

Medicare Fee-for-Service 2012 Improper Payments Report

FOREWORD

The Medicare Fee-for-Service (FFS) 2012 Improper Payments Report was written concurrently with the release of the FY 2012 Department of Health and Human Services (HHS) Agency Financial Report (AFR) in November 2012. On March 13, 2013 the Part A to Part B Rebilling Demonstration (see pg. 6 and 45) was terminated by CMS Ruling CMS-1455-R. This ruling established a nationwide policy that when a Part A inpatient claim for a hospital admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit a claim for services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status. The CMS has published additional proposals through proposed rulemaking to establish a more permanent policy on Part A and B rebilling. The Medicare FFS 2012 Improper Payments Report was not updated prior to public release to reflect this change in policy. To ensure consistency in reporting from year to year, future reports will also reflect the policies that are in place at the time the improper payment rate is released in the HHS AFR.

Medicare Fee-for-Service 2012 Improper Payments Report

EXECUTIVE SUMMARY

The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010, requires the heads of federal agencies, including the Department of Health and Human Services (HHS), to annually:

- 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 the Agency is taking to reduce improper payments.¹

The Medicare Fee-for-Service (FFS) program has been identified as at risk for significant improper payments and is therefore subject to the improper payment measurement mandates outlined in the IPIA of 2002. The 2012² Medicare FFS improper payment rate was 8.5 percent, representing \$29.6 billion in improper payments.

The 2012 improper payment rate calculation includes two modifications from past years' calculations. The first modification is a change to the report period to allow an additional six months for the claims to mature (i.e., to undergo the entire appeals process and for providers and suppliers to submit additional documentation to support the claims billed). The second modification is the application of an adjustment factor to account for the impact of rebilling inpatient hospital claims that were denied under Medicare Part A as outpatient claims under Medicare Part B.

¹ OMB issued guidance for IPIA of 2002 implementation requirements through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011.

² The 2012 Medicare FFS improper payment rate is published in the FY 2012 HHS Agency Financial Report, but the report period (i.e., the time period from which the sample of Medicare FFS claims are 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.

Recognizing the importance of making the most accurate calculations possible, CMS began refining the improper payment measurement methodology in 2011. During that year, an adjustment factor was applied to account for activity related to the receipt of additional documentation and the outcome of appeal decisions that, in past years, routinely occurred after the publication of the improper payment rate in the HHS Agency Financial Report. This adjustment factor was an estimate of the anticipated impact of the additional documentation and appeals decisions on the improper payment rate, based on actual historical data from prior years. As a result, the 2011 improper payment rate was adjusted down from 9.9 percent to 8.6 percent. Because 2011 was the first year such an adjustment was applied to the improper payment methodology, CMS committed to continuously monitor these factors to ensure the ongoing validity of the adjustment and the accuracy of the improper payment rate calculation.

Since the publication of the 2011 improper payment rate, CMS has made two significant observations. First, CMS observed that fewer denials were overturned on appeal than in previous years. CMS believes that this was because in 2011 and 2012 it improved the coordination of appeal hearings, encouraged medical review entities to participate at the hearings, worked to strengthen the quality of case file documentation and preparation for the hearings, and provided education to appeals entities on Medicare policies. Therefore, the historical trends of claims overturned on appeal have significantly changed. Second, CMS found that by shifting the report period back six months, the Agency was able to capture approximately 91 percent of the actual impact that late documentation and appeals had on the improper payment estimates. Based on these findings, CMS concluded that it was preferable to replace the prospective adjustment factor that estimated the anticipated impact of appeals and late documentation with a methodology that calculated the actual impact of these activities. Accordingly, in 2012, CMS modified the report period by moving it back by six months, resulting in a sample consisting of claims processed between July 1, 2010 and June 30, 2011.³

³ As a result of this modification, there is a six-month overlap between the official 2011 and 2012 report periods (both include claims sampled between July 2010 and December 2010). Had this change in report period been applied in 2011 in place of the prospective adjustment factor, the improper payment rate would have been 9.6 percent (representing \$32.4 billion in improper payments) rather than 8.6 percent (representing \$28.8 billion in improper payments), as reported in the FY 2011 HHS Agency Financial Report and the Medicare FFS 2011 Improper Payments Report.

In addition to a change in the report period, CMS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient claims for allowable Part B services (herein, the A/B rebilling adjustment factor). Under Medicare policy⁴ during the report period, hospitals that submitted a claim for Part A inpatient services that should have been billed as outpatient claims under Part B were not permitted to resubmit a claim for such payment. These hospitals could only bill for a limited set of ancillary services provided to the beneficiary, such as diagnostic laboratory and x-ray tests. Any claim that was inappropriately paid as an inpatient claim was counted as an error for the total amount paid under Part A in past years. During the past two years, the Administrative Law Judges (ALJs) and the HHS Departmental Appeals Board (DAB) (specifically, the Medicare Appeals Council), which represent the third and fourth levels of Medicare claim appeals (respectively), have concluded that policy statements in certain Medicare manuals support Part B rebilling in these circumstances, despite CMS's longstanding policy and interpretation of these provisions.⁵ The ALJs and the DAB have consequently directed Medicare to pay hospitals that appeal denied Part A inpatient claims for all of the services provided under Part B (not just the ancillary services).

To properly reflect the impact of the rebilling activity that has been allowed because of these ALJ and DAB decisions and the Part A to Part B Rebilling Demonstration, CMS incorporated an A/B rebilling adjustment factor to reflect the difference between the inpatient Part A payment and the appropriate Part B payment. A downward adjustment of 0.8 percentage points was applied to the improper payment rate, the calculation of which was based on a statistical subset of inpatient claims that were in error because the services should have been billed as outpatient services.⁶ The decision to apply this adjustment factor does not reflect a change in CMS policy with respect to rebilling in these circumstances.

To summarize, the two modifications of (1) allowing an additional six months for the receipt of late documentation and the effectuation of appeals, and (2) accounting for the impact of rebilling denied Part A inpatient hospital claims under Part B, resulted in a final 2012 improper payment rate of 8.5 percent. Based on Medicare expenditures during the report period, the rate of 8.5 percent represents \$29.6 billion in improper payments. The modifications applied to the improper payment rate calculation methodology comply with the requirements of OMB Circular A-123, Appendix C, and produce a more accurate portrayal of the incidence of improper payments in the Medicare FFS program. These changes will also be incorporated into future improper payment calculations.

⁴ With the exception of a limited number of hospitals that are voluntarily participating in the A/B Rebilling Demonstration. See pg. 5 for more information.

⁵ *In the Case of O'Connor Hospital, Claim for Hosp. Ins. Benefits (Part A)*, (February 1, 2010), <http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/oconnorhospital.pdf>.

⁶ Had this change in report period been applied in 2011, the improper payment rate would have decreased from 8.6 percent to 7.9 percent.

The Summary Table below summarizes the improper payment rates by claim type: Part A (Acute Inpatient Hospital Services); Part A (Excluding Acute Inpatient Hospital Services); Part B (Outpatient Services); and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). DMEPOS claims had the highest improper payment rate of 66.0 percent while Part A claims had the highest amount of improper payments (\$14.3 billion).

Summary Table: 2012 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions)⁷

Claim Type	Total Amount Paid	Improper Payment Amount	Improper Payment Rate	95% Confidence Interval
Part A (Total)	\$250.7	\$14.3	5.7%	5.2% - 6.2%
Part A (Excluding Acute Inpatient Hospital Claims)	\$137.9	\$6.6	4.8%	4.2% - 5.5%
Part A (Acute Inpatient Hospital Claims)	\$112.8	\$7.7	6.8%	6.0% - 7.6%
Part B	\$89.3	\$8.9	9.9%	9.1% - 10.8%
DMEPOS	\$9.7	\$6.4	66.0%	62.8% - 69.2%
Overall	\$349.7	\$29.6	8.5%	8.1% - 8.9%

⁷ Some columns and/or rows may not sum correctly due to rounding.

Reducing the incidence of improper payments is a high priority for CMS and the Agency is working on multiple fronts to meet its improper payment reduction goals. Numerous programs have been developed with the aim of creating claims payment safeguards. Examples include increased prepayment medical review, enhanced analytics, augmented education and outreach to the provider and supplier communities, expanded review of paid claims by the CMS Recovery Auditors,⁸ improved clarity and consistency of payment policy instructions, and improved targeting of providers and suppliers with a history of submitting improper Medicare claims. In addition, CMS implemented the following three demonstration programs in FY 2012 to test whether improper payments can be further reduced from current levels.

- **Recovery Audit Prepayment Review Demonstration**

In September 2012, CMS expanded the use of Medicare Recovery Auditors in the Medicare FFS program. This Medicare program demonstration allows Recovery Auditors to review certain claim types for compliance with all Medicare payment rules before they are paid to prevent improper payments.

- **Part A to Part B Rebilling Demonstration⁹**

In January 2012, CMS established a demonstration program that allows a limited number of hospitals to rebill denied inpatient claims under Medicare Part A that would have been payable in an outpatient setting under Medicare Part B.¹⁰

Permitting participating hospitals to rebill allows them to obtain reimbursement for medically necessary services while protecting beneficiaries, encourages hospitals to make proper inpatient admission determinations, and reduces appeals. The demonstration is limited to a representative sample of hospitals nationwide that volunteered to be part of the program.

⁸ In accordance with Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), a Recovery Audit demonstration was conducted from March 2005 to March 2008 in six states to determine if Recovery Auditors could effectively be used to identify improper payments for claims paid under Medicare Part A and Part B. Due to the success of the Recovery Audit demonstration, the U.S Congress passed the Tax Relief and Health Care Act of 2006, which authorized the expansion of the Recovery Audit program nationwide. Each Recovery Auditor is responsible for identifying overpayments and underpayments in a geographically defined area that is roughly one-quarter of the country. In addition, the Recovery Auditors are responsible for highlighting to CMS common billing errors, trends, and other Medicare payment issues. The Recovery Auditors are paid on a contingency fee basis for both overpayments and underpayments that are identified and corrected.

⁹ On March 13, 2013 the Part A to Part B Rebilling Demonstration was terminated by CMS Ruling CMS-1455-R. This ruling established a nationwide policy that when a Part A inpatient claim for a hospital admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit a claim for services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status.

¹⁰ Hospitals participating in the demonstration during the report period could rebill for 90 percent of the Part B payment for services provided during a Part A inpatient short stay claim deemed not reasonable and necessary due to the hospital billing for the wrong setting. The claim could either be denied through MAC audit or deemed improper through hospital participant self-audit.

- **Prior Authorization of Power Mobility Device Demonstration**

In September 2012, CMS established a limited demonstration program that tests whether prior authorization can reduce fraud and improper payments for certain power mobility devices. The CMS believes this demonstration will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program, as is evidenced by the initial results of the program.¹¹

Together, these efforts aim to achieve more accurate claim payment determinations and reduce improper payments in the Medicare FFS program. The overall goal of these efforts is to maintain the fiscal health of the Medicare FFS Trust Funds while protecting Medicare beneficiaries.

This report describes the background of the Medicare FFS and Comprehensive Error Rate Testing programs, the incidence of improper payments during the 2012 report period, the common causes of these errors, and the various steps CMS is taking to reduce the occurrence of improper payments in the future.

¹¹ The prior authorization demonstration was successfully implemented and is running smoothly. Prior authorization reviews are being performed timely, industry feedback has been positive, and CMS has received no complaints from beneficiaries. For more information, see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicarePAofPMDDemoStatusUpdateApril2013.pdf>

THE MEDICARE FEE-FOR-SERVICE PROGRAM

Features of the Medicare Fee-for-Service Program

The Social Security Act established the Medicare program in 1965. Medicare provides the health care coverage needs of people age 65 and older, people under age 65 with particular disabilities, people of all ages with End Stage Renal Disease (ESRD), and certain others who elect to purchase Medicare coverage. The Medicare program is divided into four parts, two of which (Part A and Part B) make up the Medicare FFS portion of the program. Part A coverage includes inpatient hospital and skilled nursing facility stays, home health visits, and hospice care. Part B coverage includes physician visits, outpatient care, preventive services, home health visits, and other medical services and supplies (including DMEPOS). Part C (the Medicare Advantage program) and Part D (the Medicare prescription drug benefit) are not included in this analysis.

