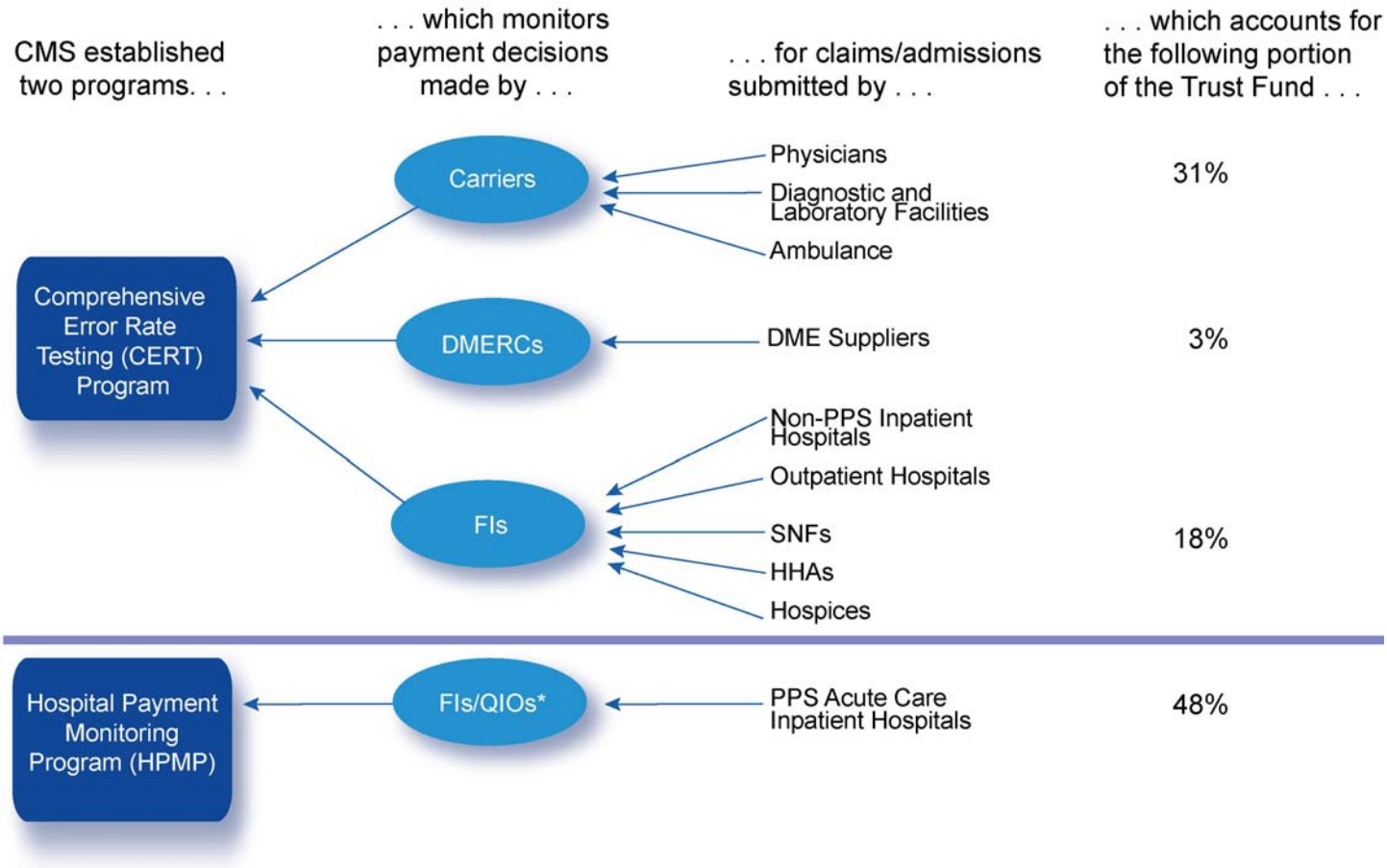
FY 2003
IMPROPER MEDICARE FFS PAYMENTS

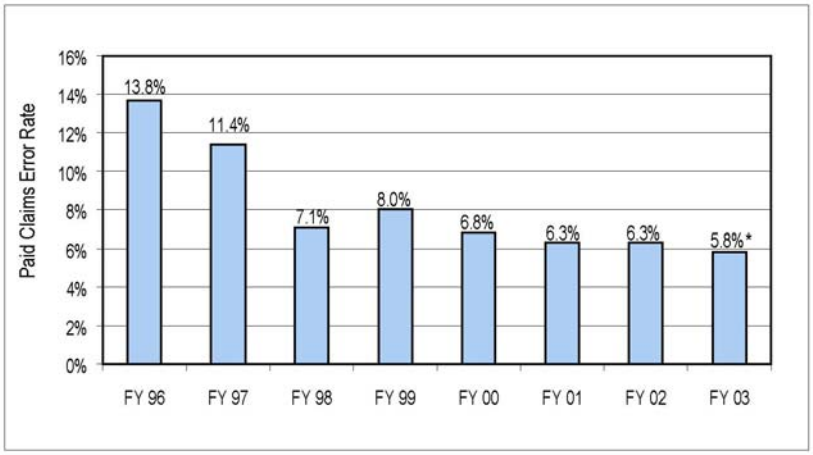
CMS' Process for Monitoring the Accuracy of Medicare Payments



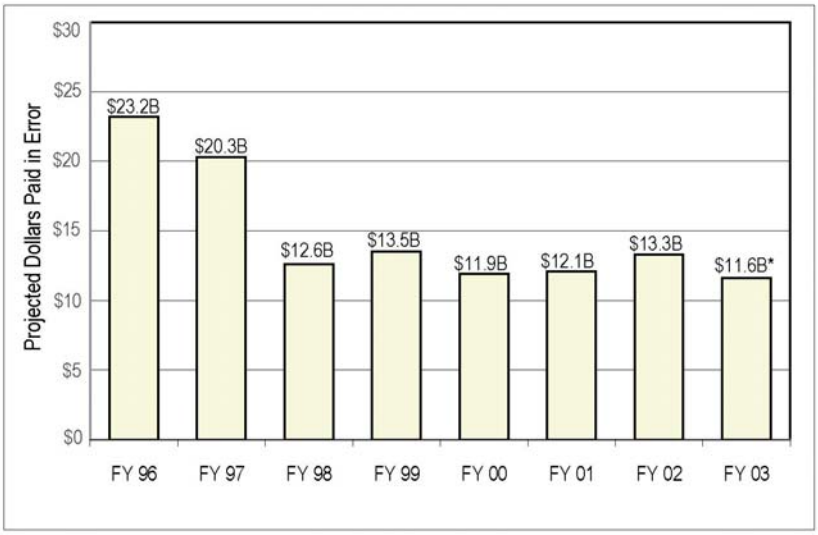
* FIs process payments; QIOs are responsible for ensuring accurate coding and coverage of PPS inpatient hospital admissions.

REPORT FINDINGS

National Paid Claims Error Rate



National Projected Dollars Paid in Error



* These figures have been adjusted to account for the high provider non-response experienced in 2003. Had the adjustment not been made, the national paid claims error rate would have been 9.8% and the projected dollars paid in error would have been $19.6B.

Percentage of Error by Category

Type of Error	1996	1997	1998	1999	2000	2001	2002	2003*
Non-Response	14.0%	18.7%	5.6%	7.3%	17.2%	12.4%	8.5%	18.5%
Insufficient Documentation	32.8%	25.6%	11.2%	33.1%	19.2%	30.5%	20.1%	45.0%
Medically Unnecessary Services	36.8%	36.9%	55.6%	32.8%	43.0%	43.2%	57.1%	21.7%
Incorrect Coding	8.5%	14.7%	18.0%	15.8%	14.7%	17.0%	14.3%	12.1%
Other	7.9%	4.1%	9.6%	11.0%	5.9%	(3.1%)	0.0%	2.7%
Total (%)	100%	100%	100%	100%	100%	100%	100%	100%

*These figures have been adjusted to account for the non-response problem experienced in 2003. Had the adjustments not been made, 54.7% of the 9.8% paid claims error rate would have been due to non-response, 25.9% due to insufficient documentation, 11.3% due to medically unnecessary services, 6.7% due to incorrect coding, and 1.4% due to other errors.

Contractor-Specific Error Rates

Carriers	Paid Claims Error Rate		Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
SSS PR/VI	25.7%	10.9%	26.7%	12.2%	28.7%	16.8%
Empire NY/NJ	20.7%	11.6%	27.4%	19.8%	21.3%	12.2%
GHI NY	19.7%	9.6%	22.6%	13.2%	21.5%	13.1%
NHIC CA	17.0%	8.1%	24.6%	17.2%	19.5%	10.9%
First Coast FL	16.9%	7.2%	24.8%	16.7%	18.8%	10.7%
BCBS AR NM/OK/LA	16.6%	7.8%	23.3%	15.9%	17.2%	11.0%
Trailblazer TX	16.5%	7.5%	25.9%	18.8%	19.5%	10.5%
Trailblazer MD/DC/DE/VA	14.8%	6.4%	25.5%	19.2%	22.2%	17.0%
Average = 14.4%						
WPS WI/IL/MI/MN	13.9%	6.8%	22.7%	17.0%	16.9%	11.7%
Highmark PA	13.8%	6.3%	22.4%	16.3%	15.8%	9.0%
BCBS RI	13.7%	10.1%	28.5%	25.8%	24.0%	20.8%
BCBS AR AR/MO	13.4%	7.4%	16.9%	11.4%	15.2%	10.3%
Cahaba AL/GA/MS	13.3%	6.9%	20.7%	15.2%	14.6%	9.8%
BCBS UT	12.1%	6.0%	20.6%	15.4%	13.7%	9.1%
NHIC MA/ME/NH/VT	12.0%	6.2%	19.2%	14.3%	15.2%	9.1%
Palmetto OH/WV	11.8%	6.8%	18.0%	13.7%	14.6%	9.5%
Palmetto SC	11.7%	7.0%	13.7%	9.3%	14.6%	10.6%
CIGNA ID/TN/NC	11.3%	7. 6%	14.2%	10.7%	15.2%	11.2%
HealthNow NY	11.0%	5.5%	15.4%	10.4%	16.0%	9.3%
BCBS KS KS/NE/Kansas City	9.7%	6.4%	11.9%	8.8%	11.5%	8.9%
Noridian AZ/HI/NV/AK/OR/WA	9.3%	5.1%	16.3%	12.8%	12.3%	7.9%
Noridian CO/ND/SD/WY/IA	8.9%	4.7%	18.3%	14.9%	10.7%	6.9%
AdminaStar IN/KY	8.9%	6.3%	10.1%	7.6%	10.7%	8.4%
First Coast CT	7.4%	5.1%	24.3%	20.7%	37.3%	35.8%
BCBS MT	6.1%	4.2%	11.5%	9.9%	11.0%	9.1%
All Carriers	**14.4%**	**7.3%**	**21.5%**	**15.5%**	**17.2%**	**11.0%**

DMERCs	Paid Claims Error Rate		Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Palmetto -- Region C	17.8%	11.5%	21.2%	15.4%	15.9%	11.8%
Average = 13.6%						
CIGNA -- Region D	11.8%	8.8%	13.1%	10.2%	13.7%	11.9%
Tricenturion PSC – Region A	10.5%	6.9%	11.6%	8.1%	12.9%	10.1%
AdminaStar -- Region B	7.3%	5.7%	8.0%	6.5%	9.7%	8.1%
All DMERCs	**13.6%**	**9.2%**	**15.9%**	**11.6%**	**13.7%**	**10.7%**

FIs	Paid Claims Error Rate	
	Including Non-Response Claims	Excluding Non-Response Claims
All FIs	**14.4%**	**3.9%**

QIOs	Paid Claims Error Rate Including Non-Response Claims
Kentucky	6.8%
Massachusetts	5.8%
Texas	5.6%
Ohio	4.9%
Puerto Rico	4.8%
Louisiana	4.6%
Tennessee	4.4%
Indiana	4.3%
Iowa	4.3%
South Dakota	4.3%
Arkansas	4.1%
Illinois	4.0%
Alaska	4.0%
Florida	3.9%
Pennsylvania	3.9%
Arizona	3.9%
New Jersey	3.9%
California	3.7%
Maryland	3.7%
New York	3.7%
Maine	3.6%
New Mexico	3.6%
South Carolina	3.6%
Average = 3.5%	
Nevada	3.2%
West Virginia	3.1%
Rhode Island	2.9%
Michigan	2.9%
Colorado	2.7%
Missouri	2.7%
Mississippi	2.5%
Vermont	2.4%
Delaware	2.4%
Utah	2.4%
Nebraska	2.4%
Oregon	2.4%
Washington	2.3%
New Hampshire	2.3%
Oklahoma	2.2%
Virginia	2.0%
North Dakota	1.9%
Alabama	1.8%
DC	1.6%
Georgia	1.4%
Connecticut	1.3%
Minnesota	1.3%
Wisconsin	1.1%
Kansas	1.1%
Idaho	0.8%
North Carolina	0.8%
Montana	0.6%
Wyoming	0.3%
Hawaii	0.3%
All QIOs	**3.5%**

Error Rates by Provider Type

Provider Type	Paid Claims Error Rate		Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Chiropractic	16.3%	11.3%	30.6%	27.3%	14.2%	10.6%
Physical Therapy	23.7%	18.2%	29.4%	24.7%	21.4%	16.4%
Internal Medicine	23.1%	13.5%	26.3%	17.5%	21.8%	15.3%
Independent Laboratory (billing a Carrier)	12.2%	2.8%	25.1%	18.1%	12.1%	4.4%
Other Carrier Billers	14.9%	7.3%	22.7%	16.3%	19.2%	12.9%
General Practitioner	17.7%	7.8%	21.6%	12.7%	21.0%	13.0%
Hematology/ Ontology	9.9%	5.4%	21.1%	17.7%	15.5%	10.0%
Urology	8.9%	5.3%	20.9%	18.2%	13.2%	10.6%
Family Practitioner	16.5%	10.0%	19.8%	13.9%	17.5%	13.1%
Cardiologist	15.0%	8.8%	19.2%	13.6%	20.1%	13.2%
Podiatry	9.2%	4.0%	18.7%	14.5%	11.7%	8.5%
Diagnostic Radiology	10.8%	1.9%	18.2%	10.7%	13.6%	5.8%
All DMERCs	13.6%	9.2%	15.9%	11.7%	13.7%	10.7%
Ophthalmology	5.6%	3.0%	14.3%	12.3%	8.8%	6.2%
Ambulance (billing a Carrier)	8.8%	4.7%	13.8%	10.2%	13.6%	8.9%
Non-PPS Hospital In-patient	53.0%	9.2%	N/A	N/A	29.6%	9.9%
FQHC	23.0%	1.8%	N/A	N/A	18.5%	1.5%
ESRD	20.7%	6.9%	N/A	N/A	20.8%	10.9%
SNF	20.2%	12.5%	N/A	N/A	9.3%	5.1%
Other FI Billers	15.1%	3.4%	N/A	N/A	14.0%	6.0%
OPPS, Laboratory (Billing an FI), Ambulatory (Billing an FI)	14.7%	4.4%	N/A	N/A	18.5%	6.4%
RHCs	12.3%	2.1%	N/A	N/A	10.2%	1.7%
Hospice	7.6%	1.6%	N/A	N/A	7.2%	1.5%
HHA	4.7%	0.6%	N/A	N/A	5.5%	0.7%
Inpatient PPS	3.5%	N/A	N/A	N/A	N/A	N/A
Free Standing Ambulatory Surgery	0.0%	0.0%	N/A	N/A	1.2%	1.2%
Total	**9.8%**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Displays the error rates by type of provider and category or error. Some provider types are not displayed due to insufficient representation in the claim sample volume.

QUESTIONS & ANSWERS

Q1: What was the reporting period for this report?

A1: *For Carriers and DMERCs, the report included claims submitted between 01/01/02 – 12/31/02. For FIs, it includes claims submitted between 06/01/02 – 12/31/02. For QIOs, it includes PPS inpatient hospital discharges between 04/01/01 – 03/31/02.*

Q2: Will these rates be updated to reflect late documentation?

A2: *Yes. Although CMS will not amend the written report, the rates will be updated quarterly to reflect late documentation. The following table is the update schedule for National Medicare FFS Paid Claims Error Rate and Carrier-specific, DMERC-specific, and FI Error Rates.*

Date Quarterly Update will be Posted to www.cms.hhs.gov/CERT	Including Late Documentation Received From Providers Through the Following Dates
January 1, 2004	September 30, 2003
April 1, 2004	December 31, 2004
July 1, 2004	March 31, 2004
October 1, 2004	June 30, 2004

Q3: What are the differences between the OIG and CERT methodologies?

A3: *The table below shows a comparison between the OIG and CERT methodologies.*

	OIG	CMS
Sample Size	6,000 claims	2003: 120,000 claims 2004+: 150,000 claims
Types of Error Rates	1 type: - Paid claims error rate	3 types: - Paid claims error rate - Provider compliance error rate - Services processed error rate
Level of Detail	National	- National - Contractor-specific - Service-type - Provider-type
Reviewers	Carriers/DMERCs/FIs	CERT contractor for Carriers/DMERCs/FIs; QIOs for QIOs
Follow-up to Obtain Records	Up to 4 letters and 3 calls; In-person visits if necessary	Up to 4 letters and 1 call; no in-person visits

Q4: How will CMS fix the non-response problem?

A4: *CMS has implemented numerous initiatives that reduced the paid claims error rate from 14% in 1996 to 6.3% in 2002. However, in 2003 when the task of calculating the error rate shifted from the OIG to CMS, a significant non-response problem developed. In order to reach the goal of lowering the error rate to 4% by 2008, CMS must correct the non-response problem. CMS is implementing a number of new corrective actions to correct the non-response problem including:*

1. *CMS revised the letters requesting medical records by clarifying the role of the CERT contractor and explaining that it is not a HIPAA compliance violation to submit records to the CERT contractor.*
2. *Carriers/DMERCs/FIs have been educating providers about the CERT contractor so that providers are not hesitant about sending in requested medical records.*
3. *CMS has requested funding to support an Electronic Medical Record (EMR) Submission Pilot to facilitate the process and timeliness of submitting medical records.*
4. *The CERT contractor has initiated a new process for contacting providers who fail to respond to CERT requests, including multiple letters, phone calls, and faxes to remind providers to submit medical records.*
5. *The CERT contractor will develop a mechanism to allow Carriers/DMERCs/FIs to see which providers have not responded to CERT documentation requests. Carriers/DMERCs/FIs can then assist in the process of contacting non-responding providers to encourage them to respond.*
6. *The CERT contractor is using a more advanced system to identify multiple provider addresses when letters are undeliverable due to incorrect addresses.*
7. *The CERT contractor has established a fax line for providers who wish to fax medical records rather than mailing them.*
8. *CMS plans to change the Medicare provider directory to allow providers to update their addresses, which should lead to faster updates.*
9. *CMS plans to conduct a Non-Responder Special Study to estimate the degree to which non-response claims represent "true" errors.*
10. *CMS will change the CERT methodology to adjust the error rates when a provider appeals a non-response case to the Carrier/DMERC/FI and the Carrier/DMERC/FI concludes that the claim should be paid. This change will make the CERT program more consistent with the HPMP (where appeals have always been reflected in the error rate) and will allow CMS and Carriers/DMERCs/FIs to focus on "real" problems rather than focusing on the non-responder problem.*
11. The CERT contractor will provide lists of the highest non-responders to requests for medical records to the OIG for them to consider further action.

Q5: How will CMS lower the rest of the error rate (the "real" errors)?

A5: *During the past several years, CMS and its contractors have undertaken a number of educational actions aimed at lowering the error rates. These actions will continue because CMS believes that provider*

education is one of the best tools to prevent errors. In addition, CMS and its contractors will undertake a series of new actions aimed at lowering the error rates. For example:

1. *CMS will increase and refine one-on-one educational contacts with providers found to be billing in error.*
2. *CMS will make it easier for providers to find the Medicare rules by developing a centralized database of national coverage, coding, and billing articles.*
3. *CMS will encourage contractors to address provider billing/payment questions more consistently.*
4. *CMS will develop and install new Correct Coding Initiative edits.*
5. *Contractors will clarify the chiropractic coverage and billing rules.*
6. *CMS will develop procedure code modifiers to allow chiropractors to better distinguish between covered care and non-covered care.*
7. *CMS will conduct a pilot test to determine if recovery audit firms can help identify Medicare overpayments.*
8. *CMS will develop a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data.*
9. *CMS will develop projects with the QIOs that address state-specific admissions necessity and coding concerns as well as conduct surveillance and monitoring of inpatient payment error trends by error type.*
10. *CMS will accelerate the production of error rates so that contractors can get feedback about the effect that their initiatives are having on the error rates faster.*
11. *CMS will use the Carrier-specific and DMERC-specific error rates in the contractor performance evaluation program.*
12. *CMS will closely monitor and evaluate each contractor's development and implementation of their Contractor Error Rate Reduction Plans.*

CMS has widely advertised the CERT contractor's activities and their effectiveness in detecting improper billing. CMS believes that the mere existence of the program as well as the initial results of CERT activities have encouraged providers to be more careful regarding how they bill Medicare and thus has increased the probability that a claim that appears error free at first sight is truly error free.

Q6: Why was the FY 2003 error rate adjusted?

A6: *Although the response rate from providers was very high (95%), it was not as high as in previous years. This was due to providers' misconceptions about HIPAA privacy rules, record requests being made by an unfamiliar entity, and CMS shared systems limitations. This unsually high non-response meant that over half of the unadjusted error rate (9.8%) was due to non-response. In order to provide a more meaningful estimate of the FY2003 paid claims error rate, CMS adjusted this rate to account for the unusual non-response rate. CMS did this by assuming that without these unusual factors contributing to non-response, the FY 2003 portion of errors due to non-response would equal the average percentage of errors due to non-response from 1996 – 2002.*