%	1.7% - 3.6%
Wisconsin	2.8%	$45,504,665	0.5%	1.8% - 3.8%
West Virginia	5.6%	$44,906,671	0.8%	4.1% - 7.1%
Wyoming	1.1%	$1,174,114	0.2%	0.7% - 1.5%
Short-term Acute Paid Claims	**4.5%**	**$4,355,435,349**	**0.1%**	**4.2% - 4.7%**
Long-term Acute Paid Claims	**5.3%**	**$225,205,176**	**0.5%**	**4.3% - 6.3%**
Denied Claims	**N/A**	**$0**	**N/A**	**N/A**
Total	**4.5%**	**$4,580,640,526**	**0.1%**	**4.2% - 4.8%**

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
Office visits - established	$622,528,034	6.0%	5.6% - 6.4%	4.4%	14.8%	1.2%	79.4%	0.3%
Hospital visit - subsequent	$602,033,573	12.2%	10.9% - 13.5%	9.2%	33.8%	0.1%	55.2%	1.7%
Consultations	$516,912,824	16.6%	15.1% - 18.2%	3.0%	10.2%	0.0%	86.4%	0.4%
All Other Codes	$346,805,535	1.2%	1.0% - 1.4%	23.1%	43.7%	5.2%	23.5%	4.4%
Hospital visit - initial	$211,886,063	17.6%	14.7% - 20.6%	1.1%	25.7%	0.0%	68.7%	4.5%
Minor procedures - other (Medicare fee schedule)	$172,040,758	6.9%	5.3% - 8.4%	4.7%	68.4%	11.5%	10.6%	4.8%
Nursing home visit	$159,919,505	14.2%	11.3% - 17.2%	10.1%	17.4%	0.8%	71.7%	0.0%
Office visits - new	$156,017,076	15.5%	13.2% - 17.7%	1.2%	8.0%	0.0%	90.8%	0.0%
Ambulance	$85,194,498	2.2%	1.2% - 3.1%	17.6%	26.8%	39.9%	14.9%	0.9%
Emergency room visit	$80,316,367	5.3%	4.0% - 6.6%	9.4%	5.3%	0.0%	85.3%	0.0%
Standard imaging - nuclear medicine	$56,886,773	3.1%	(0.6%) - 6.8%	61.1%	7.5%	6.6%	24.8%	0.0%
Ambulatory procedures - other	$56,649,382	7.6%	0.0% - 15.3%	74.1%	8.2%	0.9%	16.3%	0.5%
Chiropractic	$55,126,448	10.2%	7.9% - 12.6%	2.4%	56.3%	23.8%	16.5%	1.1%
Eye procedure - other	$37,708,628	6.8%	(4.5%) - 18.1%	0.0%	100.0%	0.0%	0.0%	0.0%
Hospital visit - critical care	$36,045,736	5.0%	2.0% - 8.0%	4.4%	33.6%	0.0%	62.0%	0.0%
Other tests - other	$31,878,027	2.7%	1.1% - 4.3%	29.6%	52.5%	0.1%	14.9%	2.8%
Other drugs	$31,758,233	0.6%	0.1% - 1.2%	57.6%	15.3%	1.2%	25.8%	0.0%

Lab tests - other (non-Medicare fee schedule)	$30,070,017	1.4%	0.7% - 2.2%	11.9%	38.7%	13.5%	30.8%	5.0%
Dialysis services (Non MFS)	$28,735,555	4.9%	1.6% - 8.3%	29.5%	40.6%	0.0%	29.8%	0.0%
Echography - heart	$25,197,633	1.8%	0.3% - 3.3%	47.7%	52.1%	0.1%	0.0%	0.0%
Oncology - radiation therapy	$22,698,932	1.6%	(0.5%) - 3.7%	1.8%	98.2%	0.0%	0.0%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$3,366,409,599**	**4.5%**	**4.2% - 4.8%**	**10.7%**	**27.0%**	**3.1%**	**57.7%**	**1.5%**

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
Wheelchairs Motorized	$183,409,771	22.1%	7.3% - 37.0%	25.6%	0.0%	74.4%	0.0%	0.0%
Glucose Monitor	$133,495,738	11.1%	9.4% - 12.9%	5.2%	0.7%	84.7%	7.3%	2.1%
Nebulizers & Related Drugs	$102,918,965	10.0%	3.7% - 16.3%	33.2%	0.3%	36.1%	28.9%	1.5%
All Other Codes	$57,337,519	4.4%	2.2% - 6.6%	9.6%	3.4%	78.3%	3.5%	5.2%
Wheelchairs Options/Accessories	$50,311,527	23.5%	7.3% - 39.8%	9.0%	0.0%	47.6%	3.2%	40.2%
Oxygen Supplies/ Equipment	$38,600,613	1.9%	1.2% - 2.5%	22.9%	0.0%	68.5%	4.8%	3.9%
CPAP	$34,587,772	8.6%	4.5% - 12.6%	23.9%	2.3%	72.1%	0.1%	1.6%
Spinal Orthoses	$32,683,930	30.2%	7.2% - 53.2%	84.2%	0.0%	15.8%	0.0%	0.0%
Infusion Pumps & Related Drugs	$30,870,823	19.6%	(6.0%) - 45.1%	0.0%	8.1%	91.9%	0.0%	0.0%
Lower Limb Orthoses	$29,445,001	17.2%	4.1% - 30.4%	82.9%	10.1%	7.0%	0.0%	0.0%
Suction Pump	$29,021,461	73.4%	46.1% -100.6%	95.4%	0.0%	4.6%	0.0%	0.0%
Support Surfaces	$27,321,672	17.6%	3.2% - 32.0%	51.6%	7.7%	40.7%	0.0%	0.0%
Wheelchairs Manual	$25,413,911	11.3%	8.2% - 14.4%	5.3%	0.0%	75.3%	16.2%	3.2%
Enteral Nutrition	$16,666,269	3.8%	0.6% - 7.0%	9.4%	0.0%	79.2%	2.4%	9.0%
Immunosuppressive Drugs	$15,622,714	6.0%	0.6% - 11.4%	0.0%	0.0%	69.0%	0.0%	31.0%
Upper Limb Orthoses	$13,859,620	24.9%	8.2% - 41.7%	94.7%	3.4%	1.8%	0.0%	0.0%
Diabetic Shoes	$13,805,493	9.4%	3.6% - 15.1%	19.5%	22.1%	38.3%	20.2%	0.0%
Surgical Dressings	$13,222,957	17.9%	(9.9%) - 45.7%	3.7%	3.3%	93.0%	0.0%	0.0%
Ostomy Supplies	$12,990,456	7.9%	2.4% - 13.4%	20.9%	7.1%	58.1%	4.9%	9.1%
Urological Supplies	$12,848,741	16.6%	(0.9%) - 34.0%	61.7%	0.0%	20.5%	17.8%	0.0%
All Policy Groups with Less than 30 Claims	$12,572,024	1.7%	(0.4%) - 3.7%	0.0%	0.0%	94.9%	5.1%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$887,006,976**	**9.0%**	**7.0% - 11.0%**	**26.9%**	**1.9%**	**60.6%**	**6.3%**	**4.3%**

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
SNF	$444,897,371	1.9%	1.3% - 2.6%	1.4%	19.4%	4.6%	56.2%	18.4%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	$428,499,743	1.7%	1.4% - 2.0%	8.7%	47.2%	8.8%	31.7%	3.6%
HHA	$209,470,928	1.4%	0.7% - 2.1%	0.0%	19.7%	46.3%	34.0%	0.0%
ESRD	$81,477,558	1.2%	0.5% - 1.9%	0.9%	49.5%	23.3%	26.3%	0.1%
Other FI Service Types	$78,347,464	1.5%	1.0% - 2.0%	12.1%	44.5%	20.8%	20.1%	2.6%
Hospice	$60,233,748	0.7%	0.2% - 1.2%	12.5%	0.5%	39.6%	30.0%	17.4%
Non-PPS Hospital In-patient	$27,015,780	0.7%	0.3% - 1.0%	4.4%	23.7%	9.6%	58.7%	3.7%
FQHC	$5,820,748	1.6%	0.5% - 2.6%	30.8%	69.2%	0.0%	0.0%	0.0%
RHCs	$2,678,773	0.5%	0.2% - 0.8%	43.0%	40.6%	0.0%	0.0%	16.4%
Free Standing Ambulatory Surgery	$959,239	0.2%	(0.0%) - 0.4%	1.2%	89.2%	0.0%	9.6%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$1,339,401,351**	**1.5%**	**1.3% - 1.7%**	**4.9%**	**31.2%**	**16.2%**	**39.5%**	**8.3%**

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)	$184,283,328	10.2%	3.3% - 17.1%	0.0%	N/A	90.2%	5.9%	3.9%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	$173,942,653	12.6%	9.6% - 15.6%	2.8%	N/A	81.8%	10.4%	5.0%
CHEST PAIN (143)	$122,478,168	20.8%	16.5% - 25.1%	0.0%	N/A	86.2%	2.8%	11.0%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	$110,544,891	11.9%	8.4% - 15.4%	4.1%	N/A	86.3%	7.5%	2.1%
RENAL FAILURE (316)	$97,045,426	5.7%	3.9% - 7.5%	0.0%	N/A	62.9%	36.4%	0.7%
HEART FAILURE & SHOCK (127)	$94,513,613	2.7%	1.6% - 3.8%	4.8%	N/A	43.4%	30.2%	21.6%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	$86,179,114	9.3%	2.9% - 15.8%	0.0%	N/A	41.3%	48.1%	10.6%
MEDICAL BACK PROB (243)	$73,164,439	19.3%	12.8% - 25.8%	0.0%	N/A	88.0%	6.1%	5.9%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	$72,985,114	8.0%	2.8% - 13.3%	0.0%	N/A	67.4%	19.2%	13.3%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W/O MAJ CV DX (558)	$64,436,229	3.0%	1.2% - 4.8%	4.8%	N/A	81.7%	11.1%	2.4%
EXT OR PROC UNREL TO PRINC DIAG (468)	$63,605,517	5.2%	1.5% - 8.9%	0.0%	N/A	40.6%	59.4%	0.0%
ECMO/TRAH W MV 96+ HR/PDX EXC FCE MTH & NCK W MAJ OR (541)	$59,581,022	2.0%	(0.8%) - 4.8%	0.0%	N/A	36.0%	64.0%	0.0%
CAR ARRHYTHMIA & CONDUCTION DISOR W CC (138)	$58,435,190	6.5%	3.8% - 9.3%	0.0%	N/A	78.0%	13.8%	8.2%
KIDNEY & URIN TRACT INFECT AGE >17 W CC (320)	$57,879,537	5.7%	3.5% - 7.8%	2.4%	N/A	68.3%	21.9%	7.4%

CHRON OBSTRUCTIVE PULM DIS (088)	$57,329,074	3.4%	1.7% - 5.0%	2.0%	N/A	82.8%	8.6%	6.7%
G.I. HEMORR W CC (174)	$56,100,066	4.2%	2.3% - 6.1%	2.7%	N/A	72.8%	22.5%	2.0%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	$54,609,166	1.2%	0.4% - 2.0%	27.2%	N/A	72.6%	0.0%	0.2%
OTH DIG SYS DX AGE >17 W CC (188)	$53,600,042	9.5%	5.3% - 13.6%	0.0%	N/A	91.5%	6.4%	2.1%
DIABETES AGE >35 (294)	$47,246,363	12.0%	5.9% - 18.2%	0.0%	N/A	78.4%	3.5%	18.1%
SEPTICEMIA W/O MV 96+ HOURS AGE >17 (576)	$44,415,778	6.4%	3.2% - 9.5%	13.6%	N/A	10.5%	72.5%	3.5%
All HPMP	**$4,580,640,526**	**4.5%**	**4.2% - 4.8%**	**2.6%**	**N/A**	**62.1%**	**29.3%**	**6.0%**