Both the number of Medicare beneficiaries and the associated health expenditures have increased dramatically since 1965. Approximately 49 million beneficiaries were enrolled in the Medicare program in calendar year (CY) 2011,¹² representing a 156 percent increase in enrollment since program inception. This increase occurred simultaneously with a rise in per-enrollee Medicare expenditures from \$341 in 1969 to \$10,949 in CY 2011.¹³

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

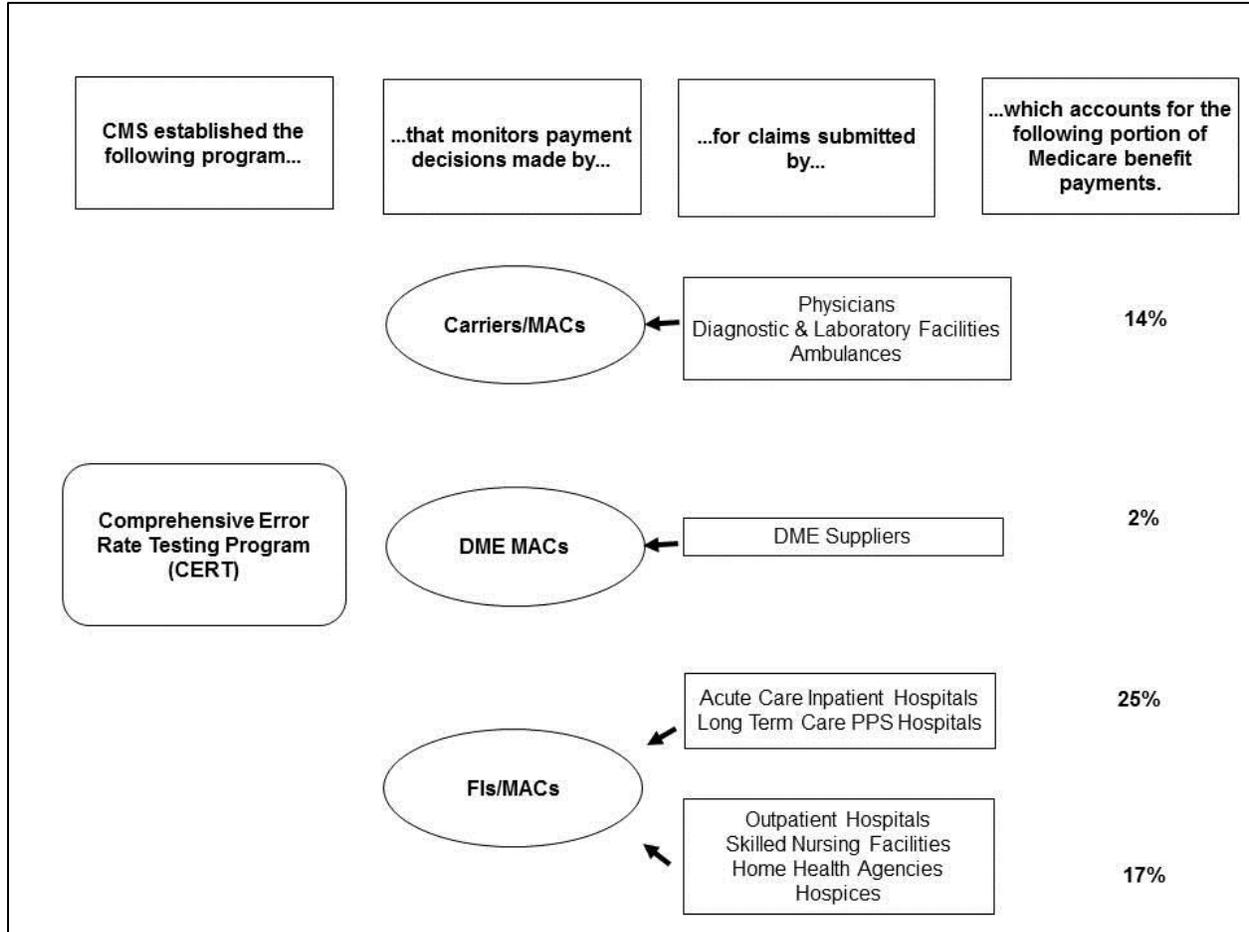
The CMS uses several types of contractors to pay claims in the Medicare FFS program: Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries (FIs). These contractors are responsible for preventing improper payments in the Medicare FFS program through their claims payment decisions and processes. Because the MACs are the dominant contractor type to pay Medicare FFS claims, the various contractor types will be collectively referred to as MACs throughout this report.

¹² Centers for Medicare & Medicaid Services, Medicare & Medicaid Statistical Supplement 2012 Edition, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2012.html>.

¹³ Centers for Medicare & Medicaid Services, National Health Expenditure Data, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>.

The following figure depicts the flow of claims by provider and supplier types through the MAC operations:

Figure 1: Flow of Claims through the Medicare Claim Payment Entities¹⁴



¹⁴ The percentages in Figure 1 do not add to 100 percent because the Medicare benefit payments include those made by Medicare Part C (the Medicare Advantage program) and Part D (the Medicare prescription drug benefit), which are not included in this analysis.

The primary goal of each MAC is to "pay it right," i.e., to pay the proper amount for covered, medically necessary, and correctly coded services. The MACs processed and paid more than 1.2 billion claims in CY 2011. MACs cannot manually review every claim that is submitted either before or after payment is rendered because of the large number of claims that the MACs must process. For this reason, automated edits in the claim systems (i.e., computer systems that are able to identify errors automatically) are largely used by the MACs to detect improper payments. However, the majority of claims pass through these automated edits because the required codes are present and all of the required billing information is present on the claim. For that reason, the MACs must actually examine the medical record in order to identify improper payments for most claims. During such reviews, professional medical reviewers review the submitted claims and supporting medical documentation to make more complex claim decisions that are not possible through automated methods (e.g., medical necessity and correct coding determinations). The CMS and the MACs decide what claim types should undergo automated, complex, pre-payment, or post-payment reviews based on analyses of contractor-specific improper payment data and national trends. This data is also used to develop strategies to reduce the number of improper claims submitted for payment, such as educational outreach efforts.

IMPROPER PAYMENT MEASUREMENT IN THE MEDICARE FEE-FOR-SERVICE PROGRAM

Statutory Background

Federal agencies are required under the IPIA of 2002, as amended by the IPERA of 2010, to annually review the programs they administer for improper payments. An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. In addition, improper payments include those to an ineligible recipient, payments for ineligible goods or services, duplicate payments, payments for goods or services not received (except for such payments where authorized by law), and any payments that do not account for credit for applicable discounts.

These laws require the Department of Health and Human Services 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 the Agency is taking to reduce improper payments.¹⁵

One of the key tenets of the IPIA of 2002 is that improper payment rate measurement programs should be incorporated as a critical part of federal agencies' internal controls. Agencies are instructed to use these key internal controls to inform decision makers about program vulnerabilities and drive corrective actions in order to reduce future improper payments.

History of Improper Payment Measurement

The Medicare FFS improper payment rate was first measured in 1996. The HHS Office of Inspector General (OIG) was responsible for estimating the national Medicare FFS improper payment rate from 1996 to 2002. Due to the small sample size of approximately 6,000 claims, the OIG was unable to produce improper payment rates by contractor type or identity, service type, or provider type.

¹⁵ OMB issued guidance for IPIA of 2002 implementation requirements through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011.

After the passage of the IPIA of 2002, CMS assumed responsibility for measuring the Medicare FFS improper payment rate in 2003. The CMS originally established two programs to monitor the payment accuracy of the Medicare FFS program: the Hospital Payment Monitoring Program (HPMP) and the CERT program. The HPMP measured the improper payment rate only for Part A inpatient hospital claims, while the CERT program measured the improper payment rate for all other Medicare FFS claim types. Beginning with the 2009 report period, the HPMP was dissolved and the CERT program became fully responsible for sampling and reviewing all Medicare FFS claim types for improper payments.

When improper payment measurement transitioned to CMS in 2003, the Agency increased the sample size substantially. Currently, the sample size is approximately 40,000 claims. This sample size allows CMS to calculate a national improper payment rate and contractor- and service-specific improper payment rates. Calculating these additional rates provides CMS and its contractors with valuable information to assist in the development of specific, robust corrective actions aimed at preventing improper payments from occurring in the future.

The Medicare FFS Improper Payment Rate Throughout the Years

Table 1 summarizes the overpayments, underpayments, overall improper payments, and improper payment rates that have been reported in the HHS Agency Financial Reports since 1996.¹⁶

¹⁶ The HHS Agency Financial Reports are located at <http://www.hhs.gov/afr>.

Table 1: National Improper Payment Rates by Year (Dollars in Billions)¹⁷

Fiscal Year	Total Dollars Paid	Overpayments		Underpayments		Overpayments + Underpayments	
		Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
1996	\$168.1	\$23.5	14.0%	\$0.3	0.2%	\$23.8	14.2%
1997	\$177.9	\$20.6	11.6%	\$0.3	0.2%	\$20.9	11.8%
1998	\$177.0	\$13.8	7.8%	\$1.2	0.6%	\$14.9	8.4%
1999	\$168.9	\$14.0	8.3%	\$0.5	0.3%	\$14.5	8.6%
2000	\$174.6	\$14.1	8.1%	\$2.3	1.3%	\$16.4	9.4%
2001	\$191.3	\$14.4	7.5%	\$2.4	1.3%	\$16.8	8.8%
2002	\$212.8	\$15.2	7.1%	\$1.9	0.9%	\$17.1	8.0%
2003	\$199.1	\$20.5	10.3%	\$0.9	0.5%	\$12.7	6.4%
2004	\$213.5	\$20.8	9.7%	\$0.9	0.4%	\$21.7	10.1%
2005	\$234.1	\$11.2	4.8%	\$0.9	0.4%	\$12.1	5.2%
2006	\$246.8	\$9.8	4.0%	\$1.0	0.4%	\$10.8	4.4%
2007	\$276.2	\$9.8	3.6%	\$1.0	0.4%	\$10.8	3.9%
2008	\$288.2	\$9.5	3.3%	\$0.9	0.3%	\$10.4	3.6%
2009 ¹⁸	\$285.1	\$34.2	12.0%	\$1.2	0.4%	\$35.4	12.4%
2010	\$326.4	\$33.2	10.2%	\$1.1	0.3%	\$34.3	10.5%
2011	\$336.6	\$28.0	8.4%	\$0.8	0.2%	\$28.8	8.6%
2012	\$349.7	\$28.5	8.2%	\$1.1	0.3%	\$29.6	8.5%

¹⁷ Some columns and/or rows may not sum correctly due to rounding.

¹⁸ There was a significant increase in the improper payment rate from 2008 to 2009. This increase was attributed to a significant change in the claim review methodology implemented in 2009. Specifically, (1) professional medical judgment could no longer be used to find a claim properly paid if a policy requirement was not met, (2) claims history alone could no longer be used as a valid source of review information, and (3) medical record documentation created by a supplier was no longer sufficient to support payment of a claim. These review changes were made based on recommendations from the Office of the Inspector General, which has responsibility for review of the CERT program. CMS continued using this review methodology in 2010 through 2012.

THE COMPREHENSIVE ERROR RATE TESTING PROGRAM

CERT Program Objectives

The CMS developed the CERT program to calculate the Medicare FFS program improper payment rate. The CERT program considers any claim that was paid when it should have been denied or paid at another amount (including both overpayments and underpayments) to be an improper payment.

To meet this objective, a random sample of Medicare FFS claims is reviewed by an independent medical review contractor (herein, CERT contractor) to determine if they were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the category of error at issue. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample is considered to be reflective of all of claims processed by Medicare FFS program during the report period.

It is important to note the improper payment rate is not a “fraud rate,” but is a measurement of payments made that did not meet Medicare requirements. The CERT program cannot label a claim fraudulent.

CERT Improper Payment Rate Calculation Process

Claims Selection

The first step in the CERT process is the selection of claims for the random sample. A stratified random sample of claims is selected on a semi-monthly basis from all Medicare claims submitted. Stratification is employed to ensure adequate representation of the various claim types that are submitted for Medicare reimbursement [i.e., Part A (acute inpatient hospital services only), Part A (excluding inpatient hospital services), Part B, and DMEPOS].¹⁹ A small portion of the claims sampled from the universe are unreviewable because they never completed the claim adjudication process (e.g., the claim was returned to the provider or supplier). The final CERT sample is comprised of claims that were either paid or denied by the MAC. This sampling methodology complies with all statutory requirements and OMB guidance. For the 2012 report period, CERT randomly sampled 43,492 claims. The aggregate number of claims sampled and the number of claims reviewed for each claim type is provided in Table 2.

¹⁹ Stratification of the random sample began in CY 2011. Prior to the introduction of stratification, the CERT program chose a simple random sample of claims processed by each MAC. As a result, the 2012 improper payment rate report period consists of claims chosen under the simple and stratified random sampling methodologies.

