# Medicare Fee-For-Service 2015 Improper Payments Report

## EXECUTIVE SUMMARY

### 87.9 Percent Accuracy Rate

The estimated 2015[1] Medicare fee-for-service (FFS)[2] accuracy rate—the estimated percentage of Medicare FFS dollars paid correctly—was 87.9 percent. This calculation included claims submitted during the 12-month period from July 2013 through June 2014. This means that Medicare paid an estimated $315.0 billion correctly during this period.

### Corrective Actions to Improve the Accuracy Rate

Centers for Medicare & Medicaid Services (CMS) strives to improve the accuracy rate in the Medicare FFS program. CMS uses data from the Comprehensive Error Rate Testing (CERT) program and other sources to reduce or eliminate improper payments through various corrective actions.

CMS previously implemented multi-faceted corrective actions to improve the accuracy rate for the 2015 report period. Established corrective actions include educational publications, data analysis, prior authorization projects, targeted medical review by the Supplemental Medical Review Contractor (SMRC) and Recovery Auditors, National Correct Coding Initiative Edits (NCCI), and risk-based provider screening. Due to the complexity of implementing corrective actions and lag time between implementation and CERT reporting, their impact on the accuracy rate may not be immediate and may often take several years to manifest.

### 12.1 Percent Improper Payment Rate

The estimated 2015 Medicare FFS improper payment rate—the percentage of Medicare dollars paid incorrectly—was 12.1 percent. This means that Medicare paid an estimated $43.3 billion incorrectly between July 2013 and June 2014. For 2015, CMS adjusted the improper payment rate by 0.4 percentage points ($1.4 billion) from 12.5 percent to 12.1 percent to account for the effect of rebilling inpatient hospital claims denied under Medicare Part A (Part A to B

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[1] HHS publishes the 2015 Medicare FFS improper payment rate in the Federal Fiscal Year (FY) 2015 HHS Agency Financial Report. The FY runs from October 1 to September 30. The Medicare FFS sampling period does not correspond with the FY due to practical constraints with claims review and rate calculation methodologies.

[2] 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 durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). Part C (the Medicare Advantage program) and Part D (the Medicare prescription drug benefit) are not included in this analysis.

rebilling)[3]. The methodology for calculating the 2015 FFS improper payment rate was the same as in 2014.

The Medicare FFS improper payment rate decreased due to the success of corrective actions implemented to address improper payments, specifically for inpatient hospital services and durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS). CMS continues to leverage successful corrective actions, conduct additional provider/supplier education, and monitor the successes of the prior authorization initiatives. CMS expanded prior authorization to repetitive scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy. CMS continues to monitor services that drive the improper payment rate, including home health and skilled nursing facility services, to more effectively target provider education efforts to address payment vulnerabilities as they are identified.

## Common Causes of Improper Payments

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

The Medicare FFS improper payment rate decreased from 12.7 percent in 2014 to 12.1 percent in 2015. CMS' "Two Midnight" rule and corresponding educational efforts led to a reduction in improper inpatient hospital claims, helping to reduce the inpatient hospital claims improper payment rate for those services from 9.2 percent in 2014 to 6.2 percent in 2015. The improper payment rate for DMEPOS also decreased from 73.8 percent in 2010, to 53.1 percent in 2014, and to 39.9 percent in 2015. Corrective actions implemented over this six-year period, including the DMEPOS Accreditation Program, contractor visits to large supplier sites, competitive bidding, and a prior authorization demonstration for power mobility devices, contributed to the reduction in the improper payment rate for these items and supplies.

While there was a reduction in the Medicare FFS improper payment rate for 2015, we must continue working to reduce the improper payment rate for the Medicare FFS program for future years.

As in previous years, during the 2015 report period the most common cause of improper payments (accounting for 65.4 percent of total improper payments) was a lