

# Medicare Fee-For-Service 2013 Improper Payments Report

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## EXECUTIVE SUMMARY

### 89.9 Percent Compliance Rate

The estimated 2013<sup>1</sup> Medicare fee-for-service (FFS) compliance rate – the percentage of Medicare dollars paid correctly – was 89.9 percent. This calculation included claims submitted during the 12-month period from July 2011 through June 2012. This means that Medicare paid an estimated \$321.4 billion correctly during this time.

### 10.1 Percent Improper Payment Rate

The estimated 2013 Medicare FFS improper payment rate – the percentage of Medicare dollars paid incorrectly - was 10.1 percent. This means that Medicare paid an estimated \$36.0 billion incorrectly between July 2011 and June 2012. For 2013, CMS adjusted the improper payment rate by 0.6 percent (\$2.2 billion) from 10.7 percent to 10.1 percent to account for the effect of rebilling inpatient hospital claims denied under Medicare Part A. The methodology for calculating the 2013 FFS improper payment rate was unchanged from 2012.

### Common Causes of Improper Payments

The most common cause of improper payments during the 2013 report period (accounting for 56.8 percent of total improper payments) was lack of documentation to support the services or supplies billed to Medicare.

The service types driving the 2013 improper payment rate were home health, hospital outpatient, skilled nursing facility, physician/lab/ambulance, durable medical equipment prosthetics orthotics and supplies (DMEPOS),and inpatient hospital services.

### The Medicare Fee-For-Service Improper Payments Report

This report supplements information in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 requires

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<sup>1</sup> The 2013 Medicare FFS improper payment rate is published in the Fiscal Year (FY) 2013 HHS Agency Financial Report. However, the time period from which the sample of Medicare FFS claims was selected does not correspond with the FY due to practical constraints with the claims review and rate calculation methodologies. The federal FY runs from October to September.

improper payment reporting in the HHS AFR. The improper payment rate calculation complies with the requirements of Office of Management and Budget (OMB) Circular A-123, Appendix C.

This report describes improper payments made during the 2013 report period, the major causes of improper payments, and actions the Centers for Medicare & Medicaid Services (CMS) is taking to reduce improper payments in the future. This report is also supported by the *Supplementary Appendices for the Medicare Fee-for-Service 2013 Improper Payment Rate Report*, which is available on CMS website: [www.cms.gov/cert](http://www.cms.gov/cert). Table 1 summarizes the 2013 improper payment rates by claim type.

Table 1: 2013 Improper Payment Rates and Projected<sup>2</sup> Improper Payments by Claim Type  
(Dollars in Billions)<sup>3</sup>

Claim Type	Total Payment	Projected Improper Payment	Improper Payment Rate	95% Confidence Interval
Part A (Total)	\$257.4	\$20.9	8.1%	7.5% - 8.7%
Part A (Excluding Inpatient Hospital PPS)	\$140.0	\$11.4	8.2%	7.2% - 9.1%
Part A (Inpatient Hospital PPS) <sup>4</sup>	\$117.4	\$9.4	8.0%	7.3% - 8.8%
Part B	\$90.3	\$9.5	10.5%	9.5% - 11.5%
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	\$9.7	\$5.7	58.2%	54.9% - 61.5%
<b>Overall</b>	<b>\$357.4</b>	<b>\$36.0</b>	<b>10.1%<sup>5</sup></b>	<b>9.5% - 10.7%</b>

<sup>2</sup> Projected amounts are based on the sample of claims actually reviewed.

<sup>3</sup> Some columns and/or rows may not sum correctly due to rounding.

<sup>4</sup> Adjusted for Medicare Part A to Part B rebilling of denied inpatient hospital claims.

<sup>5</sup> Adjusted for Medicare Part A to Part B rebilling of denied inpatient hospital claims.

## Disclaimers

All information provided in this report is for information purposes only. This report does not constitute official CMS guidance, nor is it a substitute for the referenced statute or Medicare coverage, coding and billing rules.

Categories of improper payments in this report do not correspond exactly to categories (i.e., by DRG, BETOS code or HCPCS code) reported in the more detailed *Supplementary Appendices for the Medicare Fee-for-Service 2013 Improper Payment Rate Report*.

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## The Medicare FFS Program

### Features of the Medicare FFS Program

The CMS calculates the Medicare FFS improper payment rates for four major claim types:

- Part A Inpatient Hospital;
- Part A Excluding Inpatient Hospital (including skilled nursing facility stays, home health , and hospital outpatient services);
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and
- Part B Excluding DMEPOS (including physician, laboratory, and ambulance services).

### The Claim Payment Function in the Medicare Fee-for-Service Program

Providers and suppliers submit claims to their respective Medicare Administrative Contractors (MACs) for Medicare FFS payment as follows:

**Table 2: Flow of Claims through the Medicare Claim Payment Entities**

<b>CMS established the following program...</b>	<b>...that monitors payment decisions made by...</b>	<b>...for claims submitted by...</b>	<b>...which accounts for the following portion of Medicare FFS benefit payments.<sup>6</sup></b>
Comprehensive Error Rate Testing Program (CERT)	A/B MACs	Part A Inpatient Hospitals	25%
		Part A Excluding Inpatient Hospitals	18%
		Part B Excluding DMEPOS	15%
	DME MACs	DMEPOS Suppliers	2%

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<sup>6</sup> The other 40 percent of claims are for non-FFS payments.

MACs are responsible for preventing improper Medicare FFS payments through their claims payment decisions and processes. The primary goal of each MAC is to pay the correct amount for covered, medically necessary, and correctly coded services. The MACs processed and paid more than 1.2 billion claims in calendar year 2012<sup>7</sup>.

The MACs and other Medicare review contractors perform two main types of claim reviews:

- **Non-Complex Medical Review:** The Medicare review contractor makes a claim determination without clinical review of medical documentation submitted by the provider. This includes a review that requires some form of human intervention to verify claim information, and a review that is automated (i.e., done by computer) and does not require human intervention. This type of review is used more frequently than complex medical review because of the large number of claims that the MACs must process every year.
- **Complex Medical Review:** The Medicare review contractor makes a claim determination after reviewing additional documentation associated with the claim. These reviews can be performed only by medical reviewers with appropriate professional credentials, such as licensed nurses and other licensed health care professionals. The MACs cannot manually review every claim that is submitted because of the large number of claims that the MACs must process.

The MACs use improper payment data analysis to determine which claims will undergo any type of review on either a pre-payment or post-payment basis. Improper payment data analysis also guides MAC corrective actions and educational efforts.

## **Improper Payment Measurement in the Medicare FFS Program**

### **Statutory Background**

The IPIA of 2002, as amended by the IPERA of 2010 requires federal agencies, including HHS, to review the programs they administer for improper payments every year. An improper payment is any payment made:

- In error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;

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<sup>7</sup> [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2013\\_final.pdf#tablev2](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf#tablev2)

- To an ineligible recipient;
- For ineligible goods or services;
- For goods or services not received (except for such payments where authorized by law);
- That duplicates a payment; or
- That does not account for credit for applicable discounts.

The IPIA also requires the HHS to:

- Identify programs that may be susceptible to significant improper payments,
- Estimate the amount of improper payments in those programs,
- Submit the estimates to Congress, and
- Report publicly the estimate and actions HHS is taking to reduce improper payments.

## **The Comprehensive Error Rate Testing Program**

### **CERT Program Objectives**

The objective of the CERT program is to calculate the Medicare FFS program improper payment rate. The CERT program considers any payment that should not have been made or that was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment.

It is important to note that the improper payment rate does not measure fraud. It estimates the payments that did not meet Medicare coverage, coding and billing rules.

### **Calculation of the Medicare FFS Improper Payment Rate**

#### **1. Claims Selection**

The first step in the CERT process is the selection of a stratified random sample of Medicare claims. Stratification ensures that the sample is representative of the population of claims submitted for Medicare payment. A portion of the claims sampled for the 2013 report period was unreviewable because the claim adjudication process was incomplete (e.g., the MAC returned the claim to the provider or supplier) (see Table 2 below). The final CERT sample is comprised of claims paid or denied by the MAC. This sampling methodology complies with all statutory requirements and OMB guidance.

**Table 3: Claim Counts by Type for the November 2013 Report Period**

<b>Claim Type</b>	<b>Claims Sampled</b>	<b>Claims Reviewed</b>
Part A (Excluding Inpatient Hospital PPS)	8,297	7,596
Part A (Inpatient Hospital PPS)	16,230	12,297
Part B (Excluding DMEPOS)	17,662	17,130
DMEPOS	11,547	11,204
<b>Total</b>	<b>53,736</b>	<b>48,227</b>

## 2. Medical Record Requests

After the CERT program identifies a claim as part of the sample, it requests the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim via letter. CERT makes phone calls to validate the provider's or supplier's contact information and to address their questions or concerns about the request. The CERT program sends at least three subsequent letters if the provider or supplier fails to respond to the initial request. For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), in addition to the initial request sent to the billing provider and supplier, the referring provider who ordered the item or service also receives a request for documentation. This is done because sometimes the referring provider maintains the documentation to support the medical necessity of the services billed.

If the CERT program receives no documentation within 75 days of the initial request, the claim is scored as an improper payment due to a "no documentation error" (explained below). However, the CERT program reviews late documentation that is received after the 75 days and this review will be counted in the final improper payment rate calculation if it is received in time for the final calculations to be made. The CERT program tracks improper payment determination reversals based upon the receipt of late documentation, even if they occur after the cutoff date for the official improper payment rate calculation.

## 3. Review of Claims and Assignment of Error Categories

Medical review professionals review the claim and submitted documentation to make a determination of whether the claim was paid or denied appropriately. These review professionals include nurses, medical doctors, and certified coders. Before reviewing documentation, the CERT program examines the CMS claims systems to check for (1) Medicare beneficiary eligibility, (2) duplicate claims, and (3) Medicare as the primary insurer. When

performing claim reviews, the CERT program checks for compliance with Medicare statutes and regulations, billing instructions, National Coverage Determinations (NCDs),<sup>8</sup> Local Coverage Determinations (LCDs),<sup>9</sup> and provisions in CMS instructional manuals.

The reason for the improper payment determines the error category for the claim. There are five major error categories.

### **No Documentation**

Claims are placed into this category when either the provider or supplier fails to respond to repeated requests for the medical records or the provider or supplier responds that they do not have the requested documentation.

### **Insufficient Documentation**

Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the CERT contractor reviewers could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

### **Medical Necessity**

Claims are placed into this category when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies.

### **Incorrect Coding**

Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other

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<sup>8</sup> An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. All MACs are required to follow NCDs. If an NCD does not specifically exclude or limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the MAC to make a local coverage decision (LCD).

<sup>9</sup> An LCD is a decision by the MAC to cover or non-cover a particular service, procedure or technology on a contractor-wide basis in accordance with the Social Security Act section 1862(a)(1)(A), which describes the reasonable and necessary conditions of coverage.

than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.

## **Other**

Claims are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service).

### 4. Tracking Appeals

Providers and suppliers have the right to appeal any improper payment determination made by the CERT program. There are five levels of appeals for the Medicare FFS claims, starting at the MAC level for redeterminations through federal court. CERT program claims are generally appealed to the first three levels: (1) redeterminations at the MAC level; (2) reconsiderations at the Qualified Independent Contractor (QIC) level; and (3) administrative hearings by Federal Administrative Law Judges (ALJs).<sup>10</sup>

Final appeal decisions figure into the calculation of the Medicare FFS improper payment rate.<sup>11</sup> The CERT program tracks appeals throughout all levels. The improper payment rate reported in the HHS AFR incorporates the most recent payment information as of the official cutoff date. The CERT program also tracks claim determination reversals based on late documentation.

### 5. Determining the Improper Payment Rate

Each MAC's contribution to the overall improper payment rate is proportional to their share of total Medicare payments. The CERT program projects the sample to the universe statistically. These calculations meet the national precision of 2.5 percentage points and 90 percent confidence as required by the IPIA of 2002. These calculations also achieve 3-percentage point precision and 95 percent confidence for contractor-specific rates<sup>12</sup>.

### 6. Reporting the Results

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<sup>10</sup> A small number of claims go beyond these first three levels. The fourth level of appeal consists of a claims review by the HHS Departmental Appeals Board, while the fifth level of appeal is a judicial review by a federal district court. Judicial review by a federal district court is only for claims that are greater than a specified dollar amount.