Table 2: 2012 Sample Sizes by Claim Type

Claim Type	Claims Sampled	Claims Reviewed
Part A (Excluding Acute Inpatient Hospital)	7,829	7,081
Part A (Acute Inpatient Hospital)	9,668	7,233
Part B	15,645	15,238
DMEPOS	10,350	10,117
Total	43,492	39,669

Medical Record Requests

After a claim is identified as part of the sample, the CERT program requests the associated medical records and other pertinent documentation from the provider or supplier that submitted the claim. The initial request for medical records is made via letter. Phone calls are also made to validate the provider’s or supplier’s contact information and to address any questions or concerns pertaining to the documentation request. If the provider or supplier fails to respond to the initial request within 30 days, the CERT program sends at least three subsequent letters. For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), additional documentation requests are also made to the *referring* provider who ordered the item or service, in addition to the request sent to the *billing* provider or supplier. Sometimes, the billing provider or supplier does not have documentation to support the medical necessity of the services billed but the referring provider has the complete medical records.

If no documentation is received within 75 days of the initial request, the claim is scored as an improper payment due to a “no documentation error.” Any documentation received after the 75th day is considered late documentation. If late documentation is received by the CERT contractor prior to the cut-off date for the receipt of documentation, the records are reviewed in the same fashion as if the documentation was submitted timely. Moreover, if late documentation is received after the cut-off date, the CERT contractor makes every effort to complete the review process before publication of the HHS Agency Financial Report. If this is not possible, the documentation is still reviewed and an error/non-error determination is made after the rate is reported. The results of improper payment determination reversals based upon late documentation are tracked by the CERT program on an ongoing basis.

Review of Claims

Upon receipt of medical records, medical review professionals at the CERT contractor conduct a review of the claim and submitted documentation to determine whether the claim was paid properly. These review professionals include nurses, medical doctors, and certified coders. Before reviewing documentation, the CERT contractor examines the CMS claims systems to confirm that (1) the person receiving the services was an eligible Medicare beneficiary, (2) the claim was not a duplicate, and (3) no other entity was responsible for paying the claim (i.e., Medicare is the primary insurer). When performing claim reviews, the CERT contractor ensures compliance with Medicare statutes and regulations, billing instructions, National Coverage Determinations (NCDs),²⁰ Local Coverage Determinations (LCDs),²¹ and coverage provisions in CMS instructional manuals.

Assignment of Error Categories

Based upon the review of the medical records, claims identified as containing improper payments are categorized into the appropriate error category. The five improper payment categories in the CERT program are described below.

No Documentation Errors—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 Errors—Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the reviewers at the CERT contractor 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 Errors—Claims are placed into this category when the reviewers at the CERT contractor 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.

²⁰ 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).

²¹ 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 medical reasonable and necessary criteria.

Incorrect Coding Errors—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 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 Errors— 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).

Appeals

Providers and suppliers have the right to appeal any improper payment decision made by the CERT contractor. There are three levels under which CERT program claims may generally be appealed: (1) redeterminations, which are conducted at the MAC level; (2) reconsiderations, which are conducted at the Qualified Independent Contractor (QIC) level; and (3) administrative hearings, which are conducted by Federal Administrative Law Judges (ALJs).²²

Once a final decision is made to pay or deny the claim, this appeal decision is incorporated into the calculation of the Medicare FFS improper payment rate.²³ The CERT program tracks appeals throughout all levels to ensure the accuracy of the improper payment rate. At the cutoff date for the calculation of the official improper payment rate in the HHS Agency Financial Report, the last decision made regarding payment of the claim (by the CERT contractor or during any level of appeal) is considered final for reporting purposes. The results of improper payment determination reversals based upon late documentation are tracked by the CERT program on an ongoing basis.

²² A small number of claims are elevated beyond these first three levels. The fourth level of appeal consists of a claims review by the HHS DAB, while the fifth level of appeal is a judicial review by a federal district court. Judicial review by a federal district court is limited to claims that are greater than a specified dollar amount.

²³ 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.

Determining the Improper Payment Rate

The next step in the CERT process is to calculate the improper payment rate. To complete this calculation, proper weighting must be applied. The improper payment amount for each MAC is weighted by its proportion of national total allowed charges. This weighting assures that each MAC's contribution to the overall improper payment rate is proportional to the percent of expenditures for which they were responsible during that year. After this weighting is complete, the Medicare FFS improper payment rate is calculated, the findings are projected to the universe of Medicare FFS claims submitted during the report period, and determinations of overall financial impacts are made based upon Medicare FFS expenditures. These calculations yield a rate with a 95 percent confidence interval of plus or minus 3.0 percentage points around the estimate of the percentage of improper payments.²⁴

Reporting the Results: Net and Gross Improper Payment Rates

The CERT program reports an improper payment rate that is based on the difference between what was paid and what should have been paid by the MACs. As previously mentioned, 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 the claim, partially deny the claim, or completely deny the claim). Therefore, the improper payment rate includes both overpayments (improper claim approvals) and underpayments (improper claim denials). The improper payment rate calculated for this universe of claims may be reported as either a gross rate or a net rate.

The net improper payment rate is calculated by subtracting the total underpayments from the total overpayments and dividing that result by the total dollars paid in the CERT sample. This rate focuses mainly on the impact of overpayments on the Medicare Trust Funds. The gross improper payment rate is calculated by adding together the absolute values of underpayments and overpayments and dividing that result by the total dollars paid in the CERT sample. The gross improper payment rate accounts for the percentage of total dollars that all MACs either improperly paid or improperly denied. This rate is an indicator of how both types of improper payment decisions (payments and denials) impact the Medicare Trust Funds. The gross rate is reported as the official improper payment rate by the CERT program.

²⁴ OMB issued guidance for IPPIA of 2002 implementation requirements through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011..

Reconciling Improper Payments Identified by the CERT Program

The last step in the CERT process is correcting the improper payments identified by the CERT contractor, either through recovery of overpayments or reimbursement of underpayments. The MACs are notified of overpayments and underpayments identified by the CERT contractor so that necessary payment adjustments can be implemented. MACs are only allowed to recover the actual overpayments identified in the CERT sample. The projections made to the claims universe by the CERT program cannot be used as the basis for recovering projected overpayments nationally.²⁵

Most of the actual overpayments identified by the CERT program are recovered. The CERT program identified \$19,961,109 in actual overpayments during the 2012 report period and, as of the publication date of the HHS Agency Financial Report, the MACs collected \$16,269,115 (81.5 percent) of these overpayments. There will always be some amount of the identified overpayments that is uncollectable. Some identified overpayments are not collected because the CERT contractor's decision was appealed and overturned after the improper payment rate was finalized. In addition, the MACs cannot collect overpayments if the provider or supplier has gone out of business and cannot be located. Because the majority of CERT overpayments are related to claims submitted by active Medicare providers or suppliers, the MACs may offset future payments to recoup overpayments from providers or suppliers who fail to respond to requests for repayment and who fail to appeal. The MACs are diligent in their attempts to collect the overpayments identified during the CERT process, as evidenced by the high proportion of overpayments that are recovered.

²⁵ 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 over the report period.

FISCAL YEAR 2012 MEDICARE FEE-FOR-SERVICE IMPROPER PAYMENT RATE ANALYSIS AND SUMMARY OF RESULTS

The 2012 Medicare FFS improper payment rate was 8.5 percent, representing \$29.6 billion in improper payments.

The 2012 improper payment rate calculation includes two modifications from past years' calculations. The first modification is a change in the report period to allow an additional six months for the claims to mature (i.e., to undergo the entire appeals process and for providers or suppliers to submit additional documentation to support the claims billed). The second modification is the application of an adjustment factor to account for the impact of rebilling inpatient hospital claims that were denied under Medicare Part A as outpatient claims under Medicare Part B.

Recognizing the importance of making the most accurate calculations possible, CMS began refining the improper payment measurement methodology in 2011. During that year, an adjustment factor was applied to account for activity related to the receipt of additional documentation and the outcome of appeal decisions that, in past years, routinely occurred after the publication of the improper payment rate in the HHS AFR. This adjustment factor was an estimate of the anticipated impact of the additional documentation and appeals decisions on the improper payment rate, based on actual historical data from prior years. As a result, the 2011 improper payment rate was adjusted downward from 9.9 percent to 8.6 percent. Because 2011 was the first year such an adjustment was applied to the improper payment methodology, CMS committed to continuously monitor these factors to ensure the ongoing validity of the adjustment and the accuracy of the improper payment rate calculation.

Since the publication of the 2011 improper payment rate, CMS has made two significant observations. First, CMS observed that fewer denials were overturned on appeal than in previous years. CMS believes that this was because in 2011 and 2012 it improved the coordination of appeal hearings, encouraged medical review entities to participate at the hearings, worked to strengthen the quality of case file documentation and preparation for the hearings, and provided education to appeals entities on Medicare policies. Therefore, the historical trends with claim overturns on appeal that were experienced in the past were significantly changed. Second, CMS found that by shifting the report period back six months, the Agency was able to capture approximately 91 percent of the actual impact that late documentation and appeals had on the improper payment estimates. Based on these findings, CMS concluded that it was preferable to replace the prospective adjustment factor that estimated the anticipated impact of appeals and late documentation with a methodology that calculated the actual impact of these activities. Accordingly, in 2012, CMS modified the report period by moving it back by six months, resulting in a sample consisting of claims processed between July 1, 2010 and June 30, 2011.²⁶

In addition to a change in the report period, CMS refined the improper payment methodology by accounting for the impact of rebilling of denied Part A inpatient claims for allowable Part B services (herein, the A/B rebilling adjustment factor). Under Medicare policy²⁷ during the report period, hospitals that submitted a claim for Part A inpatient services that should have been billed as outpatient claims under Part B were not permitted to resubmit a claim for such payment. These hospitals could only bill for a limited set of ancillary services provided to the beneficiary, such as diagnostic laboratory and x-ray tests. Any claim that was inappropriately paid as an inpatient claim was counted as an error for the total amount paid under Part A in past years. During the past two years, the Administrative Law Judges (ALJs) and the HHS Departmental Appeals Board (DAB), which represent the third and fourth levels of Medicare claim appeals (respectively), have concluded that policy statements in certain Medicare manuals support Part B rebilling in these circumstances, despite CMS's longstanding policy and interpretation of these manual provisions.²⁸ The ALJs and the DAB have consequently directed Medicare to pay hospitals that appeal denied Part A inpatient claims for all of the services provided under Part B (not just the ancillary services).

²⁶ As a result of this modification, there is a six-month overlap between the official 2011 and 2012 report periods (both include claims sampled between July 2010 and December 2010). Had this change in report period been applied in 2011 in place of the prospective adjustment factor, the improper payment rate would have been 9.6 percent (representing \$32.4 billion in improper payments) rather than 8.6 percent (representing \$28.8 billion in improper payments), as reported in the FY 2011 HHS Agency Financial Report and the Medicare FFS 2011 Improper Payments Report.

²⁷ With the exception of a limited number of hospitals that are voluntarily participating in the A/B Rebilling Demonstration. See pg. 43 for more information.

²⁸ *In the Case of O'Connor Hospital, Claim for Hosp. Ins. Benefits (Part A)*, (February 1, 2010), <http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/oconnorhospital.pdf>.

To properly reflect the practical impact of the rebilling activity that has been allowed because of these ALJ and DAB decisions and the Part A to Part B Rebilling Demonstration, CMS incorporated the A/B rebilling adjustment factor to reflect the difference between the inpatient Part A payment and the appropriate Part B payment. A downward adjustment of 0.8 percentage points was applied to the improper payment rate. The calculation of this adjustment was based on a statistical subset of inpatient claims that were in error because the services should have been billed as outpatient services. The decision to apply this adjustment factor does not reflect a change in CMS policy with respect to rebilling in these circumstances.

To summarize, the two modifications of (1) changing the report period to allow an additional six months for the receipt of late documentation and the effectuation of appeals, and (2) accounting for the impact of rebilling denied Part A inpatient hospital claims under Part B, resulted in a final improper payment rate of 8.5 percent. Based on Medicare expenditures during the report period, the rate of 8.5 percent represents \$29.6 billion in improper payments. The modifications applied to the improper payment rate calculation methodology comply with the requirements of OMB Circular A-123, Appendix C, and produce a more accurate portrayal of the incidence of improper payments in the Medicare FFS program. These changes will also be incorporated into future improper payment calculations.

Table 3 summarizes the improper payment rates by claim types: Part A (Acute Inpatient Hospital Services), Part A (Excluding Acute Inpatient Hospital Services), Part B (Outpatient Services), and DMEPOS.