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	8.5%	$710,252,045	0.6%	7.4% - 9.7%	19.5%
Cardiology	4.9%	$315,805,125	0.6%	3.7% - 6.1%	15.5%
Family Practice	7.4%	$305,685,112	0.5%	6.3% - 8.5%	18.3%
Orthopedic Surgery	4.9%	$136,908,796	0.6%	3.8% - 6.1%	21.8%
Pulmonary Disease	8.6%	$119,379,041	1.1%	6.4% - 10.7%	18.2%
Nephrology	7.2%	$101,665,687	1.3%	4.7% - 9.7%	16.6%
Gastroenterology	7.5%	$99,699,644	1.0%	5.5% - 9.5%	15.3%
General Surgery	5.5%	$94,907,723	1.1%	3.4% - 7.7%	20.4%
Ophthalmology	1.9%	$86,993,842	0.8%	0.4% - 3.4%	12.2%
Neurology	9.5%	$86,319,522	1.2%	7.2% - 11.9%	26.4%
Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)	2.2%	$85,194,498	0.5%	1.2% - 3.1%	13.8%
Hematology/Oncology	1.7%	$83,030,581	0.3%	1.1% - 2.4%	8.0%
Urology	4.8%	$82,027,347	0.7%	3.4% - 6.1%	13.4%
Emergency Medicine	5.3%	$81,637,961	0.7%	4.0% - 6.6%	16.8%
Physical Therapist in Private Practice	7.0%	$74,486,760	1.1%	4.9% - 9.0%	17.8%
Diagnostic Radiology	1.7%	$70,584,174	0.4%	0.8% - 2.5%	10.9%
Infectious Disease	16.4%	$60,622,249	2.8%	11.0% - 21.9%	27.0%
Chiropractic	10.5%	$57,754,537	1.2%	8.2% - 12.9%	30.2%
Physical Medicine and Rehabilitation	8.9%	$57,618,107	1.8%	5.3% - 12.4%	23.2%
General Practice	7.8%	$51,585,141	1.2%	5.5% - 10.1%	27.4%
Podiatry	3.7%	$48,987,079	0.6%	2.5% - 4.8%	17.4%
Endocrinology	13.7%	$45,731,841	3.5%	6.8% - 20.7%	20.3%
Otolaryngology	5.9%	$40,291,043	1.0%	4.0% - 7.9%	23.3%
Psychiatry	6.2%	$40,018,622	1.3%	3.7% - 8.8%	18.2%
Dermatology	2.0%	$37,798,261	0.6%	0.9% - 3.2%	12.4%
Neurosurgery	15.3%	$33,713,561	6.6%	2.4% - 28.2%	25.1%
Clinical Laboratory (Billing Independently)	1.1%	$32,848,039	0.3%	0.5% - 1.7%	8.2%
Radiation Oncology	2.3%	$31,975,376	1.2%	(0.1%) - 4.7%	11.8%
Nurse Practitioner	5.7%	$31,516,709	1.1%	3.5% - 8.0%	15.5%

Obstetrics/Gynecology	4.5%	$19,601,508	1.0%	2.6% - 6.5%	14.9%
Medical Oncology	1.1%	$18,965,797	0.3%	0.5% - 1.6%	6.9%
Occupational Therapist in Private Practice	21.2%	$17,983,633	4.9%	11.7% - 30.7%	25.7%
Optometry	2.9%	$17,105,734	0.9%	1.2% - 4.6%	15.7%
Rheumatology	2.8%	$16,643,182	0.6%	1.5% - 4.1%	11.0%
Vascular Surgery	3.5%	$16,116,621	1.5%	0.5% - 6.5%	14.3%
Cardiac Surgery	5.0%	$14,819,205	2.9%	(0.6%) - 10.7%	17.1%
Anesthesiology	1.1%	$14,714,396	0.3%	0.4% - 1.7%	7.1%
Pathology	1.6%	$12,584,474	0.7%	0.2% - 3.1%	12.1%
Independent Diagnostic Testing Facility (IDTF)	1.4%	$12,326,298	1.0%	(0.5%) - 3.3%	14.6%
Allergy/Immunology	9.8%	$11,328,826	4.0%	2.0% - 17.6%	22.4%
Physician Assistant	2.7%	$11,213,616	0.7%	1.5% - 4.0%	14.8%
All Provider Types With Less Than 30 Claims	2.9%	$9,052,565	1.4%	0.2% - 5.6%	13.3%
Plastic and Reconstructive Surgery	7.9%	$8,760,428	2.5%	3.0% - 12.8%	27.0%
Thoracic Surgery	3.2%	$8,227,907	1.3%	0.7% - 5.8%	13.7%
Clinical Psychologist	2.6%	$6,728,754	0.9%	0.8% - 4.3%	15.0%
Geriatric Medicine	4.8%	$6,107,031	1.5%	2.0% - 7.7%	7.7%
Critical Care (Intensivists)	4.1%	$6,099,828	1.9%	0.4% - 7.8%	23.1%
Interventional Pain Management	4.4%	$5,861,168	1.9%	0.8% - 8.0%	22.2%
Pain Management	6.1%	$5,008,723	1.9%	2.3% - 9.8%	47.8%
Nuclear Medicine	4.6%	$4,974,337	1.5%	1.7% - 7.5%	22.2%
Colorectal Surgery (formerly proctology)	3.6%	$4,695,678	1.2%	1.2% - 6.1%	6.9%
Hematology	3.1%	$4,150,345	1.4%	0.4% - 5.8%	8.2%
Osteopathic Manipulative Therapy	11.6%	$2,895,102	2.9%	6.0% - 17.2%	25.6%
Clinical Social Worker	1.4%	$2,072,434	0.5%	0.4% - 2.4%	13.1%
Certified Registered Nurse Anesthetist (CRNA)	0.3%	$1,160,010	0.2%	(0.1%) - 0.7%	6.8%
Portable X-Ray Supplier (Billing Independently)	0.6%	$1,116,857	0.5%	(0.5%) - 1.6%	16.8%
Pediatric Medicine	1.9%	$561,817	0.6%	0.6% - 3.1%	37.9%
Multispecialty Clinic or Group Practice	1.8%	$410,873	1.7%	(1.6%) - 5.2%	14.7%
Clinical Nurse Specialist	0.4%	$84,031	0.4%	(0.3%) - 1.1%	7.0%
Ambulatory Surgical Center	0.0%	$0	0.0%	0.0% - 0.0%	15.8%
Interventional Radiology	0.0%	$0	0.0%	0.0% - 0.0%	25.3%
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%	13.6%
Public Health or Welfare Agencies (Federal, State, and local)	0.0%	$0	0.0%	0.0% - 0.0%	4.5%
All Provider Types	**4.5%**	**$3,366,409,599**	**0.1%**	**4.2% - 4.8%**	**15.5%**

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	11.7%	$479,707,932	2.0%	7.8% - 15.6%	18.8%
Pharmacy	8.7%	$310,348,594	1.2%	6.3% - 11.1%	15.8%
Medical Supply Company with Respiratory Therapist	5.7%	$45,752,595	1.4%	2.9% - 8.5%	11.5%
All Provider Types With Less Than 30 Claims	9.1%	$16,870,709	3.5%	2.2% - 16.0%	21.8%
Medical supply company with orthotic personnel certified by an accrediting organization	3.8%	$12,145,062	3.3%	(2.7%) - 10.2%	3.8%
Individual orthotic personnel certified by an accrediting organization	4.4%	$8,782,426	3.2%	(1.8%) - 10.6%	23.9%
Podiatry	7.2%	$5,718,924	3.4%	0.6% - 13.8%	20.9%
Unknown Supplier/Provider	4.2%	$3,511,555	2.5%	(0.7%) - 9.1%	9.2%
Ophthalmology	8.3%	$1,941,597	4.5%	(0.6%) - 17.2%	20.7%
Orthopedic Surgery	7.0%	$1,157,422	6.2%	(5.1%) - 19.0%	22.8%
Optometry	6.3%	$1,070,162	4.4%	(2.3%) - 14.9%	26.0%
Individual prosthetic personnel certified by an accrediting organization	0.0%	$0	0.0%	0.0% - 0.0%	1.0%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	0.0%	$0	0.0%	0.0% - 0.0%	41.0%
All Provider Types	**9.0%**	**$887,006,976**	**1.0%**	**7.0% - 11.0%**	**16.6%**

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
SNF	1.9%	444,897,371	0.3%	1.3% - 2.6%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	1.7%	428,499,743	0.2%	1.4% - 2.0%
HHA	1.4%	209,470,928	0.4%	0.7% - 2.1%
ESRD	1.2%	81,477,558	0.3%	0.5% - 1.9%
Other FI Service Types	1.5%	78,347,464	0.3%	1.0% - 2.0%
Hospice	0.7%	60,233,748	0.3%	0.2% - 1.2%
Non-PPS Hospital In-patient	0.7%	27,015,780	0.2%	0.3% - 1.0%
FQHC	1.6%	5,820,748	0.5%	0.5% - 2.6%
RHCs	0.5%	2,678,773	0.2%	0.2% - 0.8%
Free Standing Ambulatory Surgery	0.2%	959,239	0.1%	(0.0%) - 0.4%
Overall	**1.5%**	**1,339,401,351**	**0.1%**	**1.3% - 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	4.5%	$4,355,435,349	0.1%	4.2% - 4.7%
Long-term Acute Paid Claims	5.3%	$225,205,176	0.5%	4.3% - 6.3%
Denied Claims	N/A	$0	N/A	N/A
Total	**4.5%**	**$4,580,640,526**	**0.1%**	**4.2% - 4.8%**

CORRECTIVE ACTIONS

Please see the Corrective Actions section of the November 2007 Report for more information.

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
Hospital visit - initial	17.6%	14.7% - 20.6%	1.1%	25.7%	0.0%	68.7%	4.5%
Consultations	16.6%	15.1% - 18.2%	3.0%	10.2%	0.0%	86.4%	0.4%
Office visits - new	15.5%	13.2% - 17.7%	1.2%	8.0%	0.0%	90.8%	0.0%
Nursing home visit	14.2%	11.3% - 17.2%	10.1%	17.4%	0.8%	71.7%	0.0%
Hospital visit - subsequent	12.2%	10.9% - 13.5%	9.2%	33.8%	0.1%	55.2%	1.7%
Chiropractic	10.2%	7.9% - 12.6%	2.4%	56.3%	23.8%	16.5%	1.1%
Ambulatory procedures - other	7.6%	0.0% - 15.3%	74.1%	8.2%	0.9%	16.3%	0.5%
Minor procedures - other (Medicare fee schedule)	6.9%	5.3% - 8.4%	4.7%	68.4%	11.5%	10.6%	4.8%
Eye procedure - other	6.8%	(4.5%) - 18.1%	0.0%	100.0%	0.0%	0.0%	0.0%
Office visits - established	6.0%	5.6% - 6.4%	4.4%	14.8%	1.2%	79.4%	0.3%
Emergency room visit	5.3%	4.0% - 6.6%	9.4%	5.3%	0.0%	85.3%	0.0%
Hospital visit - critical care	5.0%	2.0% - 8.0%	4.4%	33.6%	0.0%	62.0%	0.0%
Dialysis services (Non MFS)	4.9%	1.6% - 8.3%	29.5%	40.6%	0.0%	29.8%	0.0%
Standard imaging - nuclear medicine	3.1%	(0.6%) - 6.8%	61.1%	7.5%	6.6%	24.8%	0.0%