<sup>11</sup> Common reasons for the reversal of claim denials on appeal include the acquisition of additional supporting documentation by the appeal entities and expert (third party) testimony establishing that the denied services were reasonable and necessary.

<sup>12</sup> OMB issued guidance for IPIA of 2002 implementation requirements, including attaining statistical validity, through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011.

The claims universe includes all claims that have undergone final adjudication by the MACs, regardless of the final decision (i.e., the decision to pay, reduce, or deny the claim). Therefore, the improper payment rate includes both overpayments (improper claim approvals) and underpayments (improper claim denials).

Net improper payments equal the overpayments less the absolute value of underpayments. The net improper payment rate equals the net improper payments in the CERT sample divided by the total dollars paid in the CERT sample. This rate shows the net impact of overpayments on the Medicare Trust Funds.

Gross improper payments equal overpayments plus the absolute value of underpayments. The gross improper payment rate equals the gross improper payments in the CERT sample divided by the total dollars paid in the CERT sample. This rate shows the impact of both overpayments and underpayments on the Medicare Trust Funds. The official improper payment rate is the gross improper payment rate.

## 7. Reconciliation of Improper Payments

The CERT program notifies the MACs of improper payments identified through the CERT process. The MACs then reimburse underpayments and recoup overpayments. MACs can recover the overpayments identified in the CERT sample but cannot recoup projections made to the claims universe.<sup>13</sup>

MACs recover most of the overpayments identified, on sampled claims, by the CERT program. MACs cannot recover projected overpayments. Overpayments during the 2013 report period were \$40,000,013 and, as of the publication date of the HHS AFR, actual MAC collections for these overpayments were \$33,196,339 (or 83 percent). MACs do not collect overpayments if they cannot locate providers or suppliers who have gone out of business. MACs also do not collect overpayments when a claim decision is overturned on appeal. When active Medicare providers or suppliers fail to respond to requests for repayment and do not appeal, MACs may recoup overpayments by offsetting future payments.

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<sup>13</sup> For example, if a hospital submits an erroneous claim that leads to an overpayment, the MAC can only collect the amount due for that particular claim. The MAC cannot use this claim denial to extrapolate and collect the estimated amount of overall overpayments that hospital may have submitted during the report period.

## ANALYSIS AND SUMMARY OF RESULTS

All rates and amounts in the detailed analysis are unadjusted.

### Part A Drivers of the Medicare FFS Improper Payment Rate

#### Inpatient Hospital Services

The Hospital Inpatient Prospective Payment System (IPPS) covers Part A inpatient hospital claims. The IPPS reimburses hospitals based upon the procedures performed, the severity of the beneficiary's condition, and other factors. Hospitals must meet all documentation requirements specified in Medicare policy to receive Medicare payment for an inpatient hospital stay.

The 2013 improper payment rate for inpatient hospital services was 8.0 percent, accounting for 24.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for inpatient hospital services during the 2013 report period was \$9.4 billion (adjusted for A/B rebilling).

The 2013 inpatient hospital improper payment rate and amount are adjusted. This adjustment, called the Part A to B rebilling adjustment, accounts for the difference between the improper inpatient payment made under Medicare Part A and the amount that would have been payable if the hospital claim was rebilled as a Medicare Part B claim. The Part A to B rebilling adjustment only applies to the overall improper payment rate for Part A inpatient services and not to procedure-specific rates.<sup>14</sup>

The CERT program identified many improper payments due to inpatient hospital incorrect status errors. Incorrect status errors occur when the physician admits a Medicare beneficiary as inpatient when the medical record supports the provision of care in an outpatient or other non-hospital based setting.<sup>15</sup> The CERT program categorizes these situations as "medical necessity

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<sup>14</sup> For this report and for the 2012 Medicare FFS Improper Payments Report, the A/B rebilling adjustment factor was calculated by selecting a random sub-sample of Part A inpatient claims selected by the CERT program and repricing the individual services provided under Part B. Because this repricing process was not applied to all of the Part A inpatient claims selected by the CERT program, the A/B rebilling adjustment factor could only be applied to the high-level calculations (i.e., the overall, Part A Total, and Part A Inpatient Hospital Service improper payment rates).

<sup>15</sup> CMS implemented two major policies pertaining to inpatient hospital claims that are expected to reduce improper payments:

- CMS issued an interim measure, CMS Ruling 1455-R (78 FR 16614, issued on March 13, 2013), which ended the demonstration project that allowed hospital participants to bill for inpatient Part B claims when their Part A claim that was denied as not reasonable and necessary, and expanded this concept to all hospitals. Proposed Rule 1455-P (78 FR 16632, issued on March 13, 2013), as finalized in 1599-F (78 FR 50495, issued on August 2, 2013), permitted inpatient Part B billing within one year from the date of

errors.” The CERT program denied 1,975 claims for this reason during the 2013 report period. These sampled errors totaled \$21.8 million in actual overpayments, which projected to \$7.6 billion in overpayments for the universe of Medicare FFS claims (not adjusted for Part A to B rebilling).

Incorrect status errors are more likely to occur when the length of stay is shorter. Particularly, elective surgical procedures cause many incorrect status errors. In these cases, the beneficiary is typically admitted as an inpatient after the procedure is completed for post-operative overnight monitoring, and discharged the next day. There was typically no need for the beneficiary to be admitted as an inpatient for post-procedure monitoring even if the procedure itself was reasonable and necessary. Generally, billing an outpatient claim for these services is appropriate in this situation.

### **Example**

The beneficiary went to the emergency room with left sided arm and leg weakness that started that morning. The physical examination and vital signs were normal. A computed tomography (CT) scan of the head showed that the beneficiary did not have a stroke. The treating physician learned that the beneficiary recently stopped taking his anti-anxiety medication. The beneficiary developed nervousness and anxiety during the 48 hours prior to admission. When the beneficiary took his medication, the symptoms subsided. Outpatient services are appropriate in this situation. The CERT program scored this claim as an improper payment due to a “medical necessity error.”

### **Joint Replacements**

Medicare covers medically necessary major joint replacements and the inpatient hospital services related to these procedures. The improper payment rate for major joint replacements was 5.8 percent, accounting for 0.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for major joint replacements during the 2013 report period was \$353 million (without the Part A to B rebilling adjustment). Extensive provider education efforts resulted in improved compliance with documentation requirements and reduced the improper payment rate for joint replacements from 12.6 percent (\$732 million) in 2012 (without the Part A to B rebilling adjustment).

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service. The final rule 1599-F became effective on October 1, 2013. This will affect claims reviewed for the 2015 Medicare FFS Improper Payments Report.

- Final rule 1599-F (78 FR 50495) also clarified and modified HHS policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A and how Medicare review contractors will assess inpatient hospital claims for payment purposes.

“Medical necessity errors” accounted for the majority of these improper payments, meaning that the records submitted did not support that the major joint replacement was reasonable and necessary. Information considered when making a medical necessity determination includes, but is not limited to:

- Descriptions of the pain (onset, duration, character, aggravating and relieving factors);
- Limitations of activities of daily living;
- Safety issues, such as falls;
- Contraindications to non-surgical treatments;
- Descriptions of failed non-surgical treatments (e.g., medications, weight loss, physical therapy, intra-articular injections, braces, orthotics, assistive devices);
- Physical exam findings (e.g., joint deformity, reduced range of motion, crepitus, effusions, tenderness, gait disturbances);
- Results of tests, such as x-rays; and
- Reasons for deviating from a stepped care approach of conservative treatment directly to surgical intervention

### **Example**

A physician admitted a beneficiary to the hospital for knee replacement surgery. The medical reviewers received adequate documentation from the medical records to make an informed decision that the surgery was not medically necessary based upon Medicare coverage policies. Specifically, the medical record did not show limitation of beneficiary’s activities of daily living. Findings of the physical examination of the knee, and information regarding the use of prior conservative treatment modalities (e.g., such as medications, therapy, joint support, or reason why such treatments were not appropriate) did not support advanced joint disease. The CERT program scored the claim as an improper payment due to a “medical necessity error.”

### **Cardiovascular Stents**

Stents (i.e., tiny tubes) are placed in narrowed arteries to improve blood flow, such as in the arteries that supply the heart muscle. The improper payment rate for cardiovascular stent placement procedures was 18.5 percent, accounting for 1.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for cardiovascular stent placement procedures during the 2013 report period was \$511 million (without the Part A to B rebilling adjustment).

These are minimally invasive procedures that are generally safely performed on an outpatient basis. The majority of the improper payments identified for cardiovascular stents are medical necessity errors because the services were provided on an inpatient rather than outpatient basis. Although the placement of the cardiovascular stent was medically necessary, under Medicare coverage guidelines it is generally an outpatient procedure.

## Example

A physician admitted a beneficiary as an inpatient for an elective stent placement. The risk of complications was low and she experienced no complications during or after the procedure. She stayed overnight for monitoring and was discharged the following morning. The submitted documentation did not support that an inpatient admission was medically necessary. This inpatient claim should have been submitted as an outpatient claim. The CERT program scored the claim as an improper payment due to a “medical necessity error.”

## Cardiac Pacemakers

Cardiac pacemakers are battery-operated devices that send electrical pulses to the heart. A pacemaker helps monitor and control a person’s heartbeat. The improper payment rate for services related to cardiac pacemakers was 35.1 percent, accounting for 1.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for services related to pacemakers during the 2013 report period was \$427.4 million (without the Part A to B rebilling adjustment).

Medicare has specific coverage criteria that provide the medical reasons for which Medicare will pay for a single-chamber or a dual-chamber pacemaker implantation.<sup>16</sup> The majority of the improper payments identified for cardiac pacemaker-related services were medical necessity errors. Most of these medical necessity errors occurred when Medicare covered a single-chamber pacemaker but the beneficiary received a dual-chamber pacemaker.

## Example

A beneficiary underwent placement of a dual-chamber pacemaker during a medically necessary inpatient admission. The provider submitted a heart catheterization report to support the medical necessity of the dual-chamber pacemaker. The report showed no indication for a dual-chamber pacemaker under Medicare coverage criteria. Therefore, the CERT program removed the procedure code and revised the diagnosis-related group (DRG).<sup>17</sup> The CERT program scored the

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<sup>16</sup>For updated coverage information see the Decision Memo for Cardiac PACEMAKERS: Single-Chamber and Dual-Chamber Permanent Cardiac PACEMAKERS (CAG-00063R3) dated August 13, 2013; retrieved from <http://www.cms.gov/medicare-coverage-database/details/ncd-details> on 12/04/2013.

<sup>17</sup> Section 1886(d) of the Social Security Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

claim as an improper payment due to a “medical necessity error.” The improper payment is the difference between the amount allowed under the original DRG and the amount allowed under the recalculated DRG.

## **Acute Psychiatric Care**

The Medicare Inpatient Psychiatric Facility (IPF) benefit provides for inpatient psychiatric treatment for beneficiaries in psychiatric hospitals, distinct psychiatric units of acute care hospitals, and critical access hospitals. The improper payment rate for acute psychiatric care services was 14.4 percent, accounting for 1.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for acute psychiatric care services during the 2013 report period was \$511.6 million.

The medical record for an IPF claim must contain physician certification and recertification statements. The certification must state that inpatient psychiatric services are required:

- For treatment where there is a reasonable expectation of improvement in the beneficiary’s condition, or
- For diagnostic study.

If the beneficiary continues to require active inpatient psychiatric treatment, a physician must then recertify as of the 12<sup>th</sup> day of hospitalization that the services were and continue to be required for treatment that could reasonably be expected to improve the patient’s condition, or for diagnostic study, and that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel. Subsequent recertifications are required at intervals to be determined by the institution’s Utilization Review committee, but no less frequently than every thirty days.

These statements must be in the medical record within specific timeframes. These statements are often missing from the medical record.

## **Example**

A psychiatric hospital admitted a beneficiary for acute psychiatric care for schizoaffective disorder, bipolar disorder, and alcohol induced dementia. The medical record did not contain the certification or recertification statements. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

## **Skilled Nursing Facility**

The Medicare skilled nursing facility (SNF) benefit pays for certain skilled services provided in various skilled nursing settings, including swing-bed hospitals, nursing homes, and other freestanding facilities. Covered SNF services require the skills of qualified technical or professional health personnel. The SNF benefit does not cover custodial services alone, such as assistance with bathing, dressing, and using the bathroom. The improper payment rate for SNF

services was 7.5 percent, accounting for 6.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2013 report period was \$2.6 billion.