Table 3: 2012 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions)²⁹

Claim Type	Total Amount Paid	Improper Payment Amount	Improper Payment Rate	95% Confidence Interval
Part A (Total)	\$250.7	\$14.3	5.7%	5.2% - 6.2%
Part A (Excluding Acute Inpatient Hospital Claims)	\$137.9	\$6.6	4.8%	4.2% - 5.5%
Part A (Acute Inpatient Hospital Claims)	\$112.8	\$7.7	6.8%	6.0% - 7.6%
Part B	\$89.3	\$8.9	9.9%	9.1% - 10.8%
DMEPOS	\$9.7	\$6.4	66.0%	62.8% - 69.2%
Overall	\$349.7	\$29.6	8.5%	8.1% - 8.9%

²⁹ Some columns and/or rows may not sum correctly due to rounding.

COMMON CAUSES OF IMPROPER PAYMENTS IN THE MEDICARE FFS PROGRAM: MEDICARE PART A

Inpatient Hospital Services

As in previous years, inpatient hospital services were a large driver of the improper payment rate. The dollar amounts for inpatient hospital claims are generally much higher than other claim types. Because of the large amount of improper payments stemming from errors identified with inpatient hospital claims, a focus on reducing errors in these claims is key to reducing the improper payment rate. For the 2012 report period, inpatient hospital claims had an improper payment rate of 6.8 percent, accounting for 32.3 percent of overall Medicare FFS improper payments. The projected improper payment amount for inpatient hospital services was approximately \$7.7 billion (rates and dollar amounts adjusted for A/B rebilling).

An inpatient is defined as a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.³⁰ Medicare covers an inpatient stay only if the inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. In making this determination, it must be established whether the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive environment than an inpatient setting. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. Absent these requirements, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, and/or factors that may cause the beneficiary to worry, do not justify a continued hospital stay.³¹

Moreover, CMS has also designated a select number of procedures as “inpatient-only procedures” that are reimbursable only when provided in an inpatient setting. Even if a procedure is not on the inpatient only list, it still may be reasonable and necessary for the patient to be admitted to the hospital as an inpatient. The decision whether to admit the patient as an inpatient will depend on the medical needs of the particular patient and the expectations of the admitting physician. Unless the procedure is on the Inpatient Only List, beneficiaries should generally be admitted as inpatients when the physician expects that the patient will need hospital care for 24 hours or more. The decision to admit is a complex medical judgment and the criteria the physician uses are described in Publication 100-02, Medicare Benefit Policy Manual, Chapter 1, section 10.

Part A inpatient hospital claims are covered under the Inpatient Prospective Payment System (IPPS). Under the IPPS, claims are reimbursed through the Medicare Severity Diagnosis Related Groups (MS-DRG) coding scheme, whereby hospitals are reimbursed for entire hospital stays

³⁰ Medicare Benefit Policy Manual, CMS Pub. 100-02, §10.

³¹ Medicare Program Integrity Manual, CMS Pub. 100-8, §6.5.2.

based upon the procedures performed, the severity of the beneficiary's condition, and other factors. To receive Medicare payment for an inpatient hospital stay, hospitals must meet all documentation requirements specified in the NCDs issued by CMS and the LCDs issued by the MACs. The NCDs and LCDs require that hospitals maintain a variety of documents that support the beneficiary's need for, and appropriateness of, the hospital services provided.

As previously described, an adjustment factor was applied to the 2012 improper payment rate to reflect the difference between the Part A claim payments determined to be erroneous because the services should have been billed as outpatient claims and the amount that would have been payable if claim resubmission was allowed under Part B. 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). As a result of these limitations, the breakdowns of inpatient hospital service errors in the following sections are not adjusted for the impact of Part B rebilling and will be indicated as such.

Incorrect Setting

Claims are often submitted for beneficiaries who were admitted as inpatients but the medical care and/or procedures should have been provided in an outpatient or other non-hospital based setting. The CERT contractor determined that there were 837 inpatient hospital claims in the sample that were denied in full because the services provided in an inpatient setting were medically appropriate in an outpatient setting. These sampled errors totaled \$9.1 million in actual overpayments, which projected to approximately \$6.5 billion in overpayments for the universe of Medicare FFS claims (rates and dollar amounts unadjusted for A/B rebilling).

Example: An inpatient hospital claim was submitted for a beneficiary who presented to the hospital with generalized weakness and low blood pressure. Documentation supported that the beneficiary received intravenous fluids in the emergency room and was quickly stabilized with no further complications. The beneficiary was not admitted to the hospital as an inpatient until the next morning and was discharged seven hours later. The CERT contractor determined that the inpatient admission was not medically necessary because the beneficiary's treatment would not have been compromised if outpatient observation care was continued until the beneficiary was discharged. The claim was scored as an improper payment due to a "medical necessity error."

Inpatient Hospital Short Stays

The frequency of inpatient hospital claim errors was positively correlated with decreasing lengths of stay. A majority of the short stay improper payments were due to the incorrect setting problem (see preceding section entitled *Incorrect Setting*). These trends have been observed in past reports as well (rates and dollar amounts unadjusted for A/B rebilling).

- Stays of one day or less had an improper payment rate of 36.1 percent, resulting in projected improper payments of approximately \$3.4 billion.
- Two day stays had a projected improper payment rate of 13.2 percent, resulting in projected improper payments of approximately \$1.6 billion.
- Three day stays had an improper payment rate of 13.1 percent, resulting in projected improper payments of approximately \$2.0 billion.

Inpatient hospital short stay claim errors are frequently related to the performance of elective surgical procedures. In such a situation, the beneficiary is typically admitted as an inpatient after the procedure is completed, monitored overnight, and discharged in the morning. The CERT contractor found that many of these cases should have been billed as outpatient services, even when the need for post-operative recovery and monitoring continued through the night.

Example: A beneficiary had been experiencing increasing symptoms of benign prostatic hypertrophy (non-cancerous enlargement of the prostate) unresponsive to appropriate medications. The beneficiary was admitted as an inpatient after undergoing an elective transurethral resection of the prostate (TURP), which was done without operative complications (nor were complications anticipated due to his general health). On the morning after surgery he was unable to void spontaneously so an indwelling catheter was reinserted, and he was discharged home with instructions to follow-up with his urologist in a few days. The CERT contractor determined that the procedure should have been billed as an outpatient service and the inpatient hospital claim was scored as an improper payment due to a “medical necessity error.”

Joint Replacements

Medicare covers medically necessary major joint replacements, in addition to the inpatient hospital services related to these procedures. The services related to major joint replacements had an improper payment rate of 12.6 percent, accounting for 2.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for joint replacements during the 2012 report period was approximately \$732 million (rates and dollar amount unadjusted for A/B rebilling).

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. CERT reviewers look at the totality of the medical documentation to make the determination of whether the total joint replacement was medically 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
- Reasons for deviating from a stepped approach from conservative treatment to surgical intervention

The following document types often provide the information needed to support the medical necessity of a total joint replacement, but were frequently missing from the submitted record. This list is not exhaustive; the presence or absence of this documentation does not conclusively determine whether the joint replacement was medically necessary.

- Admission history and physical exam
- Pre-operative physical or occupational therapy notes
- Nursing notes with pre-operative assessments of mobility and function
- Pre-operative outpatient notes
- Intra-operative findings documented in the operative notes
- Gross pathology findings from joint samples

The most common pieces of information missing from the medical record were the pre-operative condition of the joint ailment and any history of non-surgical therapies to treat the ailment (or reasoning for why such treatment was not attempted).

Example: The beneficiary was admitted to the hospital for hip replacement surgery. The only documentation submitted was a pre-operative assessment that stated “conservative treatments failed, planned hip replacement.” There was no submitted documentation of the beneficiary’s history and physical examination, pre-operative course of care, or radiological results. Because the submitted documentation did not support that the hip replacement was reasonable and necessary, the claim was scored as an improper payment due to a “medical necessity error.”

Cardiovascular Stents

Cardiovascular stents may be placed in narrowed arteries in order to improve blood flow, such as in the coronary arteries (arteries that supply the heart muscle). Several cardiovascular stent placement procedures were identified as having a sizeable impact on the Medicare FFS improper payment rate. These procedures had an improper payment rate of 10.7 percent, accounting for 1.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for cardiovascular stent procedures during the 2012 report period was approximately \$352 million (rates and dollar amount unadjusted for A/B rebilling).

These procedures are minimally invasive and generally are safely performed on an outpatient basis. However, these procedures may be provided and billed on an inpatient basis if the beneficiary's condition was appropriate for an inpatient level of care (e.g., complications during the procedure, presence of extensive co-morbidities). The majority of the improper payments identified for cardiovascular stents were categorized as medical necessity errors due to the fact that an inpatient claim was billed when the procedure did not need to be performed on an inpatient basis. In other words, the placement of the cardiovascular stent itself was medically necessary under Medicare coverage guidelines but should have been billed in the outpatient setting.

Example: The beneficiary had a previous heart catheterization that showed significant plaque buildup in one of the heart arteries, requiring non-urgent stent placement. The beneficiary was admitted to the hospital as an inpatient for an overnight stay for an elective stent placement. No complications were anticipated, she had no co-morbidities that required admission, and she experienced no complications during or after the procedure. Because the submitted documentation did not demonstrate medical decision-making or factors that supported the medical necessity of the admission either before or after the procedure was performed, the claim was scored as an improper payment due to a "medical necessity error."

Cardiac Pacemakers

Cardiac pacemakers are self-contained, battery-operated units that send electrical stimulation to the heart. They are generally implanted to alleviate symptoms of decreased cardiac output related to an abnormal heart rate and/or rhythm. The services related to cardiac pacemakers had an improper payment rate of 36.3 percent, accounting for 1.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for pacemakers during the 2012 report period was approximately \$600 million (rates and dollar amount unadjusted for A/B rebilling).

Medicare coverage criteria related to the implantation of permanent pacemakers are dictated by an NCD. The NCD outlines the specific medical indications that support the medical necessity of a single-chamber or a dual-chamber pacemaker. The NCD also describes non-covered medical conditions for each type of pacemaker. The majority of the improper payments identified for cardiac pacemaker-related services were medical necessity errors. Most of these medical necessity errors occurred when a dual-chamber pacemaker was inserted but the condition of the beneficiary supported the insertion of a single-chamber pacemaker under Medicare coverage guidelines outlined in the NCD.

Example: A beneficiary underwent placement of a dual-chamber pacemaker during a medically necessary inpatient admission. The report of a heart catheterization study was submitted by the provider to support the medical necessity of the dual-chamber pacemaker; however, this heart catheterization report showed that the beneficiary did not have any of the indications for the placement of a dual-chamber pacemaker under the NCD guidelines. Because the dual-chamber pacemaker was deemed not reasonable and necessary, the inpatient stay DRG was revised after the procedure code was removed. The claim was scored an improper payment due to a “medical necessity error” and the improper payment was the difference between the amount allowed under the originally paid DRG and the amount allowed under the recalculated DRG.

Skilled Nursing Facility Services

The Medicare skilled nursing facility (SNF) benefit pays for certain services provided in various settings, including nursing homes, hospitals, and other freestanding facilities. Covered SNF services require the skills of qualified technical or professional health personnel. Examples of skilled care include performing professional assessments of a beneficiary’s condition, teaching a beneficiary how to manage his or her treatment regimen, medication injections, and tube feedings. Custodial services alone are not covered by the SNF benefit, which include assistance with activities of daily living such as bathing, dressing, and using the bathroom. SNF services had an improper payment rate of 4.8 percent, accounting for 5.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2012 report period was approximately \$1.6 billion.

The majority of improper payments for SNF services were due to insufficient documentation errors. Providers of SNF services are required to submit documentation to support the medical necessity of SNF services provided. If supporting documents are missing or incomplete, then documentation is considered insufficient to support the services billed. 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 to support the medical necessity of SNF services, and therapy times to support any therapy services billed.

Example: A SNF submitted a bill for skilled services provided to the beneficiary in a nursing home setting. However, the SNF did not submit any physician records certifying that the beneficiary needed daily skilled care that could only be provided in the SNF setting. This claim was scored as an improper payment due to an “insufficient documentation error.”

Home Health Services

The Medicare FFS home health benefit pays for certain health care services in the home setting if the services are considered reasonable and necessary for the treatment of an illness or injury and certain other criteria are met. Covered services include skilled nursing care; medical social services; medical supplies; and physical, occupational, and speech-language therapies. Home health services had a projected improper payment rate of 6.1 percent, accounting for 3.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during the 2012 report period was approximately \$1.2 billion.

Home health services coverage depends on factors such as homebound status of the beneficiary and a minimum required time period for skilled services. There are several documentation elements that must be submitted with a home health service claim to support that the services were reasonable and necessary under Medicare policy. Some examples of required documentation include, but are not limited to: (1) therapy notes; (2) physician certification/recertification of homebound status and the need for home health services; (3) face-to-face encounter documentation;³² and (4) the Outcome and Assessment Information Set (OASIS), which includes a comprehensive assessment of an adult home care patient.