Other tests - other	2.7%	1.1% - 4.3%	29.6%	52.5%	0.1%	14.9%	2.8%
Ambulance	2.2%	1.2% - 3.1%	17.6%	26.8%	39.9%	14.9%	0.9%
Echography - heart	1.8%	0.3% - 3.3%	47.7%	52.1%	0.1%	0.0%	0.0%
Oncology - radiation therapy	1.6%	(0.5%) - 3.7%	1.8%	98.2%	0.0%	0.0%	0.0%
Lab tests - other (non-Medicare fee schedule)	1.4%	0.7% - 2.2%	11.9%	38.7%	13.5%	30.8%	5.0%
All Other Codes	1.2%	1.0% - 1.4%	23.1%	43.7%	5.2%	23.5%	4.4%
Other drugs	0.6%	0.1% - 1.2%	57.6%	15.3%	1.2%	25.8%	0.0%
All Types of Services	**4.5%**	**4.2% - 4.8%**	**10.7 %**	**27.0%**	**3.1%**	**57.7%**	**1.5%**

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	73.4%	46.1% -100.6%	95.4%	0.0%	4.6%	0.0%	0.0%
Spinal Orthoses	30.2%	7.2% - 53.2%	84.2%	0.0%	15.8%	0.0%	0.0%
Upper Limb Orthoses	24.9%	8.2% - 41.7%	94.7%	3.4%	1.8%	0.0%	0.0%
Wheelchairs Options/Accessories	23.5%	7.3% - 39.8%	9.0%	0.0%	47.6%	3.2%	40.2%
Wheelchairs Motorized	22.1%	7.3% - 37.0%	25.6%	0.0%	74.4%	0.0%	0.0%
Infusion Pumps & Related Drugs	19.6%	(6.0%) - 45.1%	0.0%	8.1%	91.9%	0.0%	0.0%
Surgical Dressings	17.9%	(9.9%) - 45.7%	3.7%	3.3%	93.0%	0.0%	0.0%
Support Surfaces	17.6%	3.2% - 32.0%	51.6%	7.7%	40.7%	0.0%	0.0%
Lower Limb Orthoses	17.2%	4.1% - 30.4%	82.9%	10.1%	7.0%	0.0%	0.0%
Urological Supplies	16.6%	(0.9%) - 34.0%	61.7%	0.0%	20.5%	17.8%	0.0%
Wheelchairs Manual	11.3%	8.2% - 14.4%	5.3%	0.0%	75.3%	16.2%	3.2%
Glucose Monitor	11.1%	9.4% - 12.9%	5.2%	0.7%	84.7%	7.3%	2.1%
Nebulizers & Related Drugs	10.0%	3.7% - 16.3%	33.2%	0.3%	36.1%	28.9%	1.5%
Diabetic Shoes	9.4%	3.6% - 15.1%	19.5%	22.1%	38.3%	20.2%	0.0%
CPAP	8.6%	4.5% - 12.6%	23.9%	2.3%	72.1%	0.1%	1.6%
Ostomy Supplies	7.9%	2.4% - 13.4%	20.9%	7.1%	58.1%	4.9%	9.1%
Immunosuppressive Drugs	6.0%	0.6% - 11.4%	0.0%	0.0%	69.0%	0.0%	31.0%
All Other Codes	4.4%	2.2% - 6.6%	9.6%	3.4%	78.3%	3.5%	5.2%
Enteral Nutrition	3.8%	0.6% - 7.0%	9.4%	0.0%	79.2%	2.4%	9.0%
Oxygen Supplies/Equipment	1.9%	1.2% - 2.5%	22.9%	0.0%	68.5%	4.8%	3.9%
All Policy Groups with Less than 30 Claims	1.7%	(0.4%) - 3.7%	0.0%	0.0%	94.9%	5.1%	0.0%
All Types of Services	**9.0%**	**7.0% - 11.0%**	**26.9%**	**1.9%**	**60.6%**	**6.3%**	**4.3%**

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
SNF	1.9%	1.3% - 2.6%	1.4%	19.4%	4.6%	56.2%	18.4%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	1.7%	1.4% - 2.0%	8.7%	47.2%	8.8%	31.7%	3.6%
FQHC	1.6%	0.5% - 2.6%	30.8%	69.2%	0.0%	0.0%	0.0%
Other FI Service Types	1.5%	1.0% - 2.0%	12.1%	44.5%	20.8%	20.1%	2.6%
HHA	1.4%	0.7% - 2.1%	0.0%	19.7%	46.3%	34.0%	0.0%

ESRD	1.2%	0.5% - 1.9%	0.9%	49.5%	23.3%	26.3%	0.1%
Hospice	0.7%	0.2% - 1.2%	12.5%	0.5%	39.6%	30.0%	17.4%
Non-PPS Hospital In-patient	0.7%	0.3% - 1.0%	4.4%	23.7%	9.6%	58.7%	3.7%
RHCs	0.5%	0.2% - 0.8%	43.0%	40.6%	0.0%	0.0%	16.4%
Free Standing Ambulatory Surgery	0.2%	(0.0%) - 0.4%	1.2%	89.2%	0.0%	9.6%	0.0%
All Types of Services	**1.5%**	**1.3% - 1.7%**	**4.9%**	**31.2%**	**16.2%**	**39.5%**	**8.3%**

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)	57.0%	19.4% - 94.6%	0.0%	N/A	100.0%	0.0%	0.0%
SHLD,ELBFOREARM PROC,EXC MAJ JNT PROC, W/O CC (224)	47.7%	(7.8%) -103.2%	46.3%	N/A	53.7%	0.0%	0.0%
OTH EAR, NOSE, MTH & THRT DIAG AGE >17 (073)	39.0%	(1.2%) - 79.2%	0.0%	N/A	47.5%	8.0%	44.4%
NUTR & MISC METAB DISOR AGE >17 W/O CC (297)	29.7%	16.0% - 43.4%	2.7%	N/A	75.9%	20.9%	0.5%
SIGNS & SYMP - MUS-SKEL SYS & CON TIS (247)	29.2%	13.6% - 44.7%	0.0%	N/A	98.3%	1.7%	0.0%
SEIZURE AGE >17 W CC (562)	28.5%	5.3% - 51.7%	25.0%	N/A	65.9%	8.6%	0.5%
G.I. HEMORR W/O CC (175)	26.7%	10.0% - 43.4%	0.0%	N/A	64.3%	35.7%	0.0%
HERNIA PROC EXC ING & FEMORAL AGE >17 W/O CC (160)	24.8%	0.5% - 49.1%	0.0%	N/A	65.0%	0.0%	35.0%
DYSEQUILIBRIUM (065)	24.0%	9.6% - 38.4%	0.0%	N/A	83.1%	6.4%	10.5%
OTH DIG SYS DX AGE >17 W/O CC (189)	21.7%	2.5% - 40.9%	0.0%	N/A	80.9%	10.3%	8.8%
KIDNEY & URIN TRACT INFECT AGE >17 W/O CC (321)	21.5%	4.7% - 38.4%	0.0%	N/A	73.7%	26.3%	0.0%
CHEST PAIN (143)	20.8%	16.5% - 25.1%	0.0%	N/A	86.2%	2.8%	11.0%
OTH DISOR - NERV SYS W CC (034)	20.4%	9.5% - 31.3%	0.0%	N/A	87.4%	11.6%	1.1%

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

BONE DIS & SPEC ARTHROPATHIES W CC (244)	19.8%	0.1% - 39.4%	0.0%	N/A	52.5%	47.5%	0.0%
PERIPHERAL VAS DISOR W/O CC (131)	19.6%	2.9% - 36.2%	0.0%	N/A	54.1%	40.1%	5.8%
MEDICAL BACK PROB (243)	19.3%	12.8% - 25.8%	0.0%	N/A	88.0%	6.1%	5.9%
TRAUMA - SKIN, SUBCU TISS & BREAST AGE >17 W CC (280)	19.3%	6.3% - 32.3%	0.0%	N/A	93.4%	5.6%	1.0%
FX, SPR, STR & DISL - UPARM,LOLEG EX FT AGE >17 W CC (253)	19.2%	7.6% - 30.8%	0.0%	N/A	91.7%	8.3%	0.0%
SIGNS & SYMP W/O CC (464)	19.0%	2.0% - 35.9%	0.0%	N/A	59.8%	28.8%	11.5%
SIGNS & SYMP W CC (463)	18.4%	10.8% - 25.9%	4.8%	N/A	65.5%	29.7%	0.0%
All HPMP	**4.5%**	**4.2% - 4.8%**	**2.6%**	**N/A**	**62.1%**	**29.3%**	**6.0%**

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
Triple S, Inc. PR/VI 00973/00974	11.1%	0.3%	2.2%	2.4%	6.0%	0.2%
Empire NJ 00805	7.3%	0.5%	2.9%	0.2%	3.5%	0.1%
Empire NY 00803	6.8%	0.4%	2.7%	0.3%	3.4%	0.0%
GHI NY 14330	6.2%	0.3%	2.7%	0.2%	2.8%	0.2%
First Coast Service Options FL 00590	5.4%	1.5%	1.1%	0.0%	2.8%	0.0%
Cahaba AL/GA/MS 00510/00511/00512	5.1%	0.7%	2.2%	0.1%	2.0%	0.1%
BCBS AR RI 00524	4.9%	0.2%	1.5%	0.2%	3.0%	0.0%
BCBS KS/NE/W MO 00650/00655/00651	4.8%	0.8%	1.8%	0.1%	1.9%	0.1%
Trailblazer TX 00900	4.5%	0.5%	1.1%	0.1%	2.9%	0.0%
Palmetto SC 00880	4.5%	0.3%	1.6%	0.7%	1.9%	0.0%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	4.3%	0.4%	1.3%	0.1%	2.2%	0.4%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	4.3%	0.3%	1.2%	0.1%	2.7%	0.0%
NHIC CA 31140/31146	4.2%	0.2%	0.5%	0.2%	3.3%	0.0%
WPS WI/IL/MI/MN 00951/00952/00953/00954	4.1%	0.4%	1.0%	0.0%	2.6%	0.0%
CIGNA NC 05535	3.8%	0.4%	1.1%	0.0%	2.2%	0.1%
HGSA PA 00865	3.8%	0.6%	0.6%	0.0%	2.6%	0.0%
CIGNA TN 05440	3.8%	0.4%	0.7%	0.2%	2.4%	0.0%

Noridian MAC Region 3 03002	3.8%	0.1%	0.8%	0.1%	2.7%	0.0%
HealthNow NY 00801	3.7%	0.2%	1.2%	0.1%	2.3%	0.0%
Palmetto OH/WV 00883/00884	3.6%	0.2%	1.1%	0.0%	2.2%	0.1%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.3%	0.1%	1.1%	0.0%	2.0%	0.0%
Noridian UT 00823	3.2%	0.1%	1.7%	0.0%	1.5%	0.0%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	3.1%	0.3%	0.7%	0.3%	1.7%	0.1%
AdminaStar IN/KY 00630/00660	3.1%	0.1%	0.7%	0.3%	2.0%	0.0%
First Coast Service Options CT 00591	2.9%	0.4%	0.4%	0.1%	1.9%	0.0%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/ 00836	2.8%	0.3%	0.7%	0.2%	1.7%	0.0%
BCBS MT 00751	2.7%	0.2%	1.0%	0.0%	1.5%	0.0%
CIGNA ID 05130	2.3%	0.1%	0.5%	0.2%	1.5%	0.1%
Combined	**4.5%**	**0.5%**	**1.2%**	**0.1%**	**2.6%**	**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	12.3%	4.0%	0.1%	6.2%	1.2%	0.8%
Noridian Administrative Services MAC Region D 19003	11.6%	4.4%	0.0%	6.5%	0.2%	0.5%
CIGNA Government Services MAC Region C 18003	7.7%	1.9%	0.3%	5.2%	0.3%	0.0%
NHIC MAC Region A 16003	5.9%	0.5%	0.6%	4.2%	0.5%	0.1%
National Government Services MAC Region B 17003	5.3%	0.4%	0.0%	4.5%	0.4%	0.1%
Combined	**9.0%**	**2.4%**	**0.2%**	**5.4%**	**0.6%**	**0.4%**