The majority of improper payments for SNF services were due to insufficient documentation. Providers of SNF services are required to submit medical records to support the medical necessity of SNF services provided. For example, required documents may include:

- A certification that the beneficiary needed daily skilled care that could only be provided in a SNF setting;
- A plan of care; and
- The time (in minutes) for each therapy service provided

### **Example**

A SNF submitted a claim for skilled services provided to a beneficiary. The SNF admission was after a seven day acute inpatient hospital admission for pneumonia. Documentation submitted to support the SNF claim included SNF admission orders; SNF History & Physical; SNF physician notes; nursing records; records from the prior acute inpatient admission; and physical therapy and occupational therapy initial evaluations, plans of care and treatment logs. The submitted documents did not contain a certification statement by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The submitted physician notes and orders were insufficient to show that the beneficiary met the SNF level of care requirements. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

### **Example**

A SNF submitted a claim for skilled services provided to a beneficiary. The SNF billed the claim based on the beneficiary receiving 12 hours of therapy per week by at least two therapy disciplines. The submitted documentation supported that the beneficiary was receiving only speech therapy for two hours per week. The claim was re-coded based on the submitted documentation. The CERT program scored the claim as an improper payment due to an “incorrect coding error.”

## Home Health Services

The Medicare FFS home health benefit pays for certain health care services in the home setting that meet all rules including the reasonable and necessary criteria. Covered services can include:

- Skilled nursing care;
- Medical-social services;
- Medical supplies; and
- Physical, occupational, and speech-language therapies

The improper payment rate for home health services was 17.3 percent, accounting for 8.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during the 2013 report period was \$3.1 billion.

Coverage of home health services depends on factors such as the “confined to home” status of the beneficiary and an intermittent need for skilled care. Some examples of required documentation to support home health services include, but are not limited to:

- Physician certification/recertification of “confined to home” status and the need for home health services;
- Face-to-face encounter documentation;
- Therapy notes; and
- A comprehensive assessment of the home care recipient

Insufficient documentation caused a large proportion of improper payments for home health service. Face-to-face encounter documentation that does not meet guidelines was the most common reason for insufficient documentation errors.

### Example

A home health agency submitted a claim for home physical therapy, home occupational therapy, and home health aide services. Documentation submitted to support the claim included the physician’s signed plan of care, face-to-face encounter documents, a comprehensive assessment of the beneficiary, and copies of all therapy and home health aide notes. The submitted face-to-face encounter documentation stated only “unsteady gait” and “taxing effort.” The face-to-face encounter documentation did not meet the requirements of a narrative statement. Medicare policy requires that the narrative statement specifically describe how the patient’s clinical condition supports the beneficiary’s confined to home status and need for skilled services. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

### Example

A home health agency submitted a claim for home health skilled nursing visits. The submitted documentation included the home health certification and plan of care. These documents must

indicate the type of services ordered and the frequency of the services. The submitted documentation did not specify the need for skilled nursing or the frequency of the nursing visits. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

## **Inpatient Rehabilitation Facility**

The Medicare Inpatient Rehabilitation Facility (IRF) benefit provides intensive rehabilitation therapy in an inpatient environment. The IRF benefit is for a beneficiary who requires and can benefit from an inpatient stay and an interdisciplinary approach to rehabilitation care.

The improper payment rate for IRFs is 17.2 percent, accounting for 2.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for IRFs during the FY 2013 report period is \$850.1 million. Most of the improper payments for IRFs are due to insufficient documentation.

IRF coverage depends on factors such as multiple ongoing therapy disciplines, participation in intensive therapy (usually three hours per day at least five days per week), and supervision by a rehabilitation physician. Required documentation elements for an IRF claim include, but are not limited to:

- Preadmission screening;
- Post-admission physician evaluation;
- Individualized plan of care;
- Admission orders; and
- A comprehensive assessment

## **Example**

An IRF submitted a claim for services provided to a beneficiary. The IRF admission was for two weeks of intensive therapy following hip replacement surgery. Documentation submitted to support the claim included the admission orders, physician progress notes, admission history and physical, hospital discharge summary and comprehensive assessment. There was no documentation of the pre-admission screening, post-admission physician evaluation, or the individualized plan of care. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

## **Non-Hospital-Based Hospice**

Hospice care is a Medicare FFS elected benefit for Part A beneficiaries. Covered hospice services for the palliation and management of the terminal illness and related conditions include, but are not limited to:

- Hospice physician services;
- Nursing care;

- Drugs for symptom control and pain relief;
- Medical equipment and supplies;
- Grief and loss counseling for the beneficiary and his or her family; and
- Physical, occupational, and speech-language therapies

The improper payment rate for hospice services was 8.3 percent, accounting for 2.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for hospice services during the 2013 report period was \$1.0 billion. Most of the improper payments for hospice claims were due to insufficient documentation.

A physician must certify a beneficiary as terminally ill to receive the hospice benefit. The first period of hospice coverage, requires two such certifications - one from the medical director of the hospice or the physician member of the hospice interdisciplinary group and one from the beneficiary's attending physician (if the beneficiary has an attending physician). The written certification must include:

- Certification that the beneficiary is terminally ill with a prognosis of six months or less if the terminal illness runs its normal course;
- Clinical findings and other documentation that support a life expectancy of six months or less;
- A brief narrative explanation of the clinical findings, composed by the physician, that supports a life expectancy of six months or less;
- The signature of the physician and the date the certification was signed; and
- The benefit period dates to which the certification applies.

For subsequent benefit periods, either the medical director of the hospice, the physician member of the hospice interdisciplinary group or the beneficiary's attending physician can complete the recertification. To qualify for a third benefit period, a beneficiary must have a face-to-face encounter with a hospice physician or hospice nurse practitioner. For most claims with insufficient documentation, the submitted certification or recertification did not adequately address the requirements listed above.

### **Example**

A nursing facility submitted a claim for hospice services provided to a beneficiary. Documents submitted to support the claim included the election of the hospice benefit, hospice orders, plan of care, physician visit notes, nursing and interdisciplinary group visit notes, and the certification of terminal illness by the hospice medical director and the attending physician. The attending physician's certification of terminal illness was missing the benefit period and dates covered. The benefit period dates are a requirement of the certification. The CERT program scored this claim an improper payment due to an "insufficient documentation error."

## Clinic End-Stage Renal Disease Services

Medicare provides End-Stage Renal Disease (ESRD) benefits for all renal dialysis services for outpatient maintenance dialysis when a Medicare certified ESRD facility or a special purpose dialysis facility provides the services. The most common elements of dialysis treatment are:

- Laboratory tests;
- Drugs;
- Equipment and supplies; and
- Services provided by registered nurses, licensed practical nurses, technicians, social workers, and dietitians

The improper payment rate for ESRD services was 7.8 percent, accounting for 2.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for ESRD services during the 2013 report period was \$813.5 million.

The majority of improper payments for ESRD services were due to insufficient documentation errors. Providers of ESRD services are required to submit documentation to support the medical necessity of ESRD services provided. For example, required documents include:

- An authenticated plan of care;
- Orders for dialysis, medications, and laboratory tests; and
- Medication administration records

### Example

An ESRD facility submitted a claim for one month of dialysis services for a beneficiary. Documents submitted to support the claim included dialysis treatment notes, plan of care, interdisciplinary team notes, lab results, medication algorithms and provider clinic notes. The submitted documentation did not include the physician's orders for dialysis and medications. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

## Hospital Outpatient Services

Medicare FFS Part A provides coverage for some services provided in the outpatient hospital setting. Covered services can include:

- Medication administration;
- Laboratory and diagnostic testing;
- Therapy services

The improper payment for outpatient services was 5.3 percent, accounting for 6.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for outpatient services during the 2013 report period was \$2.4 billion.

The majority of improper payments for outpatient services were due to insufficient documentation errors. Many hospital outpatient claims with insufficient documentation lacked a physician's order or documentation supporting the physician's intent to order laboratory or diagnostic tests.

### **Example**

A provider submitted a claim for outpatient chemotherapy administration for a beneficiary. Documentation submitted to support the claim included the physician's progress note that supported the medical necessity and intent to proceed with the chemotherapy administration. The submitted documents lacked specific chemotherapy orders (i.e., dosage and infusion time), and the medication administration records. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

## **Part B Drivers of the Medicare FFS Improper Payment Rate**

### **DMEPOS**

DMEPOS is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Medicare provides coverage for medically necessary DMEPOS items under the Part B benefit. Medicare pays for DMEPOS items only if the beneficiary's medical record contains sufficient documentation of the patient's medical condition to support the need for the type or quantity of items ordered. In addition, all documentation requirements outlined in Medicare policies must be present for the claim to be paid.

The improper payment rate for DMEPOS was 58.2 percent, accounting for 14.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for DMEPOS during the 2013 report period was \$5.7 billion. Insufficient documentation errors caused the vast majority (94.8 percent) of improper payments for DMEPOS. In these cases, the supplier or provider did not submit a complete medical record or the record did not adequately support the supplies or services billed. Other insufficient documentation errors were found when the medical record lacked required documentation elements such as a documented face-to-face physician evaluation within a specified timeframe or a physician signature on a supplier form.

Documentation created by the DMEPOS supplier alone is insufficient for payment of the claim under Medicare requirements. It is often difficult to obtain proper documentation for DMEPOS claims because the supplier that billed for the item must obtain detailed documentation from the medical professional who ordered the item. As such, the involvement of multiple parties can contribute to missing or incomplete documentation and delays in the receipt of documentation. Due to the importance of documentation to support the necessity for DMEPOS items billed, CERT notifies ordering providers, physicians, and practitioners of claims selected for review. This notification reminds these individuals and entities of their responsibilities to document medical necessity for the DMEPOS items ordered and to submit requested documentation to the

supplier. Approximately 2.9 percent of the improper payments for DMEPOS items and services were medical necessity errors

The three DMEPOS groups with the highest improper payment rates are oxygen supplies and equipment, glucose monitors, and supplies (positive airway pressure devices) for beneficiaries with obstructive sleep apnea. These accounted for 3.1 percent, 2.4 percent, and 1.0 percent of the total Medicare FFS projected improper payments (respectively). These three DMEPOS groups combined accounted for 44.0 percent of the DMEPOS improper payments in the 2013 report period.

## **Oxygen Supplies**

Medicare FFS provides coverage for home and portable oxygen supplies for beneficiaries with severe lung disease or conditions related to low oxygen levels that improve with oxygen therapy. The improper payment rate for oxygen supplies was 75.2 percent, accounting for 3.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for oxygen supplies during the 2013 report period was \$1.2 billion.

A physician must closely monitor the beneficiary and the continued medical necessity of the oxygen supplies. For Medicare coverage, the patient's medical record must contain sufficient documentation of the patient's medical condition to support the need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as physician orders for the oxygen supplies, oxygen saturation results, physician evaluations demonstrating oversight of the beneficiary and their continued need for oxygen supplies, and the appropriateness of home and/or portable oxygen supplies.

Most of the improper payments for oxygen supplies were due to insufficient documentation to support medical necessity. Critical documentation that was often missing from the submitted records included:

- The order for the oxygen supplies;
- The most recent Certificate of Medical Necessity (CMN) documenting the beneficiary's condition;
- Oxygen saturation results;
- Physician's notes demonstrating that the beneficiary was seen by a physician within the appropriate timeframes for certification or recertification of the need for oxygen supplies; and
- Physician's notes supporting continued monitoring of oxygen supply usage and need

## **Example**

A supplier submitted a claim for an oxygen concentrator to provide a beneficiary with supplemental oxygen at home. The initial Certificate of Medical Necessity (CMN) and one office visit note from three years prior to the claim date were submitted. The coverage rules for oxygen require a recertification CMN one year after the initial CMN. The reviewer requested

the recertification CMN and the required oxygen results but received no additional documentation. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

### **Example**

A supplier submitted a claim for an oxygen concentrator to provide a beneficiary with supplemental oxygen at home. The submitted documentation included the initial and recertification CMNs and an overnight pulse oximetry (i.e., oxygen saturation level) report. The report indicated that the beneficiary’s oxygen saturation levels did not support the information provided on the CMN. The CERT program scored the claim as an improper payment due to a “medical necessity error.”

### **Glucose Testing Supplies**

Medicare provides coverage for glucose monitors and accompanying supplies (e.g., test strips and lancets) for Medicare beneficiaries with diabetes at a frequency of testing that is medically necessary. The improper payment rate for glucose testing supplies was 74.7 percent, accounting for 2.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for glucose testing supplies during the 2013 report period was \$0.9 billion.