Insufficient documentation and medical necessity errors accounted for roughly the same proportion of home health services improper payments. A home health claim is considered an insufficient documentation error if one or more documentation elements are not submitted or are incomplete. A home health claim is considered a medical necessity error if there is enough information in the submitted record to make the determination that the home health services were not medically necessary based upon the beneficiary's condition or care needs. In other words, the care given in the home setting was not considered skilled care, was provided for a stable medical condition, or was provided to a beneficiary that was not homebound and therefore did not require home health services.

Example: A beneficiary with chronic lung disease had been receiving home health services for three years. The documentation submitted showed that the home health agency provided weekly visits during which the beneficiary received instructions on diet, medications, and the disease process. There was no physician's order or documented face-to-face encounter establishing the patient's need for skilled care. There also was no documented evidence of a recent change in condition, diagnosis, treatment, plan of care, or medication regimen that would require the skilled intervention of a nurse. Because weekly general assessments with repetitive teaching on long-standing conditions are not covered under the home health benefit, this claim was scored as an improper payment due to a "medical necessity error."

³² The face-to-face documentation requirement became effective on January 1, 2011. Therefore, only claims with dates of service after January 1, 2011 were reviewed for meeting this requirement.

COMMON CAUSES OF IMPROPER PAYMENTS IN THE MEDICARE FFS PROGRAM: MEDICARE PART B

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Medicare FFS provides coverage for medically necessary DMEPOS items under Part B. 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 required documentation elements outlined in Medicare policies must be present for the claim to be paid. While the overall Medicare FFS expenditures for DMEPOS items accounted for about 2.8 percent of all Medicare FFS expenditures in the 2012 report period, the impact of the DMEPOS improper payments on the overall improper payment rate was significant. DMEPOS had an improper payment rate of 66.0 percent, accounting for 19.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for DMEPOS during the 2012 report period was approximately \$6.4 billion.

The vast majority (94.2 percent) of the DMEPOS improper payments identified by the CERT contractor were due to insufficient documentation errors. That is, for most of these improper payment claims, the supplier or provider did not submit a complete medical record to support that the billed services or supplies were actually provided, provided at the level billed, and/or were medically necessary. In other cases, documentation elements that were required as a condition of payment were missing. Examples of such required documentation were a documented face-to-face physician evaluation within a specified timeframe and a required physician signature on a supplier form.

Under Medicare requirements, documentation created by the DMEPOS supplier alone is insufficient to warrant payment of the claim. 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 substantiate the necessity for DMEPOS items billed, CMS began notifying the ordering provider in 2011 when an item is selected for CERT review. The notification reminds providers of their responsibilities to document medical necessity for the DMEPOS items ordered and to submit requested documentation to the supplier.

Approximately 4.2 percent of the improper payments for DMEPOS items and services were classified as medical necessity errors. When the submitted medical records contained adequate documentation to make a definitive determination that the services or supplies claimed were not medically necessary under Medicare coverage guidelines, and the service or supply should not have been paid.

Oxygen supplies and equipment, glucose monitors, and nebulizers & related drugs had the highest incidence of improper payments within the category of DMEPOS, accounting for 4.4

percent, 3.3 percent, and 1.4 percent of the total Medicare FFS projected improper payments (respectively). These three DMEPOS groups accounted for approximately 45.8 percent of the DMEPOS improper payments in the 2012 report period. The improper payments associated with these items, along with the improper payments associated with power wheelchairs and supplies for beneficiaries with obstructive sleep apnea, are discussed below.

Oxygen Supplies

Medicare FFS provides coverage for home and portable oxygen supplies for beneficiaries with severe lung disease or symptoms related to low oxygen levels that can be improved with oxygen therapy. The improper payment rate for oxygen supplies was 80.9 percent, accounting for 4.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for oxygen supplies during the 2012 report period was approximately \$1.4 billion.

Given the critical nature of these supplies, it is essential that the beneficiary be closely monitored by a physician and that the related physician documentation supports 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, blood oxygenation 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
- Blood oxygenation 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
- Physician's notes supporting continued monitoring of oxygen supply usage and need

Example: A claim was submitted for an oxygen concentrator to deliver supplemental oxygen within a beneficiary's home. While a physician's order was submitted, the supplier did not include the physician's notes showing that the beneficiary had a condition requiring oxygen therapy, the beneficiary's medical need for the oxygen was being monitored, or the beneficiary was using the oxygen concentrator within the home. This claim was scored as an improper payment due to an "insufficient documentation error."

Example: A claim was submitted for an oxygen concentrator to deliver supplemental oxygen within a beneficiary's home. The submitted documentation included the initial and recertification CMN and the report of overnight pulse oximetry. The oximetry report indicated that the beneficiary's oxygen saturation levels did not meet the medical necessity requirements of oxygen supplies contained in the relevant LCD. This claim was scored as an improper payment due a "medical necessity error."

Glucose Monitoring Supplies

Medicare FFS 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 monitoring supplies was 80.7 percent, accounting for 3.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for glucose monitoring supplies during the 2012 report period was approximately \$1.1 billion.

It is essential that a physician closely monitors a diabetic beneficiary and documents the continued medical necessity of glucose monitoring 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 monitoring supplies, evaluations demonstrating physician oversight of the beneficiary, and the need for glucose monitoring supplies.

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

- The order for the glucose 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 monitoring at the frequency billed
- Physician's notes showing periodic reviews of the glucose monitoring orders within Medicare's designated timeframes

Other improper payments for glucose supplies were attributed to medical necessity errors. For example, improper payments were found because the beneficiary exceeded allowable utilization limits by concurrently receiving diabetic supplies from multiple DMEPOS suppliers.

Example: A claim for diabetic test strips was submitted for a beneficiary who did not require insulin. The quantity of diabetic test strips ordered exceeded the utilization amounts covered by Medicare for non-insulin dependent beneficiaries. Clinical documentation was missing that supported the medical need for this quantity of testing supplies. In addition, no documentation was submitted supporting that the treating physician had seen the beneficiary and evaluated diabetic control within the six months prior to ordering the test strips. The claim was scored as an improper payment due to an "insufficient documentation error."

Nebulizer Machines and Related Drugs

Medicare FFS provides coverage for medically necessary nebulizer machines and related drugs for those beneficiaries with various diagnoses affecting lung function and breathing capacity. Nebulizer machines and related drugs had an improper payment rate of 46.7 percent, accounting for 1.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for nebulizer machines and related drugs during the 2012 report period was approximately \$446 million.

Over 99 percent of the improper payments identified by the CERT contractor for nebulizer machines and related drugs were caused by insufficient documentation. There must be a written order from the treating physician that specifies the name of the solution to be dispensed, the correct dosage, and administration instructions, including the prescribed frequency of use. Medicare also requires documentation from the treating physician that supports the medical necessity of the nebulizer and inhalation drugs. If any of the documentation requirements are not met, the nebulizer drug is denied as insufficiently documented.

Example: The supplier billed for a small volume nebulizer administration set and two nebulizer medications. Neither the supplier nor the ordering physician submitted clinical records that supported physician oversight of the beneficiary and the clinical need for the nebulizer medications as ordered. This claim was scored as an improper payment due to an “insufficient documentation error.”

Power Mobility Devices (PMDs)

The power mobility device (PMD) group of DMEPOS consists of such devices as power wheelchairs and power operated vehicles (scooters), along with accompanying accessories. Medicare FFS provides coverage for PMDs when a beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living within the home, the limitation cannot be sufficiently and safely 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. In addition, the beneficiary must meet additional medical necessity requirements for specific PMD categories. PMDs had an improper payment rate of 84.6 percent, accounting for 0.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for PMDs during the 2012 report period was approximately \$298 million.

Medicare pays for PMDs only when specific requirements are met. There must be a face-to-face visit with a physician or other qualified medical professional specifically assessing the beneficiary's mobility limitations and needs. In addition, the PMD order must contain certain elements and be written after the medical evaluation is complete. Lastly, the order and medical records must be sent to the PMD supplier within 45 days after completion of the evaluation. The documentation elements required for PMD claims have been made very specific by the MACs as a way to ensure the medical necessity of these devices. In addition, because Medicare's coverage of a PMD is determined solely by the beneficiary's mobility needs within the home, the examination must clearly describe the beneficiary's abilities and needs within the home.

The largest cause of improper payments for PMD claims were insufficient documentation errors, followed by medical necessity errors. If any of the required elements were not documented in the record submitted for review, the claim was considered an improper payment due to insufficient documentation. In many cases, the submitted documentation did not specifically validate that the beneficiary needed a PMD to support their activities of daily living within their home.

Example: A claim was submitted for a power wheelchair. While a face-to-face evaluation was submitted, it did not include a history of the beneficiary's mobility limitations or a measurable exam of the beneficiary's lower extremity strength and range of motion to support the need for a power wheelchair in the home. In addition, the submitted documentation did not address why the beneficiary's mobility limitations could not be sufficiently and safely resolved using an appropriately fitted cane or walker, or an optimally-configured manual wheelchair. Because the documentation submitted was inadequate to support the medical necessity of the items billed, the claim was scored as an improper payment due to an "insufficient documentation error."

Positive Airway Pressure Devices (CPAP/BiPAP)

Medicare FFS provides coverage for continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) devices for beneficiaries with sleep apnea. Sleep apnea occurs when a beneficiary stops breathing while sleeping because of obstructions or other issues with his or her airway. CPAP and BiPAP devices help to keep the airway open by blowing air into the airway through a mask worn during sleep. CPAP/BiPAP supplies had an improper payment rate of 56.0 percent, accounting for 1.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for CPAP/BiPAP supplies during the 2012 report period was approximately \$356 million.

Medicare coverage of a CPAP/BiPAP device is contingent on a qualifying sleep study, a physician evaluation of the beneficiary's sleep apnea, and instruction from the supplier regarding the proper use and care of the equipment. A BiPAP device is covered only when the CPAP has been shown to be ineffective in a clinical or home setting. Coverage of a CPAP/BiPAP device is initially limited to a 3-month period, with coverage beyond this period being contingent on a re-evaluation by the treating physician, performed within a specified period of time, showing the beneficiary is benefitting from the therapy and is adhering to specified usage guidelines.

Most of the improper payments for CPAP/BiPAP 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/BiPAP 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
- Qualifying sleep test that meets the requirements of the LCD

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 the LCD, 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. This claim was scored as an improper payment due to an “insufficient documentation error.”

Evaluation and Management Services

Evaluation and Management (E&M) services refer to visits and consultations furnished by physicians and other non-physician practitioners (NPPs) to Medicare beneficiaries. E&M services had an improper payment rate of 14.0 percent, accounting for 13.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for E&M services during the 2012 report period was approximately \$4.2 billion.

While E&M services vary in several ways, such as the nature and amount of physician work required and the complexity of the beneficiary’s needs, the following general documentation elements are required to be submitted to support the diagnosis and treatment codes reported on the Medicare claim:

- A medical record that is complete and legible
- Patient encounter information, including the reason for the encounter, relevant history and physical exam findings, results of diagnostic tests, the clinical impression or diagnosis, the plan of care, and the date and identity of the provider
- Documented or easily inferred rationale for ordering diagnostic and other ancillary services
- Past, present, and revised beneficiary diagnoses
- Appropriate health risk factors
- The beneficiary’s progress, along with responses to and changes in treatment

Most of the improper payments for E&M services were due to incorrect coding and insufficient documentation errors. Incorrect coding errors for E&M services were commonly found when the provider submitted medical documentation that supported a different E&M code than the code billed. Another major driver of E&M improper payments during the 2012 report period was insufficient documentation. Many of these claims were identified by the CERT contractor as errors because the submitted records lacked physician authentication or the physician did not obtain the records for E&M services that were not performed in their office (e.g., E&M services that were provided to a beneficiary in the hospital, rather than in the physician's clinic).

Example: For an initial hospital care code, a physician must meet three key components for the service: (1) comprehensive history, (2) comprehensive exam, and (3) high complexity medical decision-making. In circumstances where the submitted documentation did not meet this requirement, the CERT reviewer down-coded the service so that the physician received some payment for the services documented in the medical record. The claim was scored as a partial improper payment due to an "incorrect coding error" and the amount in error was the difference between the higher payment billed and the lower payment rendered.

Split/Shared E&M Services

A split/shared E&M visit is defined as a medically necessary encounter where the physician and a qualified NPP each personally perform a substantive portion of an E&M visit face-to-face with the same beneficiary on the same date of service. The split/shared E&M visit applies only to selected E&M visits and settings and may be billed under the physician's National Provider Identifier (NPI) if it meets the definition of a split/shared visit and meets all other requirements. The most common cause of improper payments for these claim types was insufficient documentation errors.