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

FI	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
UGS AS/CA/GU/HI/NV/NMI 00454	3.5%	0.2%	1.1%	0.5%	1.2%	0.5%
First Coast Service Options FL 00090	2.8%	0.3%	1.2%	0.0%	0.6%	0.7%
BCBS AR AR 00020	2.7%	0.1%	0.4%	0.5%	1.3%	0.3%
Noridian AK/WA 00322	2.5%	0.1%	0.7%	1.4%	0.2%	0.1%
COSVI PR/VI 57400	2.2%	0.2%	1.6%	0.0%	0.4%	0.0%
Trailblazer CO/NM/TX 00400	2.2%	0.0%	0.4%	0.2%	1.5%	0.1%
Trispan LA/MO/MS 00230	2.1%	0.1%	0.4%	0.1%	1.4%	0.1%
UGS VA/WV 00453	1.8%	0.2%	0.7%	0.1%	0.7%	0.1%
Highmark Medicare Services DC/MD 00366	1.8%	0.0%	0.7%	0.1%	1.0%	0.0%
Empire CT/DE/NY 00308	1.7%	0.1%	0.9%	0.1%	0.4%	0.1%
Anthem NH/VT 00270	1.6%	0.3%	0.5%	0.0%	0.5%	0.2%
Anthem ME/MA 00180/00181	1.5%	0.1%	0.3%	0.6%	0.4%	0.1%
Noridian MAC Region 3 03001	1.4%	0.1%	0.4%	0.1%	0.8%	0.0%
Noridian ID/OR/UT 00323/00325	1.4%	0.1%	0.4%	0.1%	0.8%	0.0%
UGS WI/MI 00450/00452	1.3%	0.0%	0.3%	0.5%	0.2%	0.4%
Palmetto NC 00382	1.3%	0.0%	0.3%	0.3%	0.5%	0.1%
Mutual of Omaha (all states) 52280	1.2%	0.0%	0.5%	0.0%	0.6%	0.0%
Riverbend NJ/TN 00390	1.2%	0.1%	0.6%	0.1%	0.3%	0.0%
Palmetto SC 00380	1.1%	0.0%	0.1%	0.5%	0.4%	0.1%
Noridian MN/ND 00320/00321	1.1%	0.0%	0.6%	0.2%	0.3%	0.0%
Chisholm OK 00340	1.0%	0.0%	0.6%	0.0%	0.3%	0.0%
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	1.0%	0.2%	0.3%	0.1%	0.4%	0.0%
BCBS AR RI 00021	1.0%	0.3%	0.2%	0.1%	0.4%	0.0%
Veritus PA 00363	0.9%	0.2%	0.3%	0.1%	0.2%	0.0%
BCBS GA GA 00101	0.8%	0.0%	0.3%	0.0%	0.5%	0.0%
Cahaba AL 00010	0.7%	0.0%	0.3%	0.0%	0.3%	0.1%
BCBS KS KS 00150	0.7%	0.0%	0.2%	0.0%	0.5%	0.0%
BCBS NE NE 00260	0.7%	0.0%	0.4%	0.0%	0.2%	0.0%
BCBS MT MT 00250	0.6%	0.0%	0.2%	0.2%	0.2%	0.0%
Cahaba IA/SD 00011	0.6%	0.0%	0.0%	0.0%	0.5%	0.0%
BCBS WY WY 00460	0.5%	0.2%	0.0%	0.0%	0.3%	0.0%
Combined	**1.5%**	**0.1%**	**0.5%**	**0.2%**	**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	5.1%	0.0%	N/A	2.5%	2.5%	0.1%
ALASKA	0.6%	0.0%	N/A	0.0%	0.1%	0.5%
ARIZONA	7.2%	0.4%	N/A	5.1%	1.7%	0.0%
ARKANSAS	3.3%	0.0%	N/A	1.7%	1.1%	0.5%
CALIFORNIA	4.1%	0.2%	N/A	2.1%	1.1%	0.8%
COLORADO	4.4%	0.9%	N/A	0.4%	2.0%	1.1%
CONNECTICUT	3.9%	0.0%	N/A	1.9%	1.7%	0.2%
DELAWARE	4.2%	0.0%	N/A	3.3%	0.6%	0.3%
DISTRICT OF COLUMBIA	3.0%	0.0%	N/A	2.6%	0.4%	0.0%
FLORIDA	5.9%	0.0%	N/A	3.9%	2.0%	0.1%
GEORGIA	5.4%	0.4%	N/A	2.9%	2.0%	0.2%
HAWAII	3.9%	0.1%	N/A	1.4%	2.4%	0.0%
IDAHO	3.3%	0.0%	N/A	1.7%	0.6%	1.1%
ILLINOIS	5.0%	0.0%	N/A	2.9%	1.9%	0.2%
INDIANA	3.7%	0.2%	N/A	3.0%	0.6%	0.0%
IOWA	3.8%	0.0%	N/A	2.2%	1.5%	0.0%
KANSAS	2.6%	0.0%	N/A	0.7%	1.6%	0.4%
KENTUCKY	4.9%	0.6%	N/A	3.8%	0.4%	0.1%
LOUISIANA	3.8%	0.5%	N/A	1.8%	1.3%	0.2%
MAINE	5.0%	0.0%	N/A	3.8%	0.9%	0.3%
MARYLAND	3.5%	0.0%	N/A	3.5%	0.0%	0.0%
MASSACHUSETTS	5.8%	0.0%	N/A	5.7%	0.1%	0.0%
MICHIGAN	4.5%	0.0%	N/A	2.5%	1.1%	0.9%
MINNESOTA	4.3%	0.2%	N/A	2.8%	1.0%	0.3%
MISSISSIPPI	5.0%	0.4%	N/A	2.3%	1.8%	0.6%
MISSOURI	3.3%	0.0%	N/A	2.5%	0.7%	0.0%
MONTANA	2.3%	0.0%	N/A	0.7%	0.7%	0.9%
NEBRASKA	0.7%	0.0%	N/A	0.4%	0.1%	0.3%
NEVADA	6.8%	0.2%	N/A	5.2%	1.0%	0.3%
NEW HAMPSHIRE	5.1%	0.1%	N/A	4.5%	0.3%	0.2%
NEW JERSEY	5.8%	0.1%	N/A	4.4%	1.3%	0.0%
NEW MEXICO	9.9%	0.0%	N/A	4.4%	4.0%	1.5%
NEW YORK	3.0%	0.0%	N/A	1.2%	1.7%	0.0%
NORTH CAROLINA	1.9%	0.0%	N/A	1.3%	0.6%	0.0%
NORTH DAKOTA	2.0%	0.0%	N/A	0.9%	1.2%	0.0%
OHIO	3.7%	0.0%	N/A	3.1%	0.4%	0.1%
OKLAHOMA	2.6%	0.0%	N/A	1.6%	1.0%	0.0%
OREGON	3.5%	0.0%	N/A	2.8%	0.4%	0.3%
PENNSYLVANIA	5.7%	0.4%	N/A	2.7%	2.6%	0.0%
PUERTO RICO	7.1%	0.1%	N/A	2.8%	4.2%	0.1%
RHODE ISLAND	4.3%	0.0%	N/A	3.1%	1.2%	0.0%
SOUTH CAROLINA	5.4%	0.5%	N/A	4.3%	0.6%	0.0%
SOUTH DAKOTA	3.5%	0.8%	N/A	2.3%	0.0%	0.4%
TENNESSEE	2.4%	0.0%	N/A	0.9%	1.3%	0.1%
TEXAS	5.4%	0.0%	N/A	3.4%	1.6%	0.4%
UTAH	5.9%	0.1%	N/A	4.2%	1.0%	0.7%
VERMONT	3.8%	0.0%	N/A	2.4%	0.6%	0.8%

VIRGINIA	8.4%	0.0%	N/A	6.8%	0.7%	0.9%
WASHINGTON	2.6%	0.0%	N/A	1.2%	0.4%	1.1%
WEST VIRGINIA	5.6%	0.3%	N/A	3.1%	2.0%	0.1%
WISCONSIN	2.8%	0.0%	N/A	0.8%	1.9%	0.1%
WYOMING	1.1%	0.1%	N/A	0.2%	0.4%	0.4%
Short-term Acute Paid Claims	**4.5%**	**0.1%**	**N/A**	**2.8%**	**1.3%**	**0.3%**
Long-term Acute Paid Claims	**5.3%**	**0.2%**	**N/A**	**2.8%**	**1.9%**	**0.4%**
Denied Claims	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**4.5%**	**0.1%**	**N/A**	**2.8%**	**1.3%**	**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
Office visits - established	6.0%	14,739	$622,528,034	0.2%	5.6% - 6.4%
Hospital visit - subsequent	12.2%	5,622	$602,033,573	0.7%	10.9% - 13.5%
Consultations	16.6%	1,900	$516,912,824	0.8%	15.1% - 18.2%
Hospital visit - initial	17.6%	700	$211,886,063	1.5%	14.7% - 20.6%
Minor procedures - other (Medicare fee schedule)	6.9%	6,216	$172,040,758	0.8%	5.3% - 8.4%
Nursing home visit	14.2%	1,603	$159,919,505	1.5%	11.3% - 17.2%
Office visits - new	15.5%	1,062	$156,017,076	1.1%	13.2% - 17.7%
Ambulance	2.2%	2,474	$85,194,498	0.5%	1.2% - 3.1%
Emergency room visit	5.3%	1,212	$80,316,367	0.7%	4.0% - 6.6%
Standard imaging - nuclear medicine	3.1%	1,092	$56,886,773	1.9%	(0.6%) - 6.8%
Ambulatory procedures - other	7.6%	609	$56,649,382	3.9%	0.0% - 15.3%
Chiropractic	10.2%	1,624	$55,126,448	1.2%	7.9% - 12.6%
Eye procedure - other	6.8%	179	$37,708,628	5.8%	(4.5%) - 18.1%
Hospital visit - critical care	5.0%	288	$36,045,736	1.5%	2.0% - 8.0%
Other tests - other	2.7%	1,702	$31,878,027	0.8%	1.1% - 4.3%
Other drugs	0.6%	2,115	$31,758,233	0.3%	0.1% - 1.2%
Lab tests - other (non-Medicare fee schedule)	1.4%	11,677	$30,070,017	0.4%	0.7% - 2.2%
Dialysis services (Non MFS)	4.9%	206	$28,735,555	1.7%	1.6% - 8.3%
Echography - heart	1.8%	1,638	$25,197,633	0.8%	0.3% - 3.3%
Oncology - radiation therapy	1.6%	553	$22,698,932	1.1%	(0.5%) - 3.7%
Lab tests - other (Medicare fee schedule)	1.4%	1,524	$21,899,528	0.4%	0.5% - 2.2%
Specialist - opthamology	1.1%	2,876	$21,487,751	0.3%	0.6% - 1.6%
Specialist - other	12.7%	455	$20,686,082	3.3%	6.1% - 19.2%

Minor procedures - skin	1.6%	1,354	$17,842,034	0.6%	0.4% - 2.9%
Minor procedures - musculoskeletal	1.8%	918	$17,112,309	0.5%	0.8% - 2.7%
Home visit	9.9%	171	$16,012,123	3.0%	3.9% - 15.8%
Standard imaging - musculoskeletal	2.4%	2,318	$14,927,029	0.6%	1.2% - 3.6%
Specialist - psychiatry	1.9%	1,475	$14,362,802	0.5%	0.9% - 3.0%
Other - Medicare fee schedule	12.8%	260	$13,704,938	3.7%	5.6% - 20.0%
Echography - other	2.9%	566	$13,121,313	1.5%	0.0% - 5.8%
Chemotherapy	0.7%	235	$13,098,605	0.4%	(0.2%) - 1.5%
Other tests - electrocardiograms	3.2%	2,367	$12,136,470	0.5%	2.3% - 4.1%
Imaging/procedure - other	3.7%	444	$11,841,118	1.5%	0.8% - 6.6%
Ambulatory procedures - skin	0.8%	1,410	$11,650,463	0.3%	0.3% - 1.4%
Dialysis services	10.9%	113	$10,125,912	6.8%	(2.5%) - 24.3%
Advanced imaging - CAT: other	0.7%	1,087	$9,654,926	0.4%	0.0% - 1.5%
Major procedure, cardiovascular-Other	0.9%	264	$9,264,608	0.7%	(0.4%) - 2.2%
Standard imaging - other	1.8%	682	$6,737,277	0.6%	0.6% - 3.1%
Anesthesia	0.5%	834	$6,645,122	0.2%	0.0% - 1.0%
Advanced imaging - MRI: other	0.5%	364	$6,603,908	0.2%	0.1% - 1.0%
Standard imaging - chest	1.2%	2,814	$6,386,507	0.3%	0.7% - 1.8%
Oncology - other	1.3%	464	$5,867,867	0.9%	(0.4%) - 3.0%
Immunizations/Vaccinations	1.6%	1,980	$5,436,365	0.5%	0.6% - 2.7%
Endoscopy - upper gastrointestinal	1.1%	222	$5,080,261	0.1%	0.9% - 1.3%
Major procedure, orthopedic - other	1.3%	97	$4,664,331	1.3%	(1.3%) - 4.0%
Other tests - cardiovascular stress tests	1.4%	412	$4,453,560	0.9%	(0.4%) - 3.1%
Lab tests - automated general profiles	1.3%	2,387	$3,972,522	0.3%	0.7% - 1.9%
Lab tests - routine venipuncture (non Medicare fee schedule)	2.5%	4,403	$3,803,133	0.7%	1.1% - 3.9%
Advanced imaging - CAT: head	1.0%	435	$3,607,001	0.6%	(0.1%) - 2.1%
Lab tests - blood counts	1.2%	2,422	$3,512,521	0.3%	0.6% - 1.8%
Major procedure - Other	0.4%	191	$3,071,749	0.4%	(0.3%) - 1.2%
Advanced imaging - MRI: brain	0.8%	162	$2,942,774	0.7%	(0.6%) - 2.2%
Ambulatory procedures - musculoskeletal	0.9%	92	$2,940,020	0.5%	(0.0%) - 1.8%
Echography - eye	2.8%	182	$2,889,470	1.0%	0.9% - 4.7%
Echography - carotid arteries	1.2%	196	$2,863,322	1.2%	(1.1%) - 3.5%
Lab tests - urinalysis	3.7%	1,362	$2,189,376	0.6%	2.5% - 5.0%
Imaging/procedure - heart including cardiac catheter	1.3%	330	$1,969,390	1.3%	(1.3%) - 3.9%

Echography - abdomen/pelvis	0.7%	367	$1,681,633	0.4%	0.0% - 1.5%
Endoscopy - cystoscopy	0.6%	103	$1,502,561	0.6%	(0.6%) - 1.8%
Lab tests - bacterial cultures	1.7%	580	$1,477,384	0.7%	0.3% - 3.2%
Other - non-Medicare fee schedule	2.7%	448	$1,434,264	1.6%	(0.3%) - 5.8%
All Codes With Less Than 30 Claims	0.1%	470	$1,433,426	0.0%	(0.0%) - 0.1%
Other tests - EKG monitoring	1.3%	96	$1,230,799	0.2%	0.8% - 1.8%
Standard imaging - contrast gastrointestinal	1.3%	109	$1,020,803	0.2%	0.9% - 1.8%
Endoscopy - other	0.8%	66	$901,030	0.8%	(0.7%) - 2.3%
Endoscopy - colonoscopy	0.1%	259	$643,913	0.1%	(0.1%) - 0.2%
Standard imaging - breast	0.1%	440	$350,075	0.1%	(0.1%) - 0.4%
Lab tests - glucose	1.4%	423	$278,743	0.7%	0.1% - 2.8%
No Service Code	0.2%	134	$149,184	0.1%	(0.1%) - 0.4%
Medical/surgical supplies	4.6%	50	$137,233	1.5%	1.6% - 7.6%
Eye procedure - cataract removal/lens insertion	0.0%	249	N/A	N/A	N/A
Orthotic devices	0.0%	87	N/A	N/A	N/A
Undefined codes	0.0%	99	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**4.5%**	**99,059**	**$3,366,409,599**	**0.1%**	**4.2% - 4.8%**

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
Wheelchairs Motorized	22.1%	43	$183,409,771	7.6%	7.3% - 37.0%
Glucose Monitor	11.1%	3,881	$133,495,738	0.9%	9.4% - 12.9%
Nebulizers & Related Drugs	10.0%	2,915	$102,918,965	3.2%	3.7% - 16.3%
Wheelchairs Options/Accessories	23.5%	572	$50,311,527	8.3%	7.3% - 39.8%
Oxygen Supplies/Equipment	1.9%	3,382	$38,600,613	0.3%	1.2% - 2.5%
CPAP	8.6%	1,222	$34,587,772	2.0%	4.5% - 12.6%
Spinal Orthoses	30.2%	47	$32,683,930	11.7%	7.2% - 53.2%
Infusion Pumps & Related Drugs	19.6%	231	$30,870,823	13.1%	(6.0%) - 45.1%
Lower Limb Orthoses	17.2%	153	$29,445,001	6.7%	4.1% - 30.4%
Suction Pump	73.4%	72	$29,021,461	13.9%	46.1% -100.6%
Support Surfaces	17.6%	113	$27,321,672	7.3%	3.2% - 32.0%
Wheelchairs Manual	11.3%	779	$25,413,911	1.6%	8.2% - 14.4%
Enteral Nutrition	3.8%	496	$16,666,269	1.6%	0.6% - 7.0%
Immunosuppressive Drugs	6.0%	306	$15,622,714	2.7%	0.6% - 11.4%
Upper Limb Orthoses	24.9%	111	$13,859,620	8.5%	8.2% - 41.7%
Diabetic Shoes	9.4%	262	$13,805,493	2.9%	3.6% - 15.1%
Surgical Dressings	17.9%	189	$13,222,957	14.2%	(9.9%) - 45.7%
Ostomy Supplies	7.9%	479	$12,990,456	2.8%	2.4% - 13.4%
Urological Supplies	16.6%	316	$12,848,741	8.9%	(0.9%) - 34.0%
All Policy Groups with Less than 30 Claims	1.7%	329	$12,572,024	1.1%	(0.4%) - 3.7%
Hospital Beds/Accessories	5.0%	504	$11,614,640	1.2%	2.7% - 7.3%
Walkers	9.1%	210	$7,929,842	4.3%	0.7% - 17.4%
Heat/Cold Application	30.9%	32	$6,561,772	18.1%	(4.6%) - 66.3%
Respiratory Assist Device	6.4%	92	$6,458,882	2.9%	0.8% - 12.1%
Lenses	9.3%	341	$5,821,600	3.3%	2.7% - 15.9%
Wheelchairs Seating	17.0%	51	$4,407,652	9.7%	(1.9%) - 36.0%
Commodes/Bed Pans/Urinals	7.9%	98	$3,311,399	3.5%	1.0% - 14.9%
TENS	8.6%	91	$3,114,298	6.0%	(3.2%) - 20.3%
Repairs/DME	21.2%	42	$3,104,585	12.0%	(2.3%) - 44.8%
Breast Prostheses	5.9%	61	$3,018,850	4.6%	(3.1%) - 14.8%
Patient Lift	7.3%	59	$1,417,858	3.6%	0.2% - 14.4%
Canes/Crutches	9.6%	36	$576,141	6.4%	(2.8%) - 22.1%
Dialysis Supplies & Equipment	N/A	35	N/A	N/A	N/A
Lower Limb Prostheses	0.0%	112	N/A	N/A	N/A
Misc Drugs	0.0%	49	N/A	N/A	N/A
Routinely Denied Items	N/A	101	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**9.0%**	**17,812**	**$887,006,976**	**1.0%**	**7.0% - 11.0%**

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
SNF	1.9%	2,578	$444,897,371	0.3%	1.3% - 2.6%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	1.7%	39,930	$428,499,743	0.2%	1.4% - 2.0%
HHA	1.4%	1,918	$209,470,928	0.4%	0.7% - 2.1%
ESRD	1.2%	1,279	$81,477,558	0.3%	0.5% - 1.9%
Other FI Service Types	1.5%	6,578	$78,347,464	0.3%	1.0% - 2.0%
Hospice	0.7%	960	$60,233,748	0.3%	0.2% - 1.2%
Non-PPS Hospital In-patient	0.7%	2,563	$27,015,780	0.2%	0.3% - 1.0%
FQHC	1.6%	589	$5,820,748	0.5%	0.5% - 2.6%
RHCs	0.5%	3,041	$2,678,773	0.2%	0.2% - 0.8%
Free Standing Ambulatory Surgery	0.2%	107	$959,239	0.1%	(0.0%) - 0.4%
All Type of Services (Incl. Codes Not Listed)	**1.5%**	**59,543**	**$1,339,401,351**	**0.1%**	**1.3% - 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)	10.2%	163	$184,283,328	3.5%	3.3% - 17.1%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	12.6%	883	$173,942,653	1.5%	9.6% - 15.6%
CHEST PAIN (143)	20.8%	675	$122,478,168	2.2%	16.5% - 25.1%
NUTR & MISC METAB DISOR AGE >17 W CC (296)	11.9%	770	$110,544,891	1.8%	8.4% - 15.4%
RENAL FAILURE (316)	5.7%	798	$97,045,426	0.9%	3.9% - 7.5%
HEART FAILURE & SHOCK (127)	2.7%	1876	$94,513,613	0.6%	1.6% - 3.8%
PERM CAR PACER IMPL W MAJ CV DX/AICD LEAD/GNRTR (551)	9.3%	162	$86,179,114	3.3%	2.9% - 15.8%
MEDICAL BACK PROB (243)	19.3%	308	$73,164,439	3.3%	12.8% - 25.8%
OTH PERM CAR PACER IMPL W/O MAJ CV DX (552)	8.0%	267	$72,985,114	2.7%	2.8% - 13.3%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W/O MAJ CV DX (558)	3.0%	489	$64,436,229	0.9%	1.2% - 4.8%
EXT OR PROC UNREL TO PRINC DIAG (468)	5.2%	150	$63,605,517	1.9%	1.5% - 8.9%
ECMO/TRAH W MV 96+ HR/PDX EXC FCE MTH & NCK W MAJ OR (541)	2.0%	72	$59,581,022	1.5%	(0.8%) - 4.8%
CAR ARRHYTHMIA & CONDUCTION DISOR W CC (138)	6.5%	691	$58,435,190	1.4%	3.8% - 9.3%