A physician must closely monitor a diabetic beneficiary and document the continued medical necessity of glucose testing supplies. As a condition of Medicare coverage, the beneficiary’s medical record must contain sufficient documentation of the beneficiary’s medical condition to support the need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as a physician’s order for the glucose testing supplies, evaluations demonstrating physician oversight of the beneficiary, and the need for glucose testing supplies.

Most of the improper payments for glucose testing supplies were due to insufficient documentation to support the glucose testing supplies billed. Critical documentation that was often missing from the submitted records included the:

- Order for the glucose testing supplies, stating the number of times per day the beneficiary is to test his or her glucose level;
- Physician’s notes showing the beneficiary’s diabetic condition and the need for glucose testing supplies at the frequency billed; and
- Physician’s notes showing periodic reviews of the glucose testing orders within Medicare’s designated timeframes

Medical necessity errors caused other improper payments for glucose testing supplies. For example, improper payments result when a beneficiary receives duplicate diabetic supplies from multiple DMEPOS suppliers. In this situation, the beneficiary receives more supplies than necessary according to Medicare guidelines.

## Example

A supplier billed for 200 blood glucose test strips with a KX modifier indicating an insulin-treated beneficiary. Submitted documentation supports that the beneficiary has insulin-treated diabetes, manages his diabetes with a physician, and checks his blood sugars at home at the appropriate frequency. However, there was no signed and dated order for the billed diabetic test strips from the treating physician. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

## Positive Airway Pressure Devices

The term positive airway pressure (PAP) refers to both continuous PAP (CPAP) and bi-level positive airway pressure (BPAP) devices.

The improper payment rate for CPAP/BPAP supplies was 56.1 percent, accounting for 1.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for CPAP/BPAP supplies during the 2013 report period was \$370 million.

Medicare covers CPAP/BPAP devices primarily for beneficiaries with a diagnosis of obstructive sleep apnea based upon a sleep test that meets the Medicare coverage criteria in effect for the date of service of the claim for the PAP device. The initial coverage is for 3-months. For coverage beyond 3 months, you will need a re-evaluation by your treating physician within a specified timeframe. This is to show that you are benefitting from the therapy and you are adhering to the usage guidelines.

To be covered, the medical record must include documentation of the:

- Qualifying sleep test;
- Physician’s evaluation of the beneficiary’s sleep apnea;
- Supplier’s instruction on the proper use and care of the equipment; and
- Ineffectiveness of CPAP (when a BPAP device is ordered)

Most of the improper payments for CPAP/BPAP devices were due to insufficient documentation to support the medical necessity of the devices. Critical documentation that was often missing from the submitted records included:

- The signed and dated order for the CPAP/BPAP device and each accessory billed;
- Physician evaluation performed prior to the sleep test, assessing the beneficiary for sleep apnea;
- Physician re-evaluation performed within the required timeframe to support that the beneficiary benefits from the therapy and adheres to specified usage guidelines; and
- Qualifying sleep test that meets Medicare requirements

## **Example**

The supplier submitted the physician's order for the CPAP device and the qualifying sleep study to support the CPAP claim. However, the supplier did not submit the other clinical documentation that was required by Medicare policy, such as the face-to-face evaluation supporting the beneficiary's medical need for the CPAP device and physician notes indicating that the beneficiary was re-evaluated by the physician within the required timeframes. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

## **Nebulizer Machines and Related Drugs**

Medicare provides coverage for medically necessary nebulizer machines and related drugs for those beneficiaries with various diagnoses affecting lung function and breathing capacity. The improper payment rate for nebulizer machines and related drugs was 36.2 percent, accounting for 0.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for nebulizer machines and related drugs during the 2013 report period was \$293 million.

The majority of improper payments for nebulizer machines and related drugs were due to insufficient documentation. There must be a written order from the treating physician that specifies the name of the dispensed solution, the correct dosage and frequency, and the instructions for administration. Medicare also requires documentation from the treating physician that supports the medical necessity of the nebulizer and inhalation drugs.

## **Example**

The supplier billed for albuterol inhalation medication for a nebulizer machine. The submitted documentation included a pharmacy transfer slip for albuterol and unauthenticated physician progress notes. The records also lacked a treating physician's detailed order for albuterol, which is a documentation requirement. The CERT program scored the claim as an improper payment due to an "insufficient documentation error".

## **Power Mobility Devices**

The power mobility devices (PMD) includes such items as power wheelchairs, power operated vehicles (scooters), and their accessories.

The improper payment rate for PMDs was 81.8 percent, accounting for 0.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for PMDs during the 2013 report period was \$329 million.

The largest causes of improper payments for PMD claims were insufficient documentation and medical necessity errors.

Medicare pays for PMDs only when the beneficiary meets the following criteria:

- A beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more activities of daily living within the home,
- The limitation cannot be resolved by the use of a cane or walker, and
- The beneficiary does not have sufficient arm strength to use an optimally configured manual wheelchair.

Medicare requires specific documentation to ensure the medical necessity of these devices. The requirements are that the:

- Physician or other qualified medical professional must conduct a face-to-face visit to assess the beneficiary's mobility limitations and needs. The evaluation must describe very clearly the beneficiary's abilities and needs within the home,
- Medical evaluation must be complete before writing the PMD order,
- PMD order must contain specific elements, and
- PMD supplier receives the physician's order and medical records within 45 days after the evaluation is completed.

### **Example**

A supplier submitted a claim for the initial rental of a Group 3 power wheelchair. The face-to-face evaluation did not meet the Medicare requirements because it failed to support medical necessity for the power wheelchair. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

### **Pressure Reducing Support Surfaces**

Pressure reducing support surfaces (PRSSs) aim to prevent and/or treat pressure ulcers. The improper payment rate for PRSSs was 73.9 percent, accounting for 0.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for PRSSs during the 2013 report period was \$53.2 million.

Medicare categorizes PRSSs into three groups and each group has different coverage criteria.

- Group 1 - Pressure pads and mattress overlays placed over the standard home or hospital mattresses.
- Group 2 - Powered air floatation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses. These are used either alone or placed over a bed frame.
- Group 3 - Complete bed systems, with filtered air circulating through silicone beads (i.e., air-fluidized beds).

The medical record must show that coverage criteria are met when the PRSS is ordered and for every month after delivery.

## Example

A supplier submitted a claim for an air-fluidized bed. Medicare requires documentation of weekly assessments and one month of conservative treatment without wound healing to qualify for coverage of air fluidized beds. The medical record included a dated order, proof of delivery, a physician's letter, a home health plan of care, nurses' notes and the treating physician's notes. There was no documentation of weekly wound assessments. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

## Evaluation and Management Services

Evaluation and Management (E&M) services are visits and consultations by physicians to Medicare beneficiaries. The improper payment rate for E&M services was 13.4 percent, accounting for 10.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2013 report period was \$3.9 billion.

The type of service, place of service, patient's status, content of the service, and the time required to provide the service determine the category of E&M service. The components that determine the correct E&M service are:

- History (includes information such as the nature of presenting problem, past history, family history, social history, review of systems),
- Physical examination,
- Medical decision making (includes such factors as the number of possible diagnoses and management options that must be considered; the amount and complexity of the medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed; the risk of significant complications, morbidity, and mortality, the beneficiary's comorbidities that are associated with the presenting problems; and the possible management options),
- Counseling provided,
- Coordination of care, and
- The amount of time spent working on the beneficiary's case.

Incorrect coding and insufficient documentation caused most of the improper payments for E&M services during the 2013 report period. Often the physician submitted medical documentation that supported a different E&M code than the one billed. Many other claims were found to have insufficient documentation errors because the submitted records lacked a physician signature. For other claims, physicians provided services in settings other than their own offices and did not submit records maintained by hospitals or other facilities.

## Example

A provider billed for Healthcare Common Procedure Coding System (HCPCS) 99214 (a level four office or other outpatient visit with an established patient). The beneficiary had no new medical problems. The beneficiary's medical condition was stable and medical decision-making

was of low complexity. The documentation did not qualify for the level of E&M service billed because it did not meet two of the three key components for HCPCS 99214. The claim was down-coded because the documentation met two of three key components for HCPCS 99213. The CERT program scored the claim as an improper payment due to an “incorrect coding error.”

The CERT program identified many improper payments for split E&M services. Split E&M services occur when the physician and a qualified non-physician practitioner (NPP) each do a substantive part of an E&M visit face-to-face with the same beneficiary on the same date of service. A physician can only bill this visit under his or her National Provider Identifier (NPI) for certain E&M visits and settings. Insufficient documentation causes most of the improper payments for these claims.

### Example

A physician billed a split/shared E&M claim. The billed service was an initial hospital visit (HCPCS 99223). Although the documentation contained a physician’s signature on the NPP’s progress note, there was nothing to show that the physician performed a substantive part of the service or had a face-to-face encounter with the patient. The CERT program scored this claim as an improper payment due to an “insufficient documentation error.”

### Chiropractic Services

Medicare pays chiropractors for manual manipulation of the spine for symptoms associated with spinal subluxation. A subluxation is “a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.”<sup>18</sup> No other diagnostic or therapeutic service furnished by a chiropractor is covered. The improper payment rate for chiropractic services was 51.7 percent, accounting for 0.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment for chiropractic services during the 2013 report period was \$273.5 million.

Improper payments for chiropractic services are usually due to insufficient documentation. There are specific documentation requirements for chiropractic patient visits. Often the following items are missing from the documentation:

- An adequate description of the service billed;
- The date of service;
- The name of the beneficiary;
- The treatment plan (at the initial visit) with objective measures to evaluate treatment effectiveness; and

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<sup>18</sup> Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services (Rev. 127, 05-28-10), <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>

- A legible provider signature

Other improper payments for chiropractic services are due to medical necessity errors. Manipulation of spinal regions for reasons other than documented subluxation is an example of a medical necessity error.

### **Example**

A chiropractor billed for Chiropractic Manipulative Treatment (CMT) for 3-4 spinal regions (i.e., HCPCS 98941). The CMT codes include a patient assessment. The chiropractor submitted treatment notes for the sampled date of service but there was no documentation of symptoms associated with a subluxation, and no patient assessment. There was a history and physical examination from 18 months earlier but there was no initial evaluation or initial treatment plan with specific goals and no updated treatment plan. The CERT program scored the claim as an improper payment due to an “insufficient documentation error.”

## **Reducing Improper Payments in the Medicare Fee-For-Service Program**

### **Government Performance and Results Act Improper Payment Rate Goals**

The Government Performance and Results Act (GPRA) of 1993, as modified by the GPRA Modernization Act of 2010, require federal agencies to establish performance goals.

The 2013 improper payment rate was 10.1 percent, which is higher than the previously established goal of 8.3 percent. CMS has many successful improper payment reduction strategies in place. However, the factors contributing to improper payments are complex and may change from year to year. As a result, CMS revises these goals on an annual basis based on data analysis and policy changes. The law requires that these goals are realistic and ambitious.

Under this mandate, as well as to comply with IPIA, CMS set the following targets for lowering improper payments over the next three years:

- 9.9 percent by FY 2014
- 9.8 percent by FY 2015
- 9.7 percent by FY 2016

The CMS sets these targets by analyzing CERT program results and trends for each claim type and error category. These goals also incorporate the anticipated reductions that will result from corrective action implemented by CMS.

### **Corrective Actions to Reduce Improper Payments**

The CMS strives to reduce improper payments in the Medicare FFS program. Improper payment data garnered from the CERT program and other sources is used to reduce or eliminate improper through various corrective actions.

The CMS has previously implemented corrective action to reduce improper payments during the 2013 report period. In addition, CMS has developed other corrective actions that are expected to reduce improper payments in future report periods.

### **New Corrective Actions**

#### *Targeting Insufficient Documentation*

1. We modified the CERT Provider website, <https://www.certprovider.com/>, by:
  - Adding a link with instructions for psychotherapy providers
  - Making Spanish versions of record request letters easier to find
2. We modified the CERT documentation request letters by:
  - Adding requests for electronic record protocols and policies for electronic signatures

- Improving specificity of items requested
- Updating Spanish translations

#### *Improving Medical Review Consistency*

1. We distributed and discussed CERT medical review templates during collaborative meetings with the MACs.
2. We held a Medical Review Operational Meeting to discuss medical review topics and CERT findings with MACs.

#### *Improving and Applying Data Analysis*

1. We provided MACs with data on error prone providers and suppliers and issued an official instruction to MACs to take administrative actions for these providers and suppliers, per the Office of Inspector General (OIG) recommendations (A-05-08-00080).
2. We added new subcategories to error categories and can define specific reasons for improper payments.
3. We identified claims with insufficient documentation errors that have a large impact on the improper payment rate. We went beyond the normal CERT procedures to recover documents that reversed the improper payment determination.

#### **Established Corrective Actions Include:**

##### *Targeting Insufficient Documentation*

We publish articles in the Medicare Quarterly Provider Compliance Newsletter. The articles discuss documentation requirements, CERT findings, and common errors.

##### *Improving and Applying Data Analysis*

We provide MACs with quarterly contractor-specific improper payment reports.

#### **Established HHS Corrective Actions Include:**

1. CMS is expanding the use of Medicare FFS Recovery Auditors including prepayment reviews to prevent improper payments and move away from the pay-and-chase model. CMS is now allowing the Recovery Auditors to review claims before they are paid, which will prevent improper payments from occurring. This demonstration project began for claims processed on or after September 1, 2012. As of September 26, 2013, through this prepayment demonstration, CMS has already saved approximately \$22.3 million in improper payments from being made.
2. In addition to utilizing Medicare FFS Recovery Auditors for prepayment reviews, CMS continued to utilize the Recovery Auditors for postpayment activities. Overall, in FY 2013, the Medicare FFS Recovery Auditors program demanded approximately \$4.2 billion and recovered \$3.7 billion in overpayments by the end of the fiscal year.

3. CMS successfully implemented the prior authorization of power mobility devices. This demonstration project has already led to a decrease in expenditures for power mobility devices in the demonstration states as well as the non-demonstration states. Specifically, based on claims submitted as of September 30, 2013, monthly expenditures for the power mobility devices included in the demonstration states decreased from \$12 million in September 2012 to \$4 million in August 2013 and from \$20 million to \$9 million in the non-demonstration states for the same time period. Prior authorization reviews are being performed timely, industry feedback has been positive, and CMS has received no complaints from beneficiaries. CMS continues to closely monitor and evaluate the effectiveness of the demonstration and plans to analyze demonstration data to assist in the investigation and prosecution of fraud.
4. CMS released the 2014 Hospital Inpatient Prospective Payment System (IPPS) final rule (78 FR 50495) which became effective for dates of admission on or after October 1, 2013. The provisions published as part of this final rule should result in greater consistency in hospital billing and reduce the incidence of Part A Medicare FFS improper payments.
5. CMS, along with both federal and private sector partners, continues to build the Healthcare Fraud Prevention Partnership (HFPP), which is a public-private partnership to improve detection and prevention of healthcare fraud, waste and abuse. The HFPP is a collaboration using data exchanges, analytical tools, and anti-fraud best practices.
6. CMS continues to provide educational events and multi-media materials for physicians, other providers and suppliers, industry stakeholders and beneficiaries.
7. CMS is requiring its Medicare review contractors to intensify their medical review efforts to identify documentation errors in certain claim types that are error prone (e.g., home health, hospital outpatient skilled nursing facility and nonhospital-based hospice claims).
8. CMS contracted with a Supplemental Medical Review Contractor to provide support for a variety of medical review tasks aimed at lowering the improper payment rate.
9. CMS implemented the Medicare Part B Outpatient Therapy Cap Exceptions Process, which mandates manual medical review on claims when the beneficiary exceeds the \$3,700 therapy threshold for the year.
10. CMS continues to allow Medicare review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors.
11. CMS continues to develop and issue Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements to enable providers to examine their billing patterns compared to their peers in the state and nation.

More information on established corrective actions is available in previous CERT reports at [www.cms.gov//CERT/CERT-Reports.html](http://www.cms.gov//CERT/CERT-Reports.html) .

## Acronyms

AFR	Annual Financial Report
ALJs	Federal Administrative Law Judges
BPAP	Bi-level positive airway pressure
CBRs	Comparative Billing Reports
CERT	Comprehensive Error Rate Testing
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CMT	Chiropractic Manipulative Treatment
CPAP	Continuous Positive Airway Pressure
CT	Computed Tomography
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DRG	Diagnosis Related Group
E&M	Evaluation and Management
ESRD	End Stage Renal Disease

FFS	Fee-For-Service
GPRA	Government Performance and Results Act of 1993
HCPCS	Healthcare Common Procedure Coding System
HFPP	Healthcare Fraud Prevention Partnership
HHS	Department of Health and Human Services
HHS DAB	Departmental Appeals Board
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPF	Inpatient Psychiatric Facility
IPIA	Improper Payments Information Act of 2002
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
LCDs	Local Coverage Determinations
MACs	Medicare Administrative Contractors
NCDs	National Coverage Determinations
NPI	National Provider Identifier
NPPs	Non-Physician Practitioners

OIG	HHS Office of Inspector General
OMB	Office of Management and Budget
PAP	Positive Airway Pressure
PMD	Power Mobility Device
PRSSs	Pressure Reducing Support Surfaces
PSCs	Program Safeguard Contractors
QIC	Qualified Independent Contractor
RAs	Recovery Auditors
SNF	Skilled Nursing Facility

## APPENDIX

**Table 4: Summary of National Improper Payment Rates by Year and by Error Category**

Fiscal Year and Rate Type (Net/Gross)		No Doc Errors	Insuff Doc Errors	Medical Necessity Errors	Incorrect Coding Errors	Other Errors	Improper Payment Rate	Correct Payment Rate
1996 <sup>19</sup>	Net	1.9%	4.5%	5.1%	1.2%	1.1%	<b>13.8%</b>	86.2%
1997	Net	2.1%	2.9%	4.2%	1.7%	0.5%	<b>11.4%</b>	88.6%
1998	Net	0.4%	0.8%	3.9%	1.3%	0.7%	<b>7.1%</b>	92.9%
1999	Net	0.6%	2.6%	2.6%	1.3%	0.9%	<b>8.0%</b>	92%
2000	Net	1.2%	1.3%	2.9%	1%	0.4%	<b>6.8%</b>	93.2%
2001	Net	0.8%	1.9%	2.7%	1.1%	-0.2%	<b>6.3%</b>	93.7%
2002	Net	0.5%	1.3%	3.6%	0.9%	0.0%	<b>6.3%</b>	93.7%
2003	Net	5.4%	2.5%	1.1%	0.7%	0.1%	<b>9.8%</b>	90.2%
2004 <sup>20</sup>	Gross	3.1%	4.1%	1.6%	1.2%	0.2%	<b>10.1%</b>	89.9%
2005	Gross	0.7%	1.1%	1.6%	1.5%	0.2%	<b>5.2%</b>	94.8%
2006	Gross	0.6%	0.6%	1.4%	1.6%	0.2%	<b>4.4%</b>	95.6%
2007	Gross	0.6%	0.4%	1.3%	1.5%	0.2%	<b>3.9%</b>	96.1%
2008	Gross	0.2%	0.6%	1.4%	1.3%	0.1%	<b>3.6%</b>	96.4%
2009	Gross	0.2%	4.3%	6.3%	1.5%	0.1%	<b>12.4%</b>	87.6%
2010	Gross	0.1%	4.6%	4.2%	1.6%	0.1%	<b>10.5%</b>	89.5%
2011 <sup>21</sup>	Gross	0.2%	5.0%	3.4%	1.2%	0.1%	<b>9.9%</b>	90.1%
2012 <sup>22</sup>	Gross	0.2%	5.0%	2.6%	1.3%	0.1%	<b>9.3%</b>	90.7%
2013 <sup>23</sup>	Gross	0.2%	6.1%	2.8%	1.5%	0.2%	<b>10.7%</b>	89.3%

<sup>19</sup> FY 1996-2003 Improper payments were calculated as Overpayments – Underpayments.

<sup>20</sup> FY 2004-2012 Improper payments were calculated as Overpayments + absolute value of Underpayments.

<sup>21</sup> The FY 2011 improper payment rate reported in the HHS Agency Financial Report was 8.6 percent, which was adjusted for the prospective impact of late appeals and documentation. Because this adjustment could not be applied on a lower level than the overall improper payment rate, the FY 2011 rates in this table are unadjusted.

<sup>22</sup> The FY 2012 improper payment rate reported in the HHS Agency Financial Report was 8.5 percent. The rate of 8.5 percent represented the rate that was adjusted for the impact of denied Part A inpatient claims under Part B. Because this adjustment could not be applied on a lower level than the overall and the Part A improper payment rates, the FY 2012 rates in this table are unadjusted.

<sup>23</sup> Unadjusted for impact of A/B rebilling.

**Table 5: Comparison of 2012 and 2013 National Improper Payment Rates<sup>24</sup>**

Error Category	2012	2013				
	Total	Total	Part A Excluding Inpatient Hospital	Part A Acute Inpatient Hospital	Part B	DMEPOS
No Documentation	0.2%	0.2%	0.0%	0.0%	0.1%	0.0%
Insufficient Documentation	5.0%	6.1%	2.5%	0.3%	1.7%	1.5%
Medical Necessity	2.6%	2.8%	0.4%	2.3%	0.1%	0.0%
Incorrect Coding	1.3%	1.5%	0.2%	0.6%	0.7%	0.0%
Other	0.1%	0.2%	0.1%	0.0%	0.0%	0.0%
<b>Total</b>	<b>9.3%</b>	<b>10.7%</b>	<b>3.2%</b>	<b>3.3%</b>	<b>2.7%</b>	<b>1.6%</b>

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<sup>24</sup> Some columns and/or rows may not sum correctly due to rounding.

**Table 6: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions)<sup>25</sup>**

Claim Type	Total Amount Paid	Overall Improper Payments			Overpayments		Underpayments	
		Improper Payment Amount	Improper Payment Rate	98% Confidence Interval	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
<b>Part A (Total)</b>	\$257.4	\$23.1	9.0%	8.3% - 9.6%	\$21.8	8.5%	\$1.3	0.5%
Part A (Excluding Acute Inpatient Hospital)	\$140.0	\$11.4	8.2%	7.2% - 9.1%	\$11.2	8.0%	\$0.2	0.1%
Part A (Acute Inpatient Hospital)	\$117.4	\$11.6	9.9%	9.0% - 10.8%	\$10.6	9.0%	\$1.1	0.9%
<b>Part B</b>	\$90.3	\$9.5	10.5%	9.5% - 11.5%	\$9.3	10.3%	\$0.1	0.2%
<b>DMEPOS</b>	\$9.7	\$5.7	58.2%	54.9% - 61.5%	\$5.7	58.2%	\$0.0	0.0%
<b>Total</b>	<b>\$357.4</b>	<b>\$38.2</b>	<b>10.7%</b>	<b>10.1% - 11.3%</b>	<b>\$36.8</b>	<b>10.3%</b>	<b>\$1.4</b>	<b>0.4%</b>

<sup>25</sup> Some columns and/or rows may not sum correctly due to rounding.

**Table 7: 2013 Projected Improper Payments (Dollars in Billions) by Type of Error and Clinical Setting<sup>26</sup>**

Examining the types of CERT review errors and their impact on improper payments is a crucial step toward reducing improper payments in the Medicare FFS program. Improper payments vary by clinical setting. Insufficient documentation errors and medical necessity errors are the main drivers of projected improper payments.

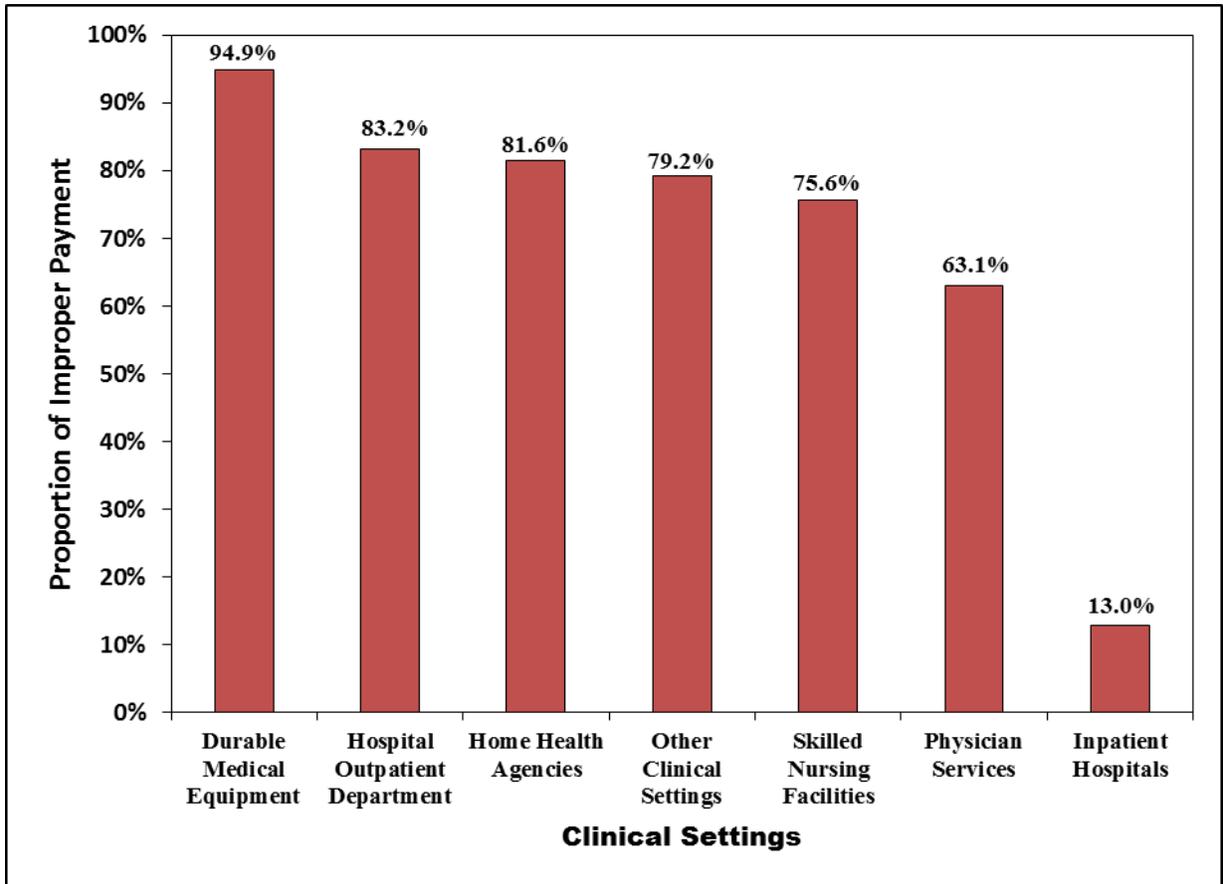
Error Category	DMEPOS	Home Health Agencies	Hospital Outpatient Departments	Acute Inpatient Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	\$0.03	\$0.05	\$0.06	\$0.00	\$0.39	\$0.00	\$0.01	\$0.55
Insufficient Documentation	\$5.38	\$2.52	\$4.00	\$1.63	\$5.09	\$1.95	\$1.14	\$21.72
Medical Necessity	\$0.16	\$0.49	\$0.45	\$8.63	\$0.14	\$0.10	\$0.20	\$10.18
Incorrect Coding	\$0.01	\$0.03	\$0.21	\$2.20	\$2.36	\$0.36	\$0.08	\$5.25
Other	\$0.09	\$0.00	\$0.09	\$0.11	\$0.08	\$0.17	\$0.00	\$0.54
<b>Total</b>	<b>\$5.67</b>	<b>\$3.09</b>	<b>\$4.81</b>	<b>\$12.58</b>	<b>\$8.07</b>	<b>\$2.58</b>	<b>\$1.44</b>	<b>\$38.23</b>

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<sup>26</sup> Some columns and/or rows may not sum correctly due to rounding.

**Figure 1: Proportion of Improper Payments Attributed to Insufficient Documentation in 2013, by Clinical Setting**

Insufficient documentation errors accounted for the greatest proportion of improper payments during the 2013 report period.



**Table 8: Projected Improper Payments, Overpayment and Underpayments by State  
(Dollars in Millions)<sup>27</sup>**

State	Overall		Overpayments		Underpayments	
	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
CA	\$3,696.5	11.7%	\$3,588.8	11.4%	\$107.7	0.3%
FL	\$3,309.0	12.3%	\$3,223.7	12.0%	\$85.3	0.3%
TX	\$3,110.1	10.5%	\$3,030.8	10.2%	\$79.2	0.3%
NY	\$2,736.7	11.3%	\$2,641.8	10.9%	\$95.0	0.4%
IL	\$2,065.7	11.0%	\$2,002.4	10.7%	\$63.2	0.3%
MI	\$1,814.8	11.7%	\$1,684.0	10.8%	\$130.8	0.8%
OH	\$1,645.0	13.0%	\$1,620.0	12.8%	\$25.0	0.2%
PA	\$1,354.5	9.3%	\$1,231.0	8.4%	\$123.5	0.8%
NJ	\$1,179.3	9.9%	\$1,152.6	9.7%	\$26.6	0.2%
NC	\$1,158.1	9.4%	\$1,053.7	8.6%	\$104.4	0.8%
<b>Overall</b>	<b>\$38,228.0</b>	<b>10.7%</b>	<b>\$36,804.3</b>	<b>10.3%</b>	<b>\$1,423.6</b>	<b>0.4%</b>

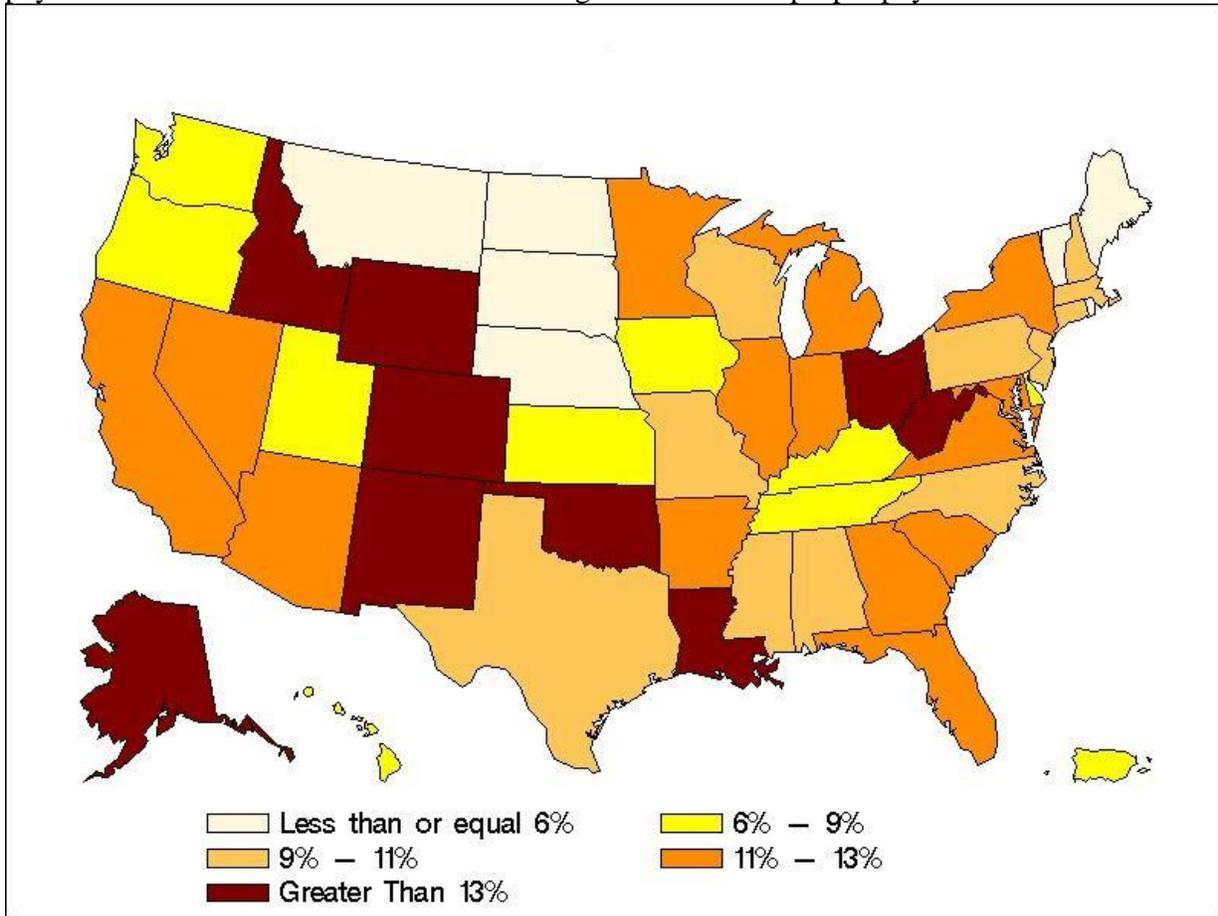
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<sup>27</sup> Some columns and/or rows may not sum correctly due to rounding. The improper payment rates in this table are unadjusted for the impact of A/B rebilling.

## Geographic Trends<sup>28</sup>

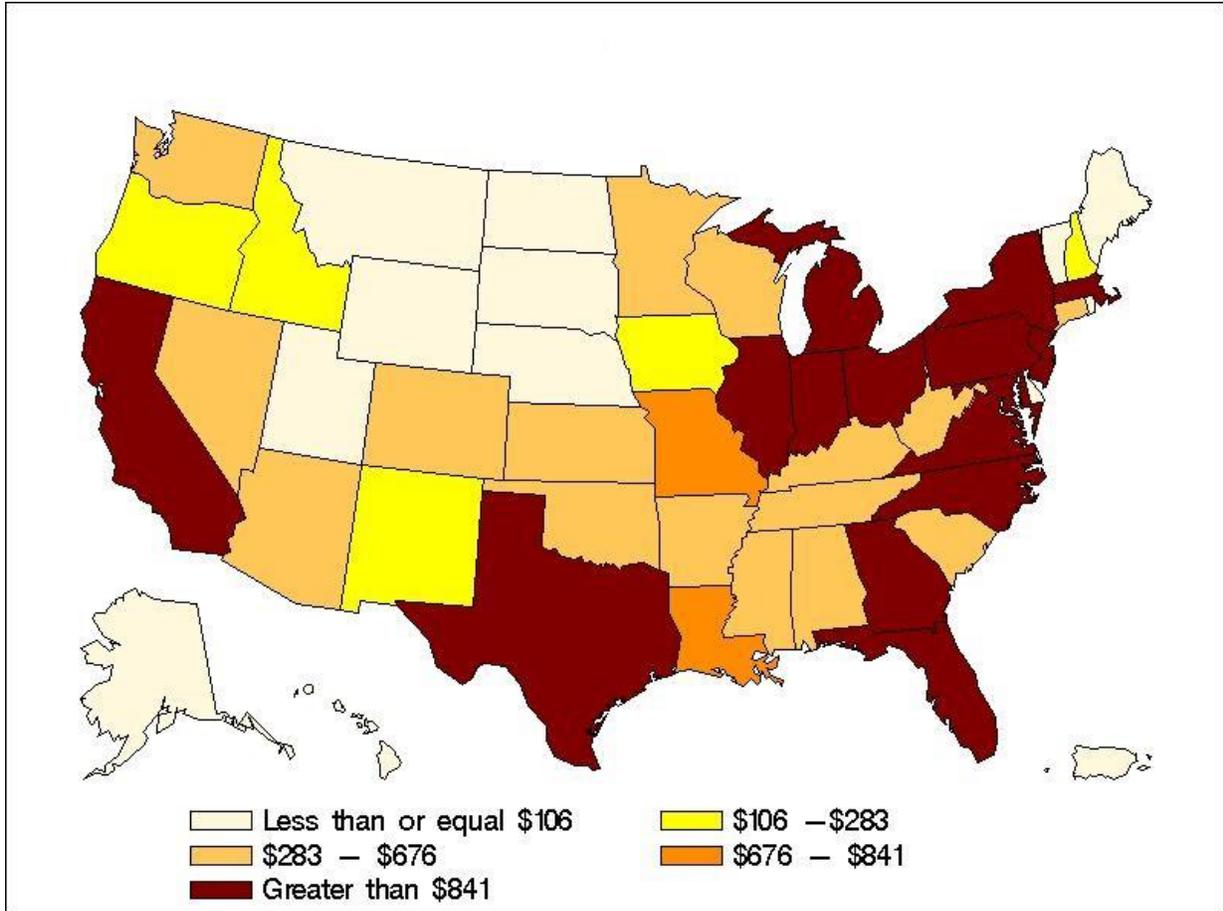
**Figure 2: 2013 Improper Payment Rates by State**

California, Florida, Texas, and New York have the highest projected improper payment and highest improper payment rate. These four states constitute 31.4 percent of overall Medicare FFS payments and 33.6 percent of total improper payments. Florida has the highest improper payment rate (12.3 percent, with \$3.3 billion in improper payments), and California has the second highest rate (11.7 percent, with \$3.7 billion in improper payments). Lowering improper payments in these states is critical to lowering the national improper payment rate.



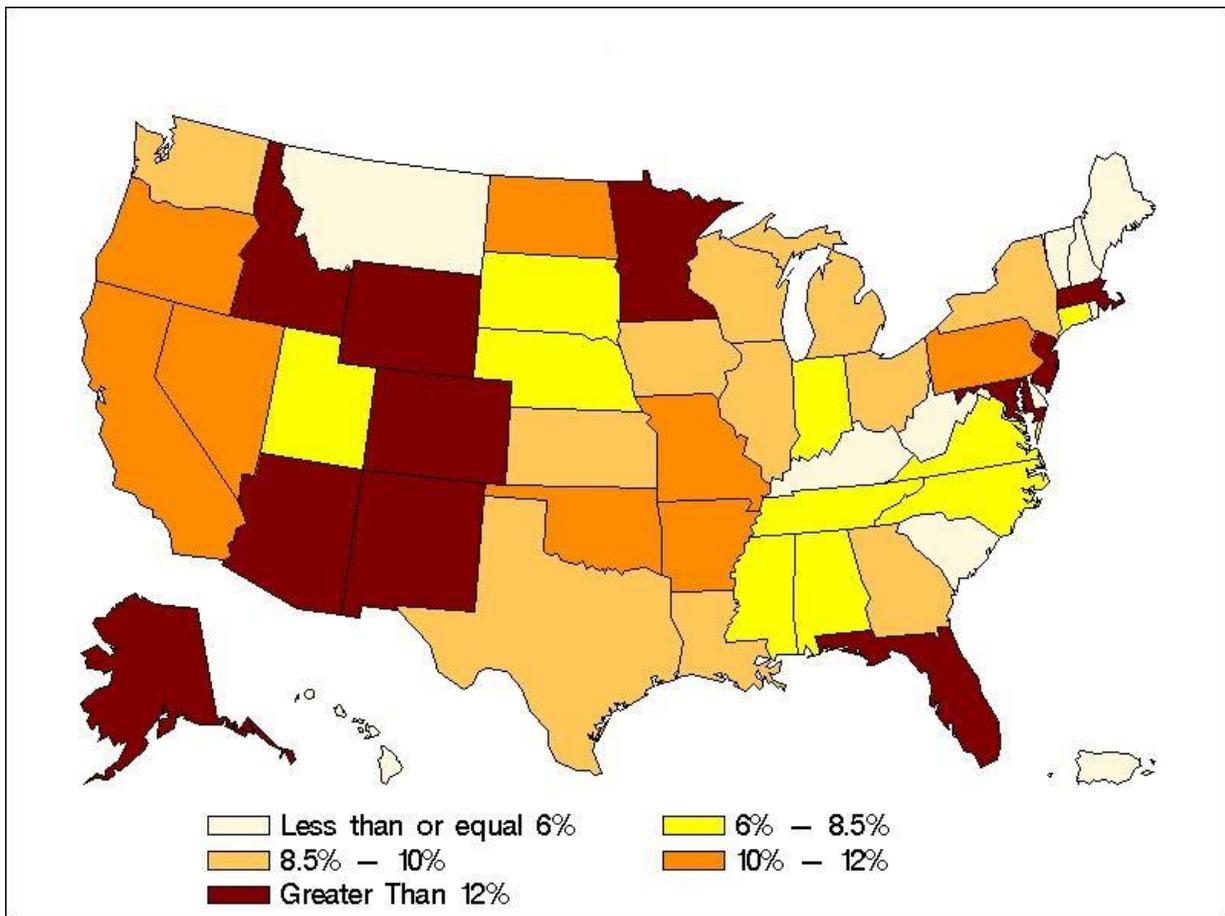
<sup>28</sup>Cutpoints and colors for maps are assigned using quintiles. Part A Inpatient Hospital maps are unadjusted for A/B rebilling; the adjustment does not apply to Part A Excluding Inpatient Hospital PPS, DMEPOS and Part B.

**Figure 3: 2013 Improper Payment Amounts by State (Dollars in Millions)**



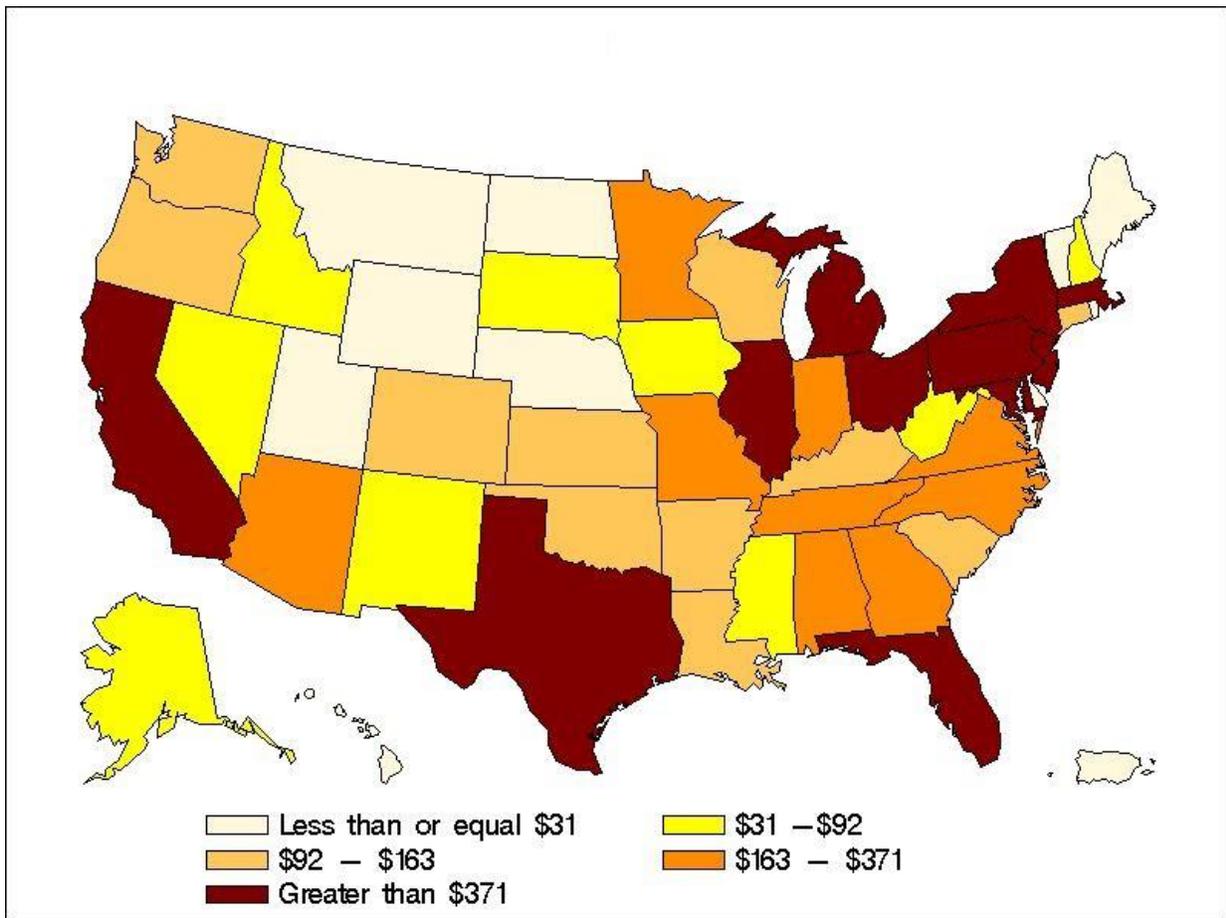
**Figure 4: Part A Inpatient Hospital Improper Payment Rates for by State<sup>29</sup>**

For Part A Inpatient Hospital claims, the states with the highest projected improper payments and highest improper payment rate are California, Texas, New York, and Florida. These four states constitute 31.8 percent of overall Part A Inpatient Hospital, Medicare FFS payments and 34.3 percent of total Part A Inpatient Hospital improper payments. Florida has the highest improper payment rate (11.9 percent, with \$846.6 million in improper payments), and California has the second highest (11.4 percent, with \$1.3 billion in improper payments).



<sup>29</sup> The improper payment amounts in this figure are unadjusted for the impact of A/B rebilling.

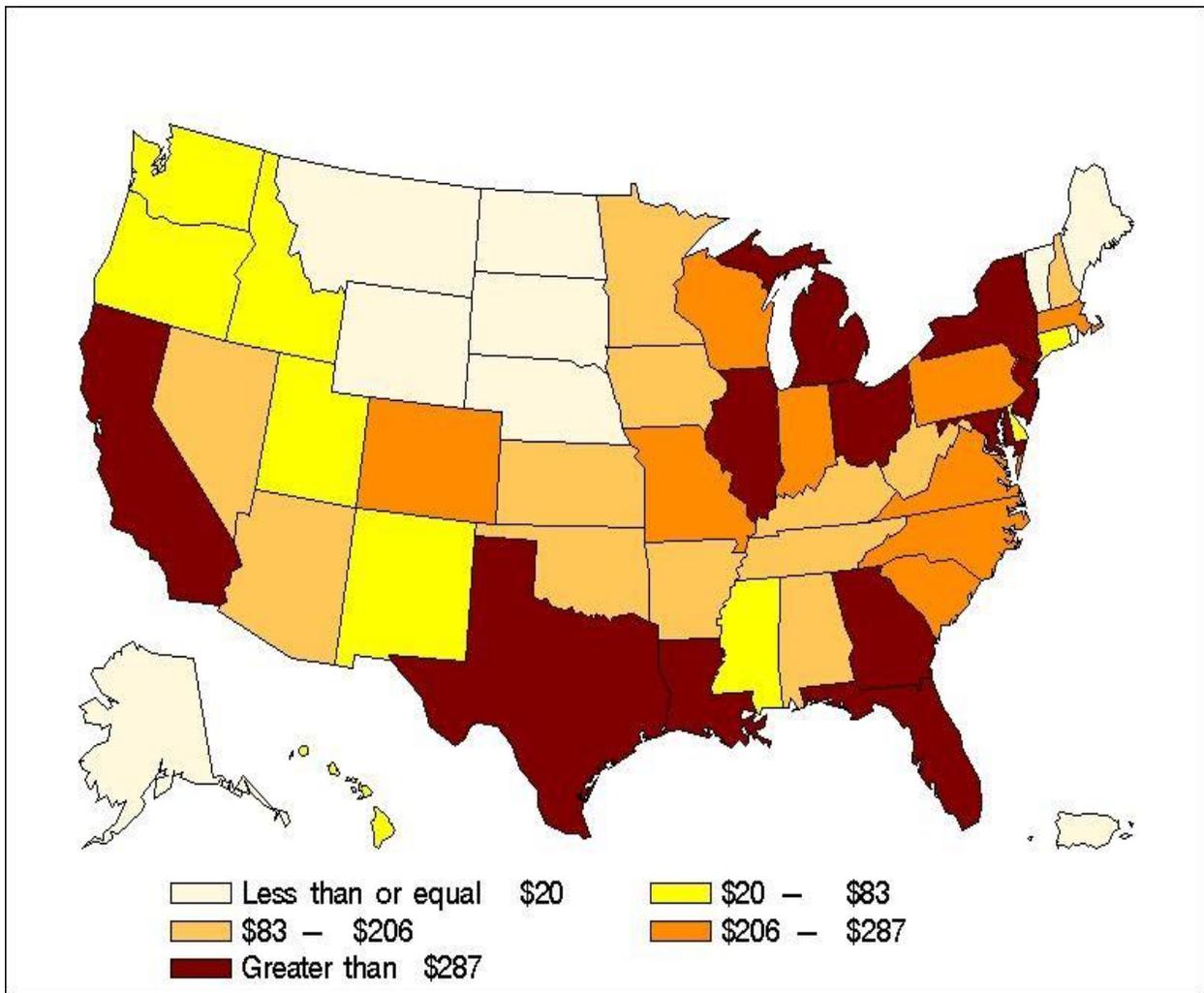
**Figure 5: Part A Inpatient Hospital Improper Payment Amounts by State  
(Dollars in Millions)<sup>30</sup>**



<sup>30</sup> The improper payment amounts in this figure are unadjusted for the impact of A/B rebilling.

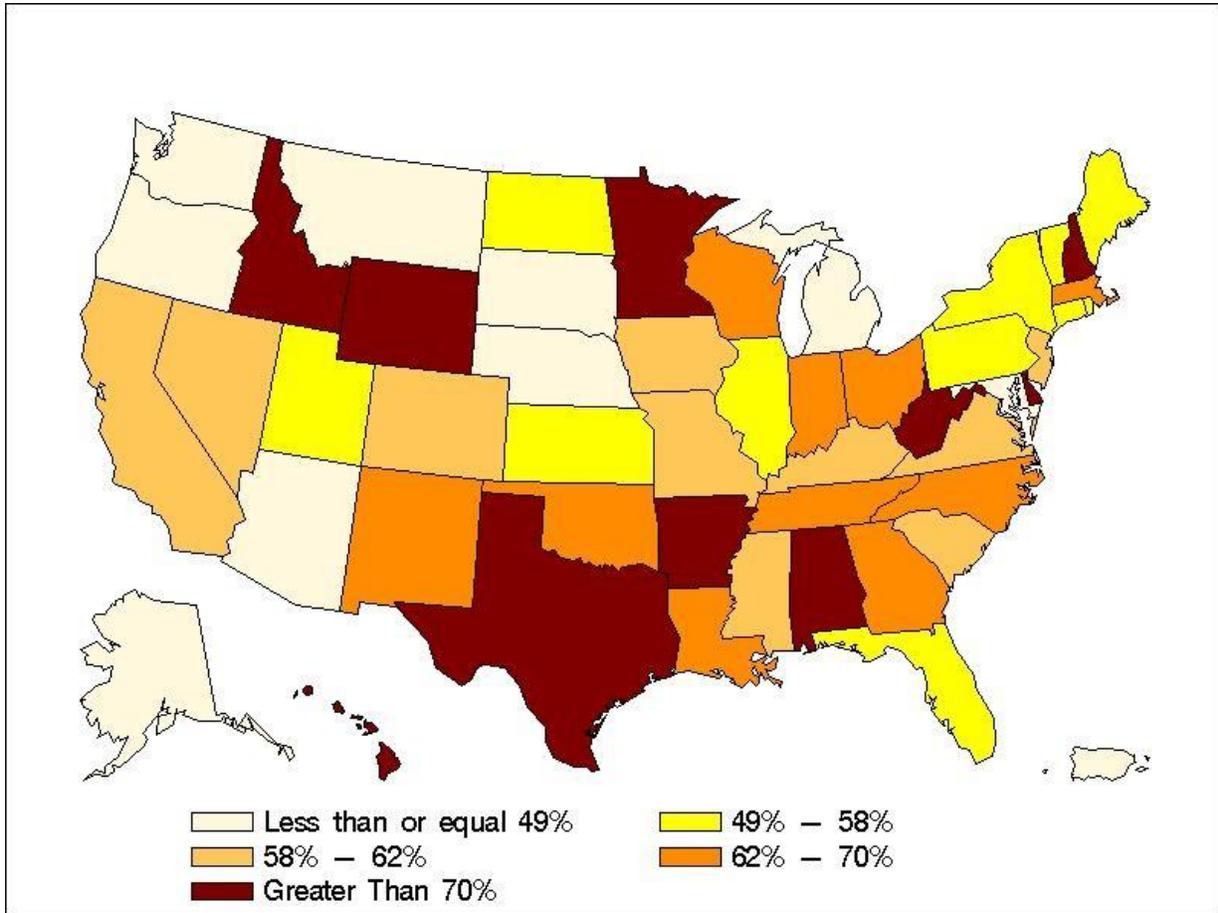


**Figure 7: Part A Excluding Inpatient Hospital Improper Payment Amounts by State  
(Dollars in Millions)**

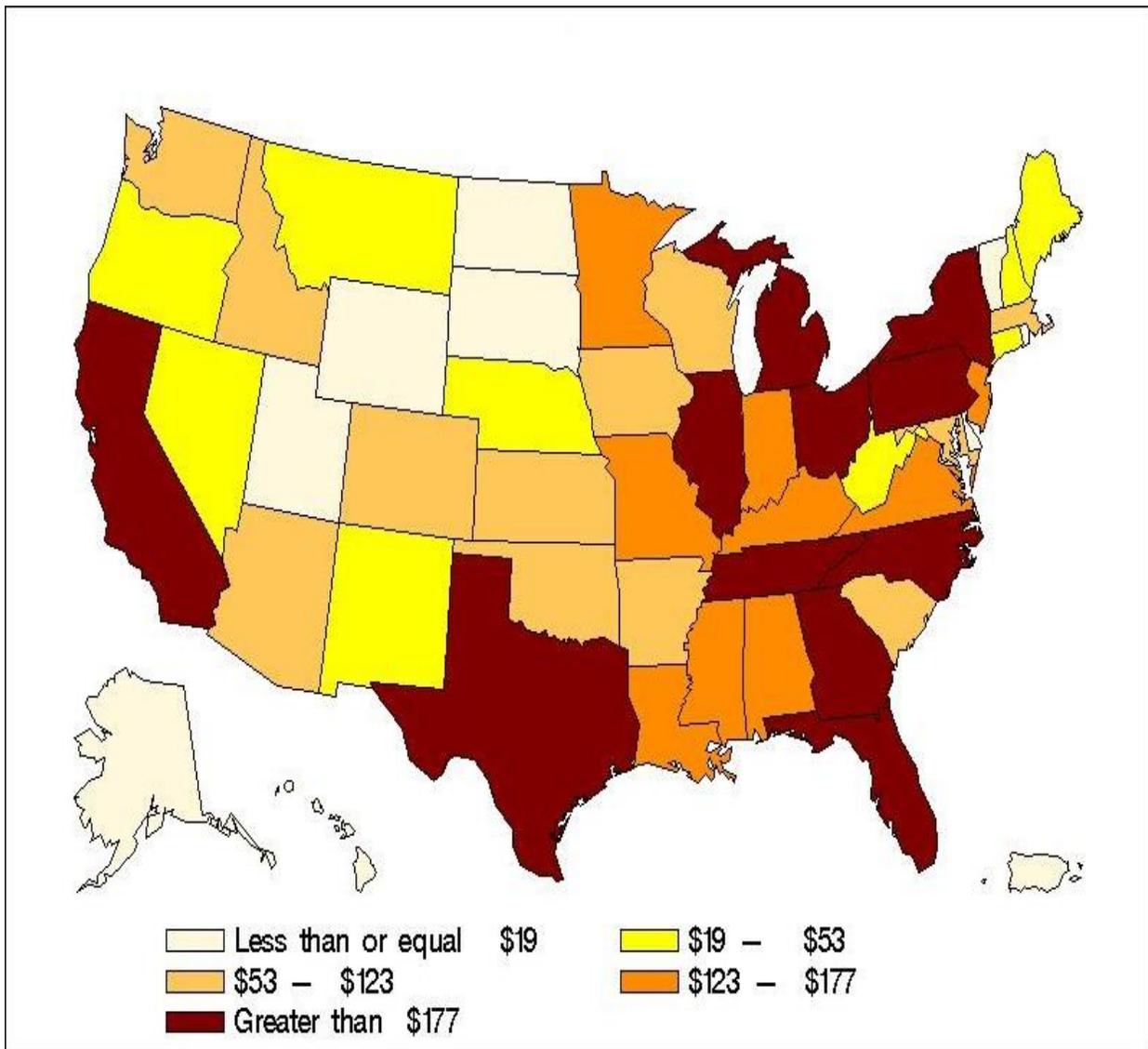


**Figure 8: DMEPOS Improper Payment Rates by State**

For DME claims, the states with the highest projected improper payments and highest improper payment rate are Texas, California, Florida, and New York. These four states constitute 25.8 percent of overall DME Medicare FFS payments and 26.4 percent of total DME improper payments. Texas has the highest improper payment rate (67.4 percent, with \$457 million in improper payments), and California has the second highest improper payment rate (a 59.5 percent improper payment rate, with \$394.7 million in improper payments).

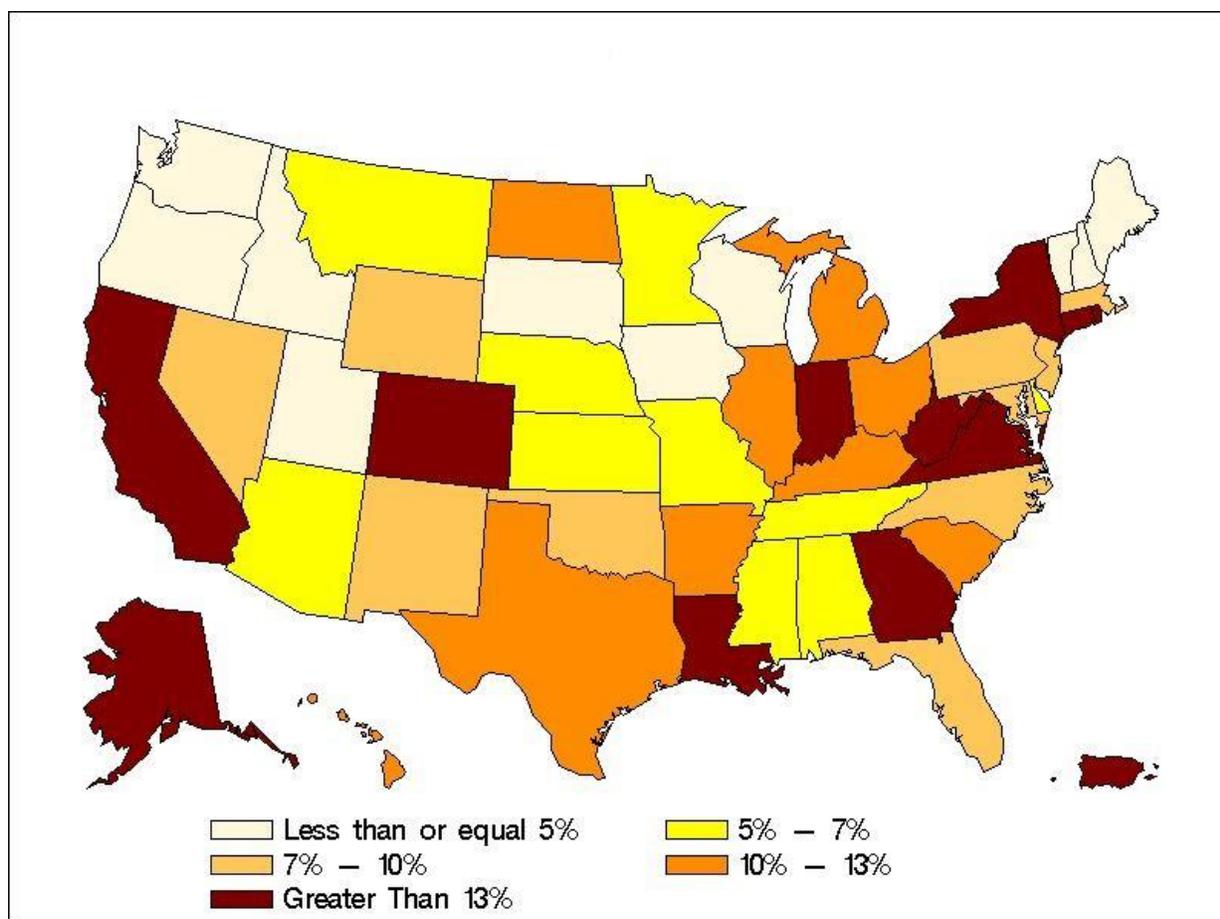


**Figure 9: DMEPOS Improper Payment Amounts by State  
(Dollars in Millions)**



**Figure 10: Part B Improper Payment Rates by State**

For Part B claims, the states with the highest improper payment rates and amounts are California, New York, Florida, and Texas. These four states constitute 34.2 percent of overall Part B Medicare FFS payments and 42.5 percent of total Part B improper payments. New York has the highest improper payment rate (17.5 percent, with \$1.2 billion in improper payments), and California has the second highest improper payment rate (14.4 percent, with \$1.3 billion in improper payments).



**Figure 11: Part B Improper Payment Amounts by State  
(Dollars in Millions)**