Example: A split/shared E&M claim was submitted for payment. While the submitted documentation contained a physician's signature on the NPP's clinical note, no other documentation was made by the physician supporting that the physician performed a substantive portion of the split/shared E&M service. This claim was scored an improper payment due to an "insufficient documentation error."

CAUSES OF IMPROPER PAYMENTS IN THE MEDICARE FFS PROGRAM: ERROR CATEGORIES

No Documentation Errors

Claims are placed into this category when either the provider or supplier fails to respond to repeated attempts to obtain the supporting documentation or the provider or supplier responds that they do not have the requested records. “No documentation errors” accounted for 0.2 percent of the total Medicare FFS payments made during the 2012 report period. The data break down as follows:

**Table 4: 2012 Improper Payment Rates by Claim Type:
“No Documentation Errors”³³**

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.0%	0.0%	0.1%	0.0%	0.2%

Example: A provider submitted a claim for complex renal testing. After multiple attempts were made to obtain the medical records associated with this test, the CERT review contractor received a letter from the provider stating that the provider was “unable to locate patient information in our system.” The claim was scored as an improper payment due to a “no documentation error.”

Insufficient Documentation Errors

Claims are placed into this category when the medical documentation submitted is inadequate to support the billing of the claimed service. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or medically necessary. Claims are also placed into this category when specific documentation that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required as a condition of payment was not completely filled out. Insufficient documentation errors accounted for 5.0 percent of the total Medicare FFS payments made during the 2012 report period. The data break down as follows:

³³ Some columns and/or rows may not sum correctly due to rounding.

**Table 5: 2012 Improper Payment Rates by Claim Type:
“Insufficient Documentation Errors”³⁴**

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
1.3%	0.4%	1.6%	1.7%	5.0%

Example: A provider submitted a claim for a visit he made to a beneficiary who was an inpatient at a local hospital. While a hospital discharge summary was received that validated the beneficiary was in the hospital on the date of service billed, additional documentation supporting a hospital visit on that date was not, despite multiple requests. The claim was scored an improper payment due to an “insufficient documentation error.”

Example: A physician submitted a claim for an office visit with a Medicare beneficiary. While an office visit note was submitted for the date of service billed, the note lacked the beneficiary’s name or other identifying information. Additional documentation to support the office visit billed was requested, but none was received. The claim was scored as an improper payment due to an “insufficient documentation error.”

Example: A claim was submitted for physician services provided to a beneficiary with end-stage renal disease. The documentation that was submitted included renal dialysis flow sheets with assessments by nurses and technicians only, while no notations were made by the billing physician. Because no documentation was submitted to support the physician services billed, the claim was scored as an improper payment due to an “insufficient documentation error.”

Example: A claim was submitted for an office visit. The office visit note was unsigned and the CERT reviewer was unable to determine the identity of the provider based on the documentation submitted. Because no statement was submitted by the provider attesting authorship of the office visit note, the claim was scored as an improper payment due to an “insufficient documentation error.”

³⁴ Some columns and/or rows may not sum correctly due to rounding.

Medical Necessity Errors

Claims are placed into this category when the CERT contractor receives adequate documentation from the medical records submitted to make the informed decision that the services billed were not medically necessary based upon Medicare coverage policies. Medical necessity errors accounted for 2.6 percent of the total Medicare FFS payments made during the 2012 report period. The data break down as follows:

**Table 6: 2012 Improper Payment Rates by Claim Type:
“Medical Necessity Errors”³⁵**

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.3%	2.2%	0.1%	0.1%	2.6%

Example: A claim was submitted for the monthly rental of a semi-electric hospital bed. Per the relevant LCD, semi-electric hospital beds are reasonable and necessary if the beneficiary’s medical condition requires one or more of the following: positioning of the body in ways not feasible with an ordinary bed, elevation of the head more than 30 degrees most of the time, traction equipment, or frequent changes in body position. The medical records received from the ordering physician failed to support that the beneficiary’s condition required any of this assistance. Because the records showed that the beneficiary’s condition did not meet the LCD medical necessity requirements for a semi-electric hospital bed, the claim was scored as an improper payment due to a “medical necessity error.”

³⁵ Some columns and/or rows may not sum correctly due to rounding.

Coding Errors

Claims are placed into this category when the provider or supplier submits medical documentation that supports (1) a different code than that billed, (2) that the service was performed by someone other 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. Incorrect coding errors accounted for 1.3 percent of the total Medicare FFS payments made during the 2012 report period. The data break down as follows:

**Table 7: 2012 Improper Payment Rates by Claim Type:
“Coding Errors”³⁶**

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.2%	0.4%	0.8%	0.0%	1.3%

Example: A SNF submitted a claim for 25 days of rehabilitation care at a reimbursement level that requires a minimum of 325 minutes of therapy performed at least 5 days per week. However, the submitted documentation supported that therapy was provided on only one day for a total of 65 minutes. This amount of rehabilitation was used to reprocess the claim at the correct reimbursement amount. The claim was scored as an improper payment due to an “incorrect coding error” and the amount in error was calculated to be the difference between the incorrectly coded and the correctly coded reimbursement levels.

Example: A claim was submitted by a hospital for a three-day inpatient hospital stay. A review of the hospital record revealed that the principal beneficiary diagnosis submitted on the claim was not supported by the beneficiary’s record and that a different code should have been submitted. Patient diagnoses are expressed by codes and code guidelines must be followed. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Guidelines for Hospitals are the guidelines with which inpatient hospital claims must comply. When the revised diagnosis code was entered into the Medicare claims system, the reimbursement level for the inpatient hospital stay was changed. The claim was scored as an improper payment due to an “incorrect coding error” and the amount in error was calculated to be the difference between the incorrectly coded and the correctly coded reimbursement levels.

³⁶ Some columns and/or rows may not sum correctly due to rounding.

Other Errors

This category includes claims that do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service). Other errors accounted for 0.1 percent of the total Medicare FFS payments made during the 2012 report period. This data break down as follows:

**Table 8: 2012 Improper Payment Rates by Claim Type:
“Other Errors”³⁷**

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.1%	0.0%	0.0%	0.0%	0.1%

Example: A claim was submitted for anesthesia used during a routine dental extraction for dental cavities. As services associated with a non-covered service (dental extraction) are not allowed, this was scored as an improper payment due to an “other error.”

Example: A claim was submitted for the monthly rental of a pneumatic compression device. Review of the Medicare claims system showed that the beneficiary’s date of death was prior to the date of service on the claim. This claim was scored as an improper payment due to an “other error.”

Example: A claim was submitted for physical therapy services. Review of the Medicare claims system showed that this was a duplicate payment, as the services were previously paid under another claim number. This was scored as an improper payment due to an “other error.”

³⁷ Some columns and/or rows may not sum correctly due to rounding.

ELIMINATING IMPROPER PAYMENTS FROM THE MEDICARE FEE-FOR-SERVICE PROGRAM

Government Performance and Results Act (GPRA) Improper Payment Rate Goals

The Government Performance and Results Act (GPRA) of 1993, as modified by the GPRA Modernization Act of 2010, requires federal agencies to establish performance goals that consist of a performance indicator, a target, and a time period. These goals are to be wisely chosen; ambitious yet realistic; and expressed in objective, quantifiable, and measurable terms. An agency performance goal that is subject to these requirements includes the anticipated reduction in improper payments through time.

In accordance with these statutory requirements, as well as the IPIA of 2002 and OMB implementing guidance requirements, CMS set targets for the progressive reduction of improper payments over the next three years: 8.3 percent by FY 2013, 8.0 percent by FY 2014, and 7.5 percent by FY 2015. The targets selected by CMS are both ambitious and realistic, providing a foundation on which CMS can develop targeted corrective actions for the purpose of reducing improper payments in the Medicare FFS program. The CMS' selection of these improper payment rate goals reflects actual reductions in Medicare FFS improper payments observed over the past three years and incorporates the anticipated reductions that will result from major projects that have been recently implemented.

Corrective Actions to Eliminate Improper Payments

The CMS strives to reduce improper payments in the Medicare FFS program to sustain the Medicare Trust Funds while protecting beneficiaries' access to Medicare benefits. Improper payment data gathered from the CERT program and other sources is used to reduce or eliminate improper payments due to programmatic weaknesses. The CMS also uses the results from the CERT program to provide feedback to the MACs, informing them of ways to enhance their medical review efforts, develop education and outreach efforts, and enhance their overall operations to reduce the incidence of improper payments.

The CMS has several corrective actions in place or under development to reduce improper payments in the Medicare FFS program. Through the formulation of corrective actions, CMS is working diligently to reach this goal. Specifically, CMS is initiating several bold projects described below to reduce improper payments.

- **Recovery Audit Prepayment Review Demonstration**

In September 2012, CMS expanded the use of Medicare Recovery Auditors in the Medicare FFS program. This Medicare program demonstration allows Recovery Auditors to review certain claim types for compliance with all Medicare payment rules before they are paid to prevent improper payments.

- **Part A to Part B Rebilling Demonstration³⁸**

In January 2012, CMS established a demonstration program that allowed a limited number of hospitals to rebill denied inpatient claims under Medicare Part A that would have been payable in an outpatient setting under Medicare Part B.³⁹

Permitting participating hospitals to rebill allows them to obtain reimbursement for medically necessary services while protecting beneficiaries, encourages hospitals to make proper inpatient admission determinations, and reduces appeals. The demonstration is limited to a representative sample of hospitals nationwide that volunteered to be part of the program.

- **Prior Authorization of Power Mobility Device Demonstration**

In September 2012, CMS established a limited demonstration program that tests whether prior authorization can reduce fraud and improper payments for certain PMDs. The CMS believes this demonstration will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program, as is evidenced by the initial results of the program.⁴⁰

³⁸ On March 13, 2013 the Part A to Part B Rebilling Demonstration was terminated by CMS Ruling CMS-1455-R. This ruling established a nationwide policy that when a Part A inpatient claim for a hospital admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit a claim for services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status.

³⁹ Hospitals participating in the demonstration during the report period could rebill for 90 percent of the Part B payment for services provided during a Part A inpatient short stay claim deemed not reasonable and necessary due to the hospital billing for the wrong setting. The claim could either be denied through MAC audit or deemed improper through hospital participant self-audit.

⁴⁰ The prior authorization demonstration was successfully implemented and is running smoothly. Prior authorization reviews are being performed timely, industry feedback has been positive, and CMS has received no complaints from beneficiaries. For more information, see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicarePAofPMDDemoStatusUpdateApril2013.pdf>

The following are additional details regarding some of the additional corrective actions CMS is taking to reduce improper payments in the future.

Improper Payments Due to Documentation Errors – The CMS implemented improvements to ensure that providers and suppliers submit the required documentation, including:

- Along with the Prior Authorization of PMDs Demonstration, to further reduce the amount of improper payments from PMDs, CMS has completed provider education calls and issued an educational article detailing documentation requirements for providers.
- The CMS continues provider outreach and education task forces that were established in 2010. These task forces consist of MAC medical review professionals who meet regularly to develop strategies addressing provider education in areas prone to improper payments. The task forces held several open door forums to discuss documentation requirements and answer provider and supplier questions. The task forces also issued several informational articles that have been distributed on an as-needed basis to improve documentation by providers and to provide education on Medicare policies. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by the public.
- The CERT program simultaneously contacts both the DMEPOS supplier and the provider who ordered the DMEPOS to advise them of their responsibility to provide medical documentation in support of the supplier's DMEPOS claim.
- The CERT program revises the medical record request letters as needed to clarify the components of the medical record that are required for a CERT review. The letter serves as a checklist for the provider or supplier to ensure that their record submission is complete. Follow-up medical record request letters have also been developed to explain the missing documentation that needs to be submitted.
- The CERT program contacts third party providers to request documentation when necessary, as indicated by the billing provider or supplier. An example of a third party provider may be a hospital that maintains the evaluation and management notes written by the billing physician.
- The CMS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- The CMS implemented the Electronic Submission of Medical Documentation (esMD) program into the CERT review process to create greater program efficiencies; allow a quicker response time to documentation requests; and provide better communication between the providers and suppliers, CERT contractors, and CMS. The first phase of esMD went live on September 15, 2011. As more Health Information Handlers (HIHs) begin to offer esMD gateway services to providers, and CMS and HIH provider outreach efforts take hold, CMS expects provider participation to increase. For more information on esMD, see www.cms.gov/esMD.

- In May 2005, CMS began offering automated services through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Eligibility Transaction System (HETS), a query and response system that provides data about Medicare beneficiaries and their eligibility to receive payment for health care services and supplies. From January through June 2012, HETS processed an average of 1.7 million to 2.2 million queries per day. The CMS implemented several hardware and software replacements and upgrades in 2011. System performance reports for the first six months of 2012 showed that providers are currently satisfied with the operational status of HETS and that the system provides more complete information and reliable service than other systems that they have used to verify eligibility with commercial health insurers.⁴¹

Improper Payments Due to Medical Necessity and Coding Errors –The CMS is dedicated to reducing medical necessity errors and is implementing various corrective actions, including:

- The CMS makes data and findings from the HHS Office of Inspector General (OIG) audit reports available to the MACs. The MACs are able to incorporate this information into their strategies and interventions to reduce improper payments.
- The CMS has developed new interface edits that will allow data from the assessment tools used for SNFs, home health agencies, and inpatient rehabilitation facilities to be compared to the claim the provider submits for payment. After implementation, when discrepancies are found between the assessment and the provider claim, the edit interface will pay the lower of the two reported.
- The CMS formed a workgroup of CMS staff to analyze the perpetually high inpatient hospital improper payment rate, identify contributing factors, and recommend corrective actions beyond provider and supplier education and increased review.
- Some MACs that identified individual hospitals with higher than average improper payments for inpatient hospital claims conducted onsite one-on-one education to explain coding and coverage rules for these claims.
- The CMS implemented the Fraud Prevention System (FPS) on June 30, 2011, as required by the Small Business Jobs Act of 2010. The FPS is using predictive analytics technology developed to identify and prevent the payment of improper claims in the Medicare FFS program on a pre-payment basis. For the first time in the history of the program, CMS is systematically applying advanced analytics against Medicare FFS claims on a streaming, nationwide basis.
- The CMS is in the process of implementing enhanced medical review policies, including new face-to-face physician encounter requirements for some services and supplies, as required under the Affordable Care Act (ACA) (Pub. L. 111-148). The requirement for a face-to-face physician encounter before receiving certain DMEPOS items will become effective in July, 2013.

⁴¹ United States Government Accountability Office, Health Information Technology: CMS Took Steps to Improve Its Beneficiary Eligibility Verification System GAO-12-973 September 2012.

- The CMS developed Comparative Billing Reports (CBRs), which compare billing patterns of Medicare non-hospital providers to their peers in the state and in the nation. The CMS also provides the Program for Evaluating Payment Patterns Electronic Report (PEPPER), which compares billing patterns of Medicare inpatient hospital providers to other providers in the state and in the nation.
- The CMS requires each MAC to develop an annual Error Rate Reduction Plan. This plan identifies the specific causes of the improper payments in their jurisdiction and outlines corrective actions for the errors, such as provider outreach and education and enhanced medical review in error-prone areas.
- The CMS developed and installed various new correct coding edits. These edits enable the claims processing systems to automatically halt payment by the MAC if certain claim requirements are not met. The CMS also developed medically unlikely auto-deny edits in the claims processing systems to catch those instances where the service level billed exceeds clinically acceptable limits. These edits are updated quarterly. For information on the limitations of automated edits in detecting improper payments, see pg. 9.
- In October 2010, CMS issued the first Medicare Quarterly Provider Compliance Newsletter to providers and suppliers to educate them on the common causes of improper payments found in the Medicare program and actions they can take to prevent improper payments from occurring in the future. The CMS publishes these newsletters on a quarterly basis.
- The CMS approved additional areas for Medicare FFS Recovery Auditors review, including inpatient hospital stays and DMEPOS. The CMS also increased medical record request limits for Recovery Auditors. Information about the results of the Recovery Audit program provides valuable information to providers and suppliers about areas where improvements are needed. In addition, the Recovery Auditors share information with the MACs regarding problematic areas on a regular basis so that corrective actions can be implemented to reduce future improper payments.
- The CMS continually updates Medicare FFS manuals to clarify review criteria in order to promote uniform application of CMS' policies across all medical reviews performed by MACs.

Assurance of Provider and Supplier Authenticity – The CMS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare FFS payments, including the following:

- The CMS is undertaking numerous aggressive actions to strengthen the provider and supplier enrollment process, provide more rigorous oversight and monitoring once a provider or supplier enrolls in the program, and strengthen the revocation process. The CMS implemented a DMEPOS accreditation program to ensure the legitimacy of the DMEPOS suppliers that bill Medicare FFS and to ensure those suppliers meet all the requirements for participation in the program.

- The ACA required CMS to screen all existing 1.5 million Medicare providers and suppliers under the new screening requirements. The CMS embarked on an ambitious project to revalidate the enrollment information of all existing providers and suppliers, and these efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Between March 2011 and March 2013, CMS validated or revalidated enrollment information for nearly 458,435 Medicare providers and suppliers under these enhanced screening requirements of the Affordable Care Act. Because of revalidation and other proactive initiatives, CMS has deactivated 159,449 enrollments and revoked 14,009 enrollments.⁴²
- In April 2012, CMS published a final rule entitled “Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements.” This rule finalized ACA provisions that were addressed in a May 5, 2010 interim final rule. It requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) to include their NPI on all enrollment applications for Medicare and Medicaid programs and on all claims for payment submitted under those programs. In addition, it requires physicians and other professionals who are permitted to order and certify covered items and services for Medicare beneficiaries to be enrolled in Medicare. Finally, it establishes document retention and provision requirements on providers and suppliers that order and certify items and services for Medicare beneficiaries.
- In February 2011, CMS published a final rule with comment entitled “Medicare, Medicaid and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” (CMS-6028-FC). This final rule implemented many of the program integrity provisions in the ACA, including the requirement that state Medicaid programs terminate a provider or supplier who has been terminated from another state Medicaid program or from the Medicare program.
- On August 27, 2010, CMS published a final rule entitled “Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards” (CMS-6036-F). This final rule clarified and expanded the existing enrollment requirements that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.
- CMS is in the process of transitioning the Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs. The ZPICs will), cover seven zones throughout the United States. These zones are aligned with the MACs and cover areas that are considered “hot spots” for fraud within the United States.

⁴² "Deactivate" means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information. Revoke means that the provider or supplier's billing privileges are terminated and cannot be reinstated.

- The CMS has taken steps to fight DMEPOS fraud in the “high risk” states of Florida, California, Texas, Illinois, Michigan, North Carolina and New York. CMS conducted a two-year project (2009-2011) in these 7 states with highest volumes of DME billing, expenditures and growth rates. These efforts include more stringent reviews of new suppliers’ applications, unannounced site visits, extensive pre- and post-payment review of claims, interviews with high volume ordering and referring physicians, and visits to high risk beneficiaries to ensure they are appropriately receiving items and services for which Medicare is being billed. Lessons learned from this collaboration of DME PSCs and ZPICs, the Pricing and Data Analysis Contractor (PDAC) and the National Supplier Clearinghouse (NSC) have been incorporated into the base DME workload of all ZPICs.

Appendix

National Improper Payment Rates by Error Category and Year

Table 9: Summary of Improper Payment Rates by Year and by Error Category⁴³

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 ⁴⁴	Net	1.9%	4.5%	5.1%	1.2%	1.1%	13.8%	86.2%
1997	Net	2.1%	2.9%	4.2%	1.7%	0.5%	11.4%	88.6%
1998	Net	0.4%	0.8%	3.9%	1.3%	0.7%	7.1%	92.9%
1999	Net	0.6%	2.6%	2.6%	1.3%	0.9%	8.0%	92%
2000	Net	1.2%	1.3%	2.9%	1%	0.4%	6.8%	93.2%
2001	Net	0.8%	1.9%	2.7%	1.1%	-0.2%	6.3%	93.7%
2002	Net	0.5%	1.3%	3.6%	0.9%	0.0%	6.3%	93.7%
2003	Net	5.4%	2.5%	1.1%	0.7%	0.1%	9.8%	90.2%
2004 ⁴⁵	Gross	3.1%	4.1%	1.6%	1.2%	0.2%	10.1%	89.9%
2005	Gross	0.7%	1.1%	1.6%	1.5%	0.2%	5.2%	94.8%
2006	Gross	0.6%	0.6%	1.4%	1.6%	0.2%	4.4%	95.6%
2007	Gross	0.6%	0.4%	1.3%	1.5%	0.2%	3.9%	96.1%
2008	Gross	0.2%	0.6%	1.4%	1.3%	0.1%	3.6%	96.4%
2009	Gross	0.2%	4.3%	6.3%	1.5%	0.1%	12.4%	87.6%
2010	Gross	0.1%	4.6%	4.2%	1.6%	0.1%	10.5%	89.5%
2011 ⁴⁶	Gross	0.2%	5.0%	3.4%	1.2%	0.1%	9.9%	90.1%
2012 ⁴⁷	Gross	0.2%	5.0%	2.6%	1.3%	0.1%	9.3%	90.7%

⁴³ Some columns and/or rows may not sum correctly due to rounding.

⁴⁴ 1996-2003 Improper payments were calculated as Overpayments – Underpayments.

⁴⁵ 2004-2012 Improper payments were calculated as Overpayments + absolute value of Underpayments.

⁴⁶ The 2011 improper payment rate reported in the FY 2011 HHS Agency Financial Report was 8.6 percent, which was adjusted for the prospective impact of late appeals and documentation (see pg. 18 for additional information). Because this adjustment could not be applied on a lower level than the overall improper payment rate, the 2011 rates in Table 9 are unadjusted.

⁴⁷ The 2012 improper payment rate reported in the FY 2012 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 (see pg. 19-20 for additional information). Because this adjustment could not be applied on a lower level than the overall and the Part A improper payment rates, the 2012 rates in Table 9 are unadjusted.

Table 10: 2011 and 2012 Error Category Comparisons⁴⁸

Error Category	2011	2012				
	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%	5.0%	1.3%	0.4%	1.6%	1.7%
Medical necessary	3.4%	2.6%	0.3%	2.2%	0.1%	0.1%
Incorrect Coding	1.2%	1.3%	0.2%	0.4%	0.8%	0.0%
Other	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	9.9%	9.3%	1.9%	3.0%	2.5%	1.8%

⁴⁸ Some columns and/or rows may not sum correctly due to rounding. The rates in this table are unadjusted. See footnote 40 and 41 for additional information.

National Improper Payment Rates by Overpayments and Underpayments

Table 11: 2012 Improper Payment Rates and Projected Improper Payments by Claim Type and Overpayments/Underpayments (Dollars in Billions)⁴⁹

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
Part A (Total)	\$250.7	\$17.1	6.8%	6.2% - 7.5%	\$16.3	6.5%	\$0.9	0.3%
Part A (Excluding Acute Inpatient Hospital)	\$137.9	\$6.6	4.8%	4.2% - 5.5%	\$6.5	4.7%	\$0.1	0.1%
Part A (Acute Inpatient Hospital)	\$112.8	\$10.5	9.3%	8.3% - 10.4%	\$9.8	8.7%	\$0.7	0.7%
Part B	\$89.3	\$8.9	9.9%	9.1% - 10.8%	\$8.7	9.8%	\$0.1	0.2%
DMEPOS	\$9.7	\$6.4	66.0%	62.8% - 69.2%	\$6.4	66.0%	\$0.0	0.0%
Total	\$349.7	\$32.4	9.3%	8.7% - 9.8%	\$31.4	9.0%	\$1.0	0.3%

⁴⁹ Some columns and/or rows may not sum correctly due to rounding. The rates and dollar amounts in this table are unadjusted for the impact of A/B rebilling. See footnote 46 and 47 for additional information.

Error Types by Clinical Setting

Examining the types of claim payment errors and their impact on the improper payment rate is a crucial step toward reducing improper payments in the Medicare FFS program.

Table 12 shows that projected improper payments are driven by insufficient documentation errors, medical necessity errors, and, to a lesser extent, incorrect coding errors. The frequency of such errors varies according to clinical setting.

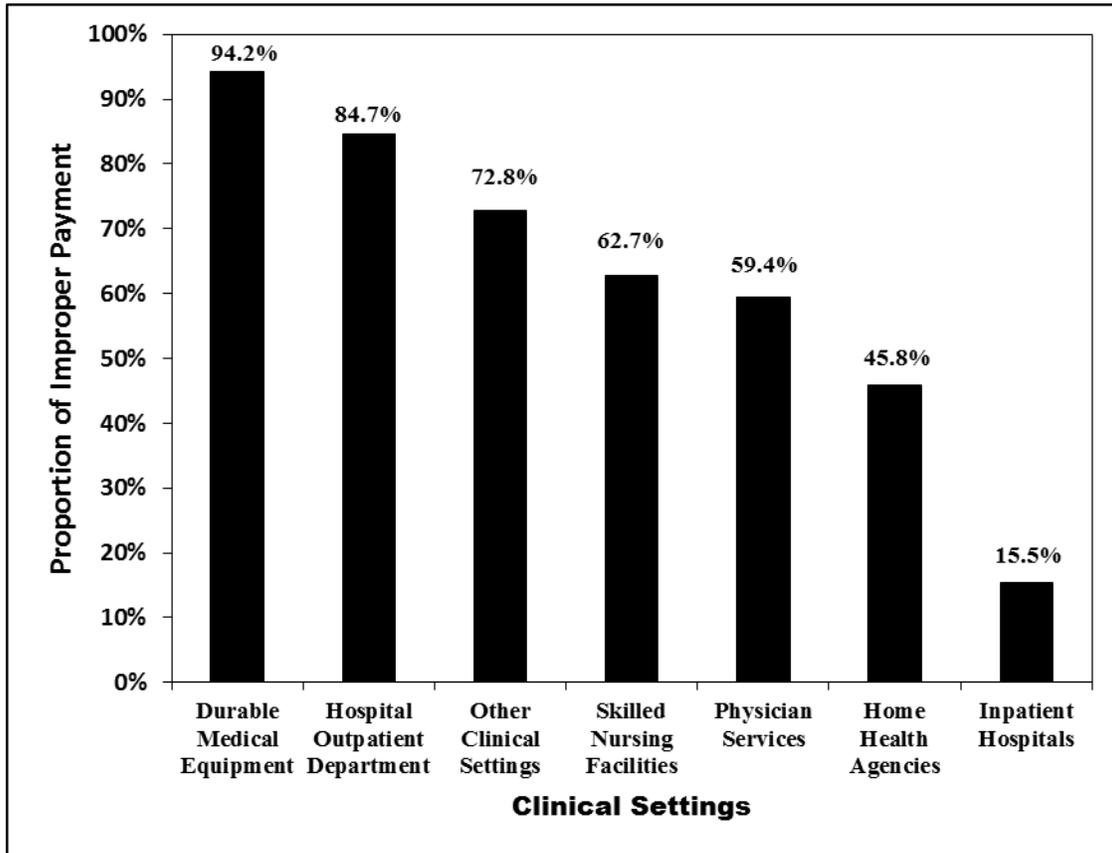
Table 12: 2012 Projected Improper Payments by Type of Error and Clinical Setting (Dollars in Billions)⁵⁰

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	\$0.02	\$0.12	\$0.13	\$0.34	\$0.00	\$0.09	\$0.74
Insufficient Documentation	\$6.04	\$0.55	\$2.43	\$1.70	\$4.58	\$1.01	\$1.18	\$17.49
Medically Unnecessary	\$0.27	\$0.53	\$0.07	\$7.83	\$0.19	\$0.09	\$0.26	\$9.24
Incorrect Coding	\$0.01	\$0.10	\$0.25	\$1.29	\$2.58	\$0.34	\$0.09	\$4.66
Other	\$0.05	\$0.00	\$0.00	\$0.05	\$0.02	\$0.17	\$0.00	\$0.30
Total	\$6.41	\$1.20	\$2.87	\$11.00	\$7.71	\$1.61	\$1.62	\$32.43

⁵⁰ Some columns and/or rows may not sum correctly due to rounding. The dollar amounts in this table are unadjusted for the impact of A/B rebilling. See footnote 41 for additional information.

Figure 2 provides an analysis of the clinical settings where most insufficient documentation errors occurred. Insufficient documentation errors accounted for the greatest proportion of improper payments during the 2012 report period.

Figure 2: Proportion of Improper Payments Attributed to Insufficient Documentation in 2012, by Clinical Setting⁵¹



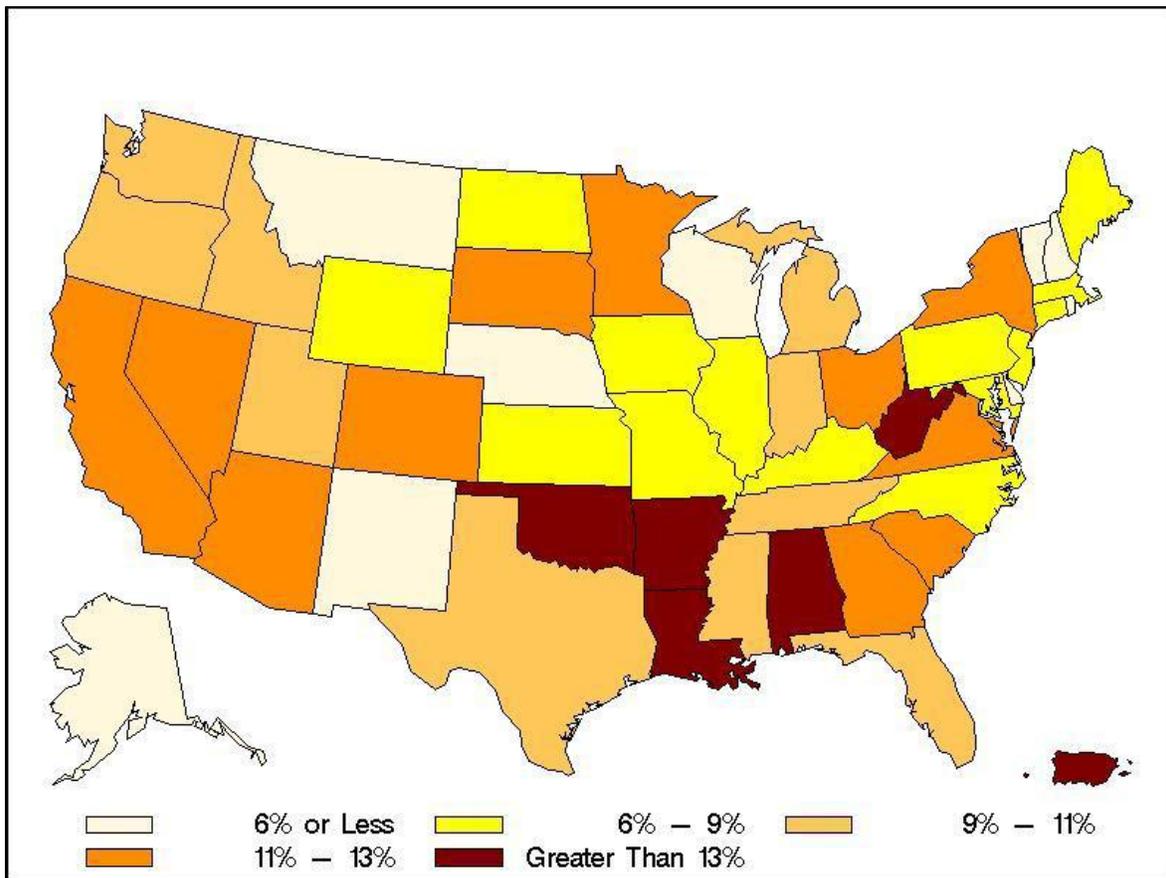
⁵¹ The improper payment rates in this figure are unadjusted for the impact of A/B rebilling. See footnote 41 for additional information.

Geographic Trends

Improper payments vary greatly by geographic location. Identifying the most problematic areas and the differentiating characteristics of those geographic locations can be useful for targeting improper payment reduction efforts.

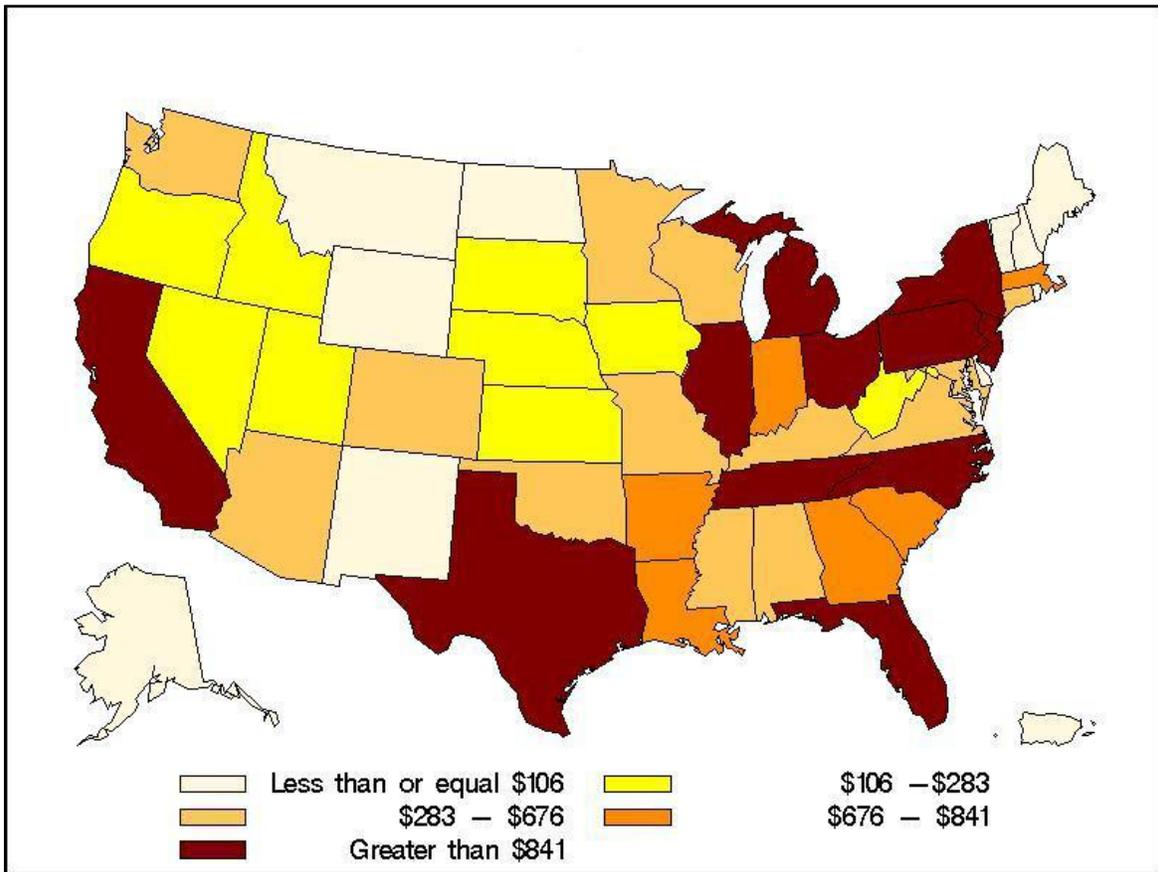
Figure 4 displays the improper payment rates by state and Figure 5 displays the projected improper payments by state. The states with high improper payment rates and extremely large expenditures are New York, California, Texas, and Florida. These four states constitute 31.6 percent of overall Medicare FFS payments and 34.8 percent of total improper payments. New York has the highest improper payment rate of 12.6 percent, with \$2.8 billion in improper payments. California has a 10.6 percent improper payment rate, with \$3.6 billion in improper payments. Lowering improper payments in these states is critical to lowering the national improper payment rate.

Figure 4: 2012 Improper Payment Rates by State⁵²



⁵² The improper payment rates in this figure are unadjusted for the impact of A/B rebilling. See footnote 41 for additional information.

Figure 5: 2012 Improper Payment Amounts by State (Dollars in Millions)⁵³



⁵³ The improper payment amounts in this figure are unadjusted for the impact of A/B rebilling. See footnote 41 for additional information.

Table 13 displays the improper payment amounts and rates for the top ten states, as well as the breakdown by overpayments and underpayments. California, New York, Texas, and Florida have very high overpayment amounts and improper payment rates.

Table 13: 2012 Projected Improper Payments, Overpayment and Underpayments by State (Dollars in Millions)⁵⁴

State	Overall		Overpayments		Underpayments	
	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
CA	\$3,643.8	10.6%	\$3,434.6	10.0%	\$209.2	0.6%
NY	\$2,757.0	12.6%	\$2,672.8	12.2%	\$84.2	0.4%
TX	\$2,543.6	9.5%	\$2,495.4	9.4%	\$48.2	0.2%
FL	\$2,343.6	8.5%	\$2,251.6	8.2%	\$91.9	0.3%
MI	\$1,389.7	9.1%	\$1,366.1	8.9%	\$23.5	0.2%
OH	\$1,364.2	12.2%	\$1,345.7	12.1%	\$18.5	0.2%
IL	\$1,270.7	7.5%	\$1,210.3	7.1%	\$60.4	0.4%
TN	\$1,137.6	10.1%	\$1,113.5	9.9%	\$24.1	0.2%
NJ	\$893.3	6.8%	\$852.8	6.4%	\$40.6	0.3%
NC	\$881.5	8.3%	\$875.3	8.2%	\$6.2	0.1%
Overall	\$32,425.7	9.3%	\$31,427.2	9.0%	\$998.4	0.3%

CMS Contacts

For further information, contact the CMS CERT Team (CERT@cms.hhs.gov)

⁵⁴ 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. See footnote 41 for additional information.