[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)	5.7%	745	$57,879,537	1.1%	3.5% - 7.8%
CHRON OBSTRUCTIVE PULM DIS (088)	3.4%	1162	$57,329,074	0.8%	1.7% - 5.0%
G.I. HEMORR W CC (174)	4.2%	829	$56,100,066	1.0%	2.3% - 6.1%
MAJ JNT REPLACE/REATTACH - LO EXTREM (544)	1.2%	1676	$54,609,166	0.4%	0.4% - 2.0%
OTH DIG SYS DX AGE >17 W CC (188)	9.5%	277	$53,600,042	2.1%	5.3% - 13.6%
DIABETES AGE >35 (294)	12.0%	300	$47,246,363	3.2%	5.9% - 18.2%
SEPTICEMIA W/O MV 96+ HOURS AGE >17 (576)	6.4%	653	$44,415,778	1.6%	3.2% - 9.5%
SIMP PNEUM & PLEURISY AGE >17 W CC (089)	1.8%	1526	$43,487,480	0.5%	0.8% - 2.7%
CIRC DISOR EXC AMI, W CAR CATH & COMPL DIAG (124)	5.1%	320	$43,390,151	1.8%	1.4% - 8.7%
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	9.1%	265	$42,501,386	2.2%	4.9% - 13.3%
TRANSIENT ISCHEMIA (524)	11.4%	313	$42,039,095	2.2%	7.0% - 15.7%
DEGEN NERV SYS DISOR (012)	14.6%	179	$39,165,474	3.0%	8.7% - 20.5%
SYNCOPE & COLLAPSE W CC (141)	7.9%	366	$38,802,305	1.9%	4.2% - 11.6%
RESP NEOPS (082)	7.8%	200	$36,480,419	2.9%	2.1% - 13.4%
OTH CIRC SYS DIAG W CC (144)	4.4%	354	$35,449,979	1.2%	2.1% - 6.8%
OTH CIRC SYS OR PROC (120)	8.0%	100	$35,126,976	3.8%	0.5% - 15.5%
RESP SYS DIAG W VENTILATOR SUPPORT 96+ HOURS (565)	11.1%	93	$35,124,532	7.6%	(3.8%) - 25.9%
NON-EXT OR PROC UNREL TO PRINC DIAG (477)	10.9%	95	$34,967,872	3.5%	4.0% - 17.9%
INFECTIOUS & PARASITIC DISS W OR PROC (578)	11.1%	110	$33,852,611	6.0%	(0.6%) - 22.8%
OTH DISOR - NERV SYS W CC (034)	20.4%	101	$33,516,393	5.6%	9.5% - 31.3%
OTH RESP SYS OR PROC W CC (076)	4.3%	143	$32,935,953	2.6%	(0.7%) - 9.3%
PERIPHERAL VAS DISOR W CC (130)	7.7%	266	$32,657,035	2.9%	2.0% - 13.4%
OTH OR PROC - INJURIES W CC (442)	10.5%	72	$31,585,608	7.8%	(4.8%) - 25.8%
OTH KIDNEY & URIN TRACT PROC (315)	7.0%	98	$31,455,591	3.2%	0.7% - 13.3%
RED BLOOD CELL DISOR AGE >17 (395)	6.0%	322	$29,349,754	1.5%	3.0% - 9.0%
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W/O CC (183)	14.7%	251	$29,152,501	2.9%	9.0% - 20.5%
OTH VAS PROC W CC W/O MAJ CV DX (554)	3.1%	261	$28,714,629	0.9%	1.3% - 4.9%
CELLULITIS AGE >17 W CC (277)	5.2%	374	$28,697,905	1.5%	2.2% - 8.3%
SEPTICEMIA AGE >17 (416)	1.2%	248	$28,142,706	0.5%	0.3% - 2.1%
DYSEQUILIBRIUM (065)	24.0%	121	$27,088,930	7.4%	9.6% - 38.4%
SKN GRFT &/ DEBR - SKN ULCER/CELLU W CC (263)	11.5%	73	$26,682,580	5.3%	1.1% - 22.0%
TRANSURETHRAL PROC W CC (310)	16.5%	79	$26,354,287	7.1%	2.6% - 30.5%

LAPAROSCOPIC CHOLE W/O C.D.E. W CC (493)	4.3%	189	$26,109,549	1.5%	1.4% - 7.3%
INTRACRANIAL HEMORR/CEREB INFARCT (014)	1.5%	850	$25,643,155	0.4%	0.8% - 2.2%
MAJ CAR-VAS PROC W/O CC (111)	17.2%	32	$25,151,064	11.9%	(6.1%) - 40.4%
OTH KIDNEY & URIN TRACT DIAG AGE >17 W CC (331)	7.1%	167	$24,689,575	2.1%	2.9% - 11.3%
SIGNS & SYMP W CC (463)	18.4%	127	$24,439,001	3.9%	10.8% - 25.9%
NUTR & MISC METAB DISOR AGE >17 W/O CC (297)	29.7%	142	$24,299,663	7.0%	16.0% - 43.4%
SEIZURE AGE >17 W CC (562)	28.5%	143	$23,769,428	11.8%	5.3% - 51.7%
DISOR - BIL TRACT W CC (207)	9.4%	136	$23,464,668	3.3%	2.8% - 15.9%
NONSPEC CEREBVAS DISOR W CC (016)	15.5%	63	$22,668,086	6.6%	2.6% - 28.4%
RESP INFECT & INFLAM AGE >17 W CC (079)	1.7%	543	$22,584,188	0.6%	0.6% - 2.8%
PERCU CARDIOVAS PROC W DRUG-ELUT STENT W MAJ CV DX (557)	1.1%	344	$22,467,113	0.4%	0.4% - 1.8%
OTH VAS PROC W/O CC (479)	9.8%	104	$21,628,188	4.5%	1.0% - 18.5%
PULM EDEMA & RESP FAILURE (087)	2.7%	356	$21,419,354	0.8%	1.1% - 4.2%
BRONCHITIS & ASTHMA AGE >17 W CC (096)	11.5%	177	$21,368,585	4.4%	2.8% - 20.2%
PATH FRACT & MUSCSKEL & CON TIS MALIG (239)	10.2%	131	$21,271,257	3.5%	3.3% - 17.1%
HERNIA PROC EXC ING & FEMORAL AGE >17 W CC (159)	13.8%	69	$20,351,760	5.7%	2.7% - 24.9%
MALIG - HEPATOBIL SYS/PANCREAS (203)	8.4%	96	$20,297,405	5.6%	(2.5%) - 19.3%
CHOLE EXC BY LAP W/O C.D.E. W CC (197)	8.9%	57	$19,414,863	6.8%	(4.4%) - 22.1%
ATHEROSCLEROSIS W CC (132)	7.7%	260	$19,348,182	2.3%	3.2% - 12.2%
SYNCOPE & COLLAPSE W/O CC (142)	15.7%	119	$19,306,063	3.9%	8.0% - 23.5%
FX, SPR, STR & DISL - UPARM,LOLEG EX FT AGE >17 W CC (253)	19.2%	78	$19,305,213	5.9%	7.6% - 30.8%
OTH VAS PROC W CC W MAJ CV DX (553)	2.3%	136	$18,741,893	1.3%	(0.3%) - 4.8%
OTH MUSCSKEL SYS & CON TIS OR PROC W CC (233)	7.4%	76	$18,428,215	3.3%	1.0% - 13.8%
CORON BYPASS W/O CAR CATH W/O MAJ CV DX (550)	3.0%	97	$18,029,654	1.9%	(0.8%) - 6.8%
SIGNS & SYMP - MUS-SKEL SYS & CON TIS (247)	29.2%	69	$17,891,544	7.9%	13.6% - 44.7%
COAGULATION DISOR (397)	12.9%	52	$17,832,716	4.6%	3.9% - 21.9%
CORON BYPASS W CAR CATH W/O MAJ CV DX (548)	2.7%	92	$17,659,168	1.6%	(0.5%) - 5.9%
CRANIAL & PERIPHERAL NERVE DISOR W CC (018)	9.9%	114	$17,527,568	3.4%	3.3% - 16.5%
UNKNOWN (148)	0.9%	107	$17,302,560	0.4%	0.0% - 1.7%
G.I. HEMORR W/O CC (175)	26.7%	73	$17,167,875	8.5%	10.0% - 43.4%

OTH EAR, NOSE, MTH & THRT DIAG AGE >17 (073)	39.0%	38	$17,097,811	20.5%	(1.2%) - 79.2%
KIDNEY & URIN TRACT INFECT AGE >17 W/O CC (321)	21.5%	102	$16,788,820	8.6%	4.7% - 38.4%
CHEMOTHAPY W/O ACUTE LEUK SEC DIAG (410)	8.4%	98	$16,729,436	3.7%	1.2% - 15.5%
DISOR - PANCREAS EXC MALIG (204)	4.0%	224	$16,280,728	1.8%	0.4% - 7.6%
SHLD,ELBFOREARM PROC,EXC MAJ JNT PROC, W/O CC (224)	47.7%	34	$15,778,766	28.3%	(7.8%) -103.2%
HYPERTENSION (134)	13.7%	103	$15,312,092	4.2%	5.4% - 22.0%
OTH RESP SYS DIAG W CC (101)	13.4%	87	$14,852,660	4.4%	4.8% - 22.1%
RESP SYS DIAG W VENTILATOR SUPPORT <96 HOURS (566)	5.4%	206	$14,194,653	2.8%	(0.1%) - 10.8%
TRAUMA - SKIN, SUBCU TISS & BREAST AGE >17 W CC (280)	19.3%	59	$13,637,744	6.6%	6.3% - 32.3%
PNEUMOTHORAX W CC (094)	16.4%	48	$13,588,088	11.7%	(6.5%) - 39.3%
WND DEBR & SKN GRFT EXC HAND, MUSCSKEL & CON TIS DIS (217)	5.2%	39	$13,488,182	2.4%	0.5% - 10.0%
CORON BYPASS W CAR CATH W MAJ CV DX (547)	1.3%	93	$13,174,277	0.8%	(0.2%) - 2.8%
BILATERAL/MULT MAJ JNT PROCS - LO EXTREM (471)	4.3%	62	$13,035,621	4.3%	(4.1%) - 12.6%
SEIZURE & HEADACHE AGE >17 W CC (024)	5.0%	43	$13,007,286	3.2%	(1.2%) - 11.2%
PERIPH & CRANIAL NERVE & OTH NERV SYST PROC W CC (007)	5.6%	42	$12,834,749	3.7%	(1.6%) - 12.8%
BONE DIS & SPEC ARTHROPATHIES W CC (244)	19.8%	48	$12,790,206	10.0%	0.1% - 39.4%
PERCU CARVAS PROC W NON-DRUG-ELUT STENT W/O MAJ CV DX (556)	5.4%	120	$12,134,414	3.1%	(0.7%) - 11.5%
FRACT - HIP & PELVIS (236)	8.3%	141	$12,096,234	4.0%	0.4% - 16.1%
CAR ARRHYTHMIA & CONDUCTION DISOR W/O CC (139)	7.7%	244	$11,902,058	2.3%	3.1% - 12.3%
G.I. OBSTR W CC (180)	2.5%	279	$11,790,219	1.1%	0.3% - 4.8%
SKN ULCERS (271)	11.0%	67	$11,766,771	6.5%	(1.7%) - 23.7%
MAJ SMALL & LARGE BOWEL PROC W CC W/O MAJ GI DX (570)	4.6%	170	$11,506,918	3.5%	(2.3%) - 11.5%
PERCU CAR-VAS PROC W/O CORON ART STENT/AMI (518)	4.6%	81	$10,806,100	2.1%	0.5% - 8.6%
HERNIA PROC EXC ING & FEMORAL AGE >17 W/O CC (160)	24.8%	38	$10,803,916	12.4%	0.5% - 49.1%
POISONING & TOXIC EFFECTS - DRUGS AGE >17 W CC (449)	5.3%	156	$10,780,638	2.7%	0.0% - 10.5%
LYMPHOMA & NON-ACUTE LEUK W CC (403)	3.3%	98	$10,618,707	1.3%	0.8% - 5.8%
ORGANIC DISTURBANCES & MENTAL RETARDATION (429)	12.1%	65	$10,533,993	4.1%	4.1% - 20.2%
MAJ GASTROINTESTINAL DISOR&PERITONEAL INFECT (572)	8.6%	148	$10,337,652	3.4%	1.9% - 15.4%
CIRC DISOR W AMI & MAJ COMP, DISC ALIVE (121)	0.9%	418	$10,300,407	0.4%	0.2% - 1.6%

PERIPHERAL VAS DISOR W/O CC (131)	19.6%	66	$10,199,260	8.5%	2.9% - 36.2%
MAJ CHEST PROC (075)	1.2%	179	$10,154,597	0.8%	(0.3%) - 2.7%
FX, SPR, STR & DISL - UPARM,LOLEG EX FT AGE >17 W/O CC (254)	57.0%	36	$10,054,737	19.2%	19.4% - 94.6%
FEVER - UNKNOWN ORIGIN AGE >17 W CC (419)	12.5%	68	$9,869,959	6.6%	(0.4%) - 25.4%
BACK & NCK PROC EXC SPINAL FUSION W CC (499)	3.7%	133	$9,636,496	1.9%	(0.1%) - 7.5%
COMPL PEPTIC ULCER (176)	11.8%	50	$9,467,744	4.6%	2.8% - 20.9%
POSTOPERATIVE & POST-TRAUM INFECT (418)	4.9%	100	$8,852,225	2.8%	(0.7%) - 10.4%
HIP & FEM PROC EXC MAJ JNT AGE >17 W CC (210)	0.7%	437	$8,807,866	0.3%	(0.0%) - 1.3%
TRACH W MV 96+ HRS/PDX EXC FCE, MTH & NCK W/O MAJ OR (542)	0.5%	69	$8,485,207	0.4%	(0.2%) - 1.3%
THYROID PROC (290)	14.6%	43	$8,280,484	10.4%	(5.8%) - 35.0%
DIG MALIG W CC (172)	3.1%	97	$8,229,008	1.2%	0.8% - 5.4%
COMPL - TREATMENT W CC (452)	4.2%	88	$7,838,774	3.0%	(1.6%) - 10.0%
OTH DIG SYS DX AGE >17 W/O CC (189)	21.7%	37	$7,690,682	9.8%	2.5% - 40.9%
OTH SKIN, SUBCU TISS & BREAST PROC W CC (269)	6.2%	46	$7,331,084	3.6%	(0.8%) - 13.3%
HIP & FEM PROC EXC MAJ JNT AGE >17 W/O CC (211)	4.9%	98	$7,240,071	2.8%	(0.6%) - 10.3%
NERV SYS NEOPS W CC (010)	5.5%	50	$7,172,131	2.9%	(0.2%) - 11.3%
CELLULITIS AGE >17 W/O CC (278)	9.5%	120	$7,122,425	6.4%	(3.2%) - 22.1%
BACK & NCK PROC EXC SPINAL FUSION W/O CC (500)	3.6%	183	$7,090,172	1.4%	0.9% - 6.3%
HIV W MAJ REL CONDITION (489)	3.8%	51	$6,958,269	2.9%	(1.9%) - 9.6%
TENDONITIS, MYOSITIS & BURSITIS (248)	8.4%	48	$6,813,497	3.9%	0.7% - 16.0%
PERCU CARDIOVAS PROC W MAJ CV DX (555)	1.1%	254	$6,693,249	0.7%	(0.2%) - 2.5%
KIDNEY&URETER PROC - NON-NEOP W CC (304)	3.2%	63	$6,611,659	2.9%	(2.5%) - 8.9%
PSYCHOSES (430)	2.1%	279	$6,481,908	0.9%	0.3% - 3.9%
MAJ HEMATOL/IMMUNDIAG EXC SICKLE CELL CRISIS & COAGUL (574)	15.5%	63	$6,475,370	12.3%	(8.7%) - 39.7%
BIOPSIES - MUSCSKEL SYS & CON TIS (216)	3.1%	65	$6,455,428	1.8%	(0.3%) - 6.6%
URIN STONES W CC, &/ ESW LITHOTRIPSY (323)	8.3%	69	$6,418,088	3.9%	0.7% - 16.0%
ALC/DRUG ABUSE/DEP W CC (521)	4.9%	118	$6,307,567	2.2%	0.7% - 9.1%
ING & FEMORAL HERNIA PROC AGE >17 W CC (161)	10.0%	35	$6,244,332	7.7%	(5.1%) - 25.0%
OTH MUSCSKEL SYS & CON TIS OR PROC W/O CC (234)	8.9%	40	$6,239,970	4.2%	0.6% - 17.2%
VIRAL ILLNESS AGE >17 (421)	13.3%	39	$5,950,002	8.5%	(3.4%) - 29.9%
CIRRHOSIS & ALC HEPATITIS (202)	2.8%	79	$5,882,730	1.2%	0.4% - 5.2%

G.I. OBSTR W/O CC (181)	9.8%	70	$5,786,294	4.2%	1.5% - 18.2%
SPINAL FUSION EXC CERVICAL W CC (497)	0.8%	136	$5,604,990	0.7%	(0.6%) - 2.2%
ANAL & STOMAL PROC W CC (157)	9.1%	34	$5,540,933	6.2%	(3.1%) - 21.3%
BRONCHITIS & ASTHMA AGE >17 W/O CC (097)	11.0%	56	$5,468,505	9.3%	(7.3%) - 29.4%
ANGINA PECTORIS (140)	9.8%	93	$5,428,556	2.8%	4.3% - 15.2%
RESP SIGNS & SYMP W CC (099)	7.0%	64	$5,410,245	2.6%	2.0% - 12.1%
STOM, ESOHP & DUOD PROC AGE >17 W CC W/O MAJ GI DX (568)	6.4%	43	$5,308,433	4.6%	(2.6%) - 15.4%
FEMALE REPROD SYS RECONSTR PROC (356)	7.3%	77	$5,264,359	5.3%	(3.1%) - 17.7%
RETICULOENDOTHELIAL & IMMUN DISOR W CC (398)	4.3%	31	$5,248,186	2.7%	(0.9%) - 9.6%
AFTERCARE, MUSCSKEL SYS & CON TIS (249)	9.7%	42	$5,206,149	5.0%	(0.2%) - 19.6%
OR PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES (415)	0.5%	52	$4,999,786	0.3%	(0.2%) - 1.1%
MAJ SHLD/ELBOW PROC,/OTH UP EXTR PROC W CC (223)	7.2%	34	$4,900,541	4.3%	(1.2%) - 15.6%
KIDNEY&URETER PROC - NEOP (303)	1.5%	74	$4,800,340	1.2%	(0.8%) - 3.9%
TRANSURETHRAL PROSTATECT W/O CC (337)	10.1%	76	$4,775,259	5.8%	(1.2%) - 21.3%
CIRC DISOR W AMI W/O MAJ COMP, DISC ALIVE (122)	2.1%	153	$4,743,058	1.1%	0.0% - 4.3%
ENDO DISOR W CC (300)	3.6%	79	$4,713,106	2.2%	(0.7%) - 7.9%
CORON BYPASS W/O CAR CATH W MAJ CV DX (549)	1.1%	44	$4,360,249	1.1%	(1.0%) - 3.3%
CON TIS DISOR W CC (240)	4.2%	36	$4,359,642	2.4%	(0.6%) - 8.9%
MIN SKIN DISOR W CC (283)	15.7%	32	$4,359,608	8.0%	(0.1%) - 31.4%
TOTAL MASTECTOMY - MALIG W/O CC (258)	12.8%	42	$4,317,031	11.8%	(10.3%) - 36.0%
SEPTICEMIA W MV 96+ HOURS AGE >17 (575)	2.2%	33	$4,195,369	1.7%	(1.2%) - 5.6%
CIRC DISOR W AMI, EXPIRED (123)	1.9%	74	$4,158,396	1.7%	(1.3%) - 5.2%
INTERSTITIAL LUNG DIS W CC (092)	3.8%	47	$3,910,469	2.2%	(0.5%) - 8.1%
INFLAM BOWEL DIS (179)	4.6%	42	$3,876,993	4.0%	(3.2%) - 12.4%
MAJ CAR-VAS PROC W CC (110)	0.3%	192	$3,866,917	0.2%	(0.1%) - 0.6%
SIGNS & SYMP W/O CC (464)	19.0%	32	$3,678,831	8.7%	2.0% - 35.9%
PLEURAL EFFUSION W CC (085)	2.4%	65	$3,678,179	1.2%	0.1% - 4.7%
TRAUM STUPOR & COMA, COMA <1 HR AGE >17 W CC (028)	2.2%	73	$3,636,332	1.6%	(0.8%) - 5.3%
RECTAL RESECT W CC (146)	2.4%	33	$3,539,176	1.8%	(1.2%) - 6.0%
DISOR - LIVER EXC MALIG,CIRR,ALC HEPA W CC (205)	1.5%	106	$3,367,191	1.2%	(1.0%) - 3.9%
TRANSURETHRAL PROSTATECT W CC (336)	3.1%	68	$3,350,508	1.6%	0.1% - 6.2%
REVIS - HIP/KNEE REPLACE (545)	0.6%	159	$3,223,997	0.5%	(0.4%) - 1.6%

CERVICAL SPINAL FUSION W/O CC (520)	2.0%	63	$3,169,430	1.3%	(0.5%) - 4.5%
SPINAL FUSION EXC CERVICAL W/O CC (498)	0.9%	90	$3,016,927	0.5%	(0.2%) - 1.9%
NONTRAUM STUPOR & COMA (023)	6.7%	30	$2,913,347	2.7%	1.4% - 12.0%
CERVICAL SPINAL FUSION W CC (519)	1.3%	40	$2,699,106	1.0%	(0.7%) - 3.3%
MAJ SM & LG BOWEL PROC W/O CC (149)	2.0%	68	$2,696,781	1.9%	(1.8%) - 5.8%
OTITIS MEDIA & URI AGE >17 W CC (068)	5.8%	44	$2,570,365	2.9%	0.2% - 11.3%
SEIZURE AGE >17 W/O CC (563)	14.6%	46	$2,531,122	6.5%	1.8% - 27.4%
ALC/DRUG ABUSE/DEP W/O REHAB THERAPY W/O CC (523)	8.2%	45	$2,402,586	5.4%	(2.3%) - 18.7%
CRANIOTOMY AGE >17 W CC (001)	0.4%	76	$2,293,146	0.4%	(0.4%) - 1.2%
OTH DIG SYS OR PROC W CC (170)	0.6%	52	$2,051,948	0.5%	(0.4%) - 1.6%
MAJ SMALL & LARGE BOWEL PROC W CC W MAJ GI DX (569)	0.4%	174	$1,752,524	0.3%	(0.2%) - 1.1%
UTER & ADNEXA PROC - NON-MALIG W/O CC (359)	1.8%	86	$1,687,249	1.3%	(0.8%) - 4.3%
POSTOPERATIVE/POST-TRAUM INFECT W OR PROC (579)	2.0%	50	$1,627,316	1.2%	(0.4%) - 4.4%
MAJ ESOHP DISOR (571)	7.1%	35	$1,396,767	4.0%	(0.6%) - 14.9%
KIDNEY & URIN TRACT SIGNS & SYMP AGE >17 W CC (325)	4.0%	33	$1,287,933	2.9%	(1.7%) - 9.7%
ACUTE ADJUST REACT & PSYCHOSOC DYSFUNCT (425)	3.6%	41	$1,166,784	2.1%	(0.4%) - 7.7%
PULM EMBOLISM (078)	0.3%	176	$1,142,098	0.2%	(0.1%) - 0.7%
UTER & ADNEXA PROC - NON-MALIG W CC (358)	0.9%	67	$1,121,363	0.6%	(0.2%) - 2.1%
NONSPEC CVA & PRECEREB OCCLUS W/O INFARCT (015)	1.7%	34	$1,120,493	0.9%	(0.1%) - 3.4%
LAPAROSCOPIC CHOLE W/O C.D.E. W/O CC (494)	1.0%	54	$1,101,588	0.6%	(0.3%) - 2.2%
UNKNOWN (475)	0.1%	90	$1,072,236	0.0%	(0.0%) - 0.1%
LOC EXC & REMOV INT FIX DEV EXC HIP & FEMUR W CC (537)	1.1%	35	$1,058,404	0.7%	(0.3%) - 2.4%
OSTEOMYELITIS (238)	1.0%	31	$748,920	0.5%	0.1% - 1.9%
EXTRACRANIAL PROC W CC (533)	0.2%	140	$717,952	0.1%	(0.1%) - 0.5%
APPEND W/O COMPLIC PRINC DIAG W CC (166)	1.7%	30	$714,096	1.0%	(0.3%) - 3.7%
PERITONEAL ADHESIOLYSIS W CC (150)	0.2%	90	$626,279	0.2%	(0.1%) - 0.5%
AMP - MUS-SKEL SYS & CON TIS DISOR (213)	0.6%	30	$587,164	0.3%	(0.0%) - 1.2%
SIMP PNEUM & PLEURISY AGE >17 W/O CC (090)	0.5%	111	$433,994	0.2%	0.1% - 0.9%
AMP - CIRC SYS DISOR EXC UP LIMB & TOE (113)	0.1%	88	$400,441	0.1%	(0.0%) - 0.2%
MAJ MALE PELVIC PROC W CC (334)	0.5%	39	$382,918	0.5%	(0.5%) - 1.6%

LO EXTREM & HUMER PROC EXC HIP,FT,FEMUR AGE >17 W/O CC (219)	0.3%	68	$316,587	0.3%	(0.2%) - 0.9%
EXTRACRANIAL PROC W/O CC (534)	0.2%	119	$298,843	0.2%	(0.1%) - 0.5%
MAJ MALE PELVIC PROC W/O CC (335)	0.4%	46	$280,425	0.3%	(0.2%) - 0.9%
VAGINA, CERVIX & VULVA PROC (360)	0.5%	55	$275,663	0.4%	(0.3%) - 1.2%
TOTAL MASTECTOMY - MALIG W CC (257)	0.1%	41	$76,110	0.1%	(0.0%) - 0.3%
CAR DEFIB IMPL W CAR CATH W/O AMI/HF/SHOCK (536)	0.0%	31	$0	0.0%	0.0% - 0.0%
UTER,ADNEXA PROC - NON-OVAR/ADNEX MALIG W CC (354)	0.0%	30	$0	0.0%	0.0% - 0.0%
MAJ JNT & LIMB REATTACH PROC - UP EXTREM (491)	0.0%	100	$0	0.0%	0.0% - 0.0%
STOM, ESOHP & DUOD PROC AGE >17 W CC W MAJ GI DX (567)	0.0%	30	$0	0.0%	0.0% - 0.0%
LO EXTREM & HUMER PROC EXC HIP,FT,FEMUR AGE >17 W CC (218)	0.0%	101	$0	0.0%	0.0% - 0.0%
CRANIOTOMY AGE >17 W/O CC (002)	0.0%	32	$0	0.0%	0.0% - 0.0%
CAR VALVE & OTH MAJ CAR-THOR PROC W/O CAR CATH (105)	0.0%	136	$0	0.0%	0.0% - 0.0%
CAR VALVE & OTH MAJ CAR-THOR PROC W CAR CATH (104)	0.0%	74	$0	0.0%	0.0% - 0.0%
All HPMP	**4.5%**	**N/A**	**$4,580,640,526**	**0.1%**	**4.2% - 4.8%**

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
Occupational Therapist in Private Practice	21.2%	60	0.0%	88.9%	0.4%	10.8%	0.0%
Infectious Disease	16.4%	208	16.2%	28.4%	0.0%	55.4%	0.0%
Neurosurgery	15.3%	121	51.7%	8.6%	0.0%	39.7%	0.0%
Endocrinology	13.7%	247	4.3%	45.3%	0.0%	50.4%	0.0%
Osteopathic Manipulative Therapy	11.6%	41	0.0%	1.1%	0.0%	98.9%	0.0%
Chiropractic	10.5%	1,232	3.0%	55.3%	22.7%	17.9%	1.0%
Allergy/Immunology	9.8%	152	1.1%	21.7%	5.0%	72.1%	0.0%
Neurology	9.5%	569	1.2%	27.0%	0.6%	71.3%	0.0%
Physical Medicine and Rehabilitation	8.9%	500	7.3%	28.0%	15.1%	49.6%	0.0%
Pulmonary Disease	8.6%	776	4.6%	28.4%	0.9%	63.5%	2.7%
Internal Medicine	8.5%	7,730	12.7%	24.0%	0.8%	62.3%	0.2%
Plastic and Reconstructive Surgery	7.9%	63	0.0%	0.0%	0.0%	100.0%	0.0%
General Practice	7.8%	793	2.8%	23.1%	0.0%	74.2%	0.0%
Gastroenterology	7.5%	772	0.9%	21.0%	0.0%	76.2%	2.0%
Family Practice	7.4%	4,652	7.6%	22.5%	2.4%	63.6%	3.9%
Nephrology	7.2%	649	7.7%	26.9%	0.4%	65.0%	0.0%
Physical Therapist in Private Practice	7.0%	1,088	1.7%	81.5%	2.6%	11.3%	2.8%
Psychiatry	6.2%	738	6.8%	27.5%	0.0%	65.7%	0.0%
Pain Management	6.1%	54	0.0%	17.9%	0.0%	82.1%	0.0%
Otolaryngology	5.9%	493	6.6%	16.0%	1.3%	76.2%	0.0%
Nurse Practitioner	5.7%	815	10.6%	20.2%	0.0%	59.0%	10.2%
General Surgery	5.5%	756	6.1%	16.8%	3.0%	73.2%	1.0%
Emergency Medicine	5.3%	1,121	9.2%	11.2%	0.2%	78.7%	0.7%
Cardiac Surgery	5.0%	55	48.6%	29.2%	0.0%	22.2%	0.0%
Orthopedic Surgery	4.9%	1,233	7.4%	18.4%	0.5%	73.5%	0.3%
Cardiology	4.9%	3,743	18.6%	22.3%	0.0%	57.3%	1.7%
Geriatric Medicine	4.8%	114	20.1%	0.0%	0.0%	79.8%	0.1%
Urology	4.8%	898	15.0%	18.3%	0.1%	66.7%	0.0%
Nuclear Medicine	4.6%	60	0.0%	24.9%	0.0%	68.8%	6.2%
Obstetrics/Gynecology	4.5%	391	4.5%	4.5%	0.0%	90.9%	0.0%
Interventional Pain Management	4.4%	72	0.0%	0.0%	0.0%	100.0%	0.0%
Critical Care (Intensivists)	4.1%	64	0.0%	44.6%	0.0%	55.4%	0.0%
Podiatry	3.7%	1,537	8.9%	18.4%	8.0%	64.7%	0.0%
Colorectal Surgery (formerly proctology)	3.6%	40	28.9%	12.5%	0.0%	58.6%	0.0%
Vascular Surgery	3.5%	171	0.0%	40.7%	0.0%	33.8%	25.5%
Thoracic Surgery	3.2%	52	2.1%	0.0%	0.0%	97.9%	0.0%
Hematology	3.1%	62	0.0%	31.9%	0.0%	68.1%	0.0%
Optometry	2.9%	615	0.0%	22.2%	0.0%	77.8%	0.0%

All Provider Types With Less Than 30 Claims	2.9%	180	0.0%	48.4%	11.3%	32.5%	7.8%
Rheumatology	2.8%	323	1.9%	20.9%	0.0%	76.9%	0.3%
Physician Assistant	2.7%	548	23.0%	29.8%	2.3%	41.0%	4.0%
Clinical Psychologist	2.6%	230	0.9%	0.0%	36.8%	62.3%	0.0%
Radiation Oncology	2.3%	277	1.3%	60.8%	0.7%	37.3%	0.0%
Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)	2.2%	1,024	17.6%	26.8%	39.9%	14.9%	0.9%
Dermatology	2.0%	907	23.7%	9.0%	3.4%	59.4%	4.6%
Ophthalmology	1.9%	1,984	5.9%	54.6%	1.8%	36.0%	1.8%
Pediatric Medicine	1.9%	46	0.0%	0.0%	0.0%	100.0%	0.0%
Multispecialty Clinic or Group Practice	1.8%	48	0.0%	56.5%	0.0%	43.5%	0.0%
Hematology/Oncology	1.7%	886	7.4%	27.6%	1.6%	60.6%	2.7%
Diagnostic Radiology	1.7%	5,246	20.0%	54.3%	3.7%	14.0%	7.9%
Pathology	1.6%	683	65.9%	20.6%	0.0%	13.5%	0.0%
Clinical Social Worker	1.4%	246	55.8%	3.0%	0.0%	41.2%	0.0%
Independent Diagnostic Testing Facility (IDTF)	1.4%	282	62.0%	8.3%	29.6%	0.0%	0.0%
Clinical Laboratory (Billing Independently)	1.1%	4,901	10.1%	30.5%	13.4%	40.9%	5.1%
Anesthesiology	1.1%	690	16.3%	40.2%	0.0%	43.5%	0.0%
Medical Oncology	1.1%	332	2.0%	34.5%	16.4%	47.1%	0.0%
Portable X-Ray Supplier (Billing Independently)	0.6%	211	0.0%	97.3%	0.0%	2.7%	0.0%
Clinical Nurse Specialist	0.4%	50	0.0%	0.0%	0.0%	100.0%	0.0%
Certified Registered Nurse Anesthetist (CRNA)	0.3%	313	0.0%	80.8%	0.0%	3.5%	15.7%
Ambulatory Surgical Center	0.0%	269	N/A	N/A	N/A	N/A	N/A
Interventional Radiology	0.0%	142	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%	185	N/A	N/A	N/A	N/A	N/A
Public Health or Welfare Agencies (Federal, State, and local)	0.0%	100	N/A	N/A	N/A	N/A	N/A
All Provider Types	**4.5%**	**52,778**	**10.7%**	**27.0%**	**3.1%**	**57.7%**	**1.5%**

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
Medical supply company not included in 51, 52, or 53	11.7%	3,721	37.5%	0.8%	54.0%	2.4%	5.3%
All Provider Types With Less Than 30 Claims	9.1%	205	1.0%	11.8%	76.2%	0.4%	10.5%
Pharmacy	8.7%	4,701	16.0%	1.9%	66.6%	12.2%	3.3%
Ophthalmology	8.3%	41	29.7%	0.0%	70.3%	0.0%	0.0%
Podiatry	7.2%	78	27.1%	18.4%	47.0%	7.5%	0.0%
Orthopedic Surgery	7.0%	63	0.0%	7.7%	92.3%	0.0%	0.0%
Optometry	6.3%	46	0.0%	0.0%	0.0%	39.0%	61.0%
Medical Supply Company with Respiratory Therapist	5.7%	1,251	14.7%	0.0%	81.6%	3.6%	0.1%
Individual orthotic personnel certified by an accrediting organization	4.4%	78	0.0%	0.0%	74.2%	25.8%	0.0%
Unknown Supplier/Provider	4.2%	103	3.1%	0.0%	91.5%	5.4%	0.0%
Medical supply company with orthotic personnel certified by an accrediting organization	3.8%	76	0.0%	30.9%	56.7%	12.4%	0.0%
Individual prosthetic personnel certified by an accrediting organization	0.0%	42	N/A	N/A	N/A	N/A	N/A
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	0.0%	71	N/A	N/A	N/A	N/A	N/A
All Provider Types	**9.0%**	**10,476**	**26.9%**	**1.9%**	**60.6%**	**6.3%**	**4.3%**

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
SNF	1.9%	2,578	1.4%	19.4%	4.6%	56.2%	18.4%
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	1.7%	39,930	8.7%	47.2%	8.8%	31.7%	3.6%
FQHC	1.6%	589	30.8%	69.2%	0.0%	0.0%	0.0%
Other FI Service Types	1.5%	6,578	12.1%	44.5%	20.8%	20.1%	2.6%
HHA	1.4%	1,918	0.0%	19.7%	46.3%	34.0%	0.0%
ESRD	1.2%	1,279	0.9%	49.5%	23.3%	26.3%	0.1%
Hospice	0.7%	960	12.5%	0.5%	39.6%	30.0%	17.4%
Non-PPS Hospital In-patient	0.7%	2,563	4.4%	23.7%	9.6%	58.7%	3.7%
RHCs	0.5%	3,041	43.0%	40.6%	0.0%	0.0%	16.4%
Free Standing Ambulatory Surgery	0.2%	107	1.2%	89.2%	0.0%	9.6%	0.0%
All Provider Types	**1.5%**	**59,543**	**4.9%**	**31.2%**	**16.2%**	**39.5%**	**8.3%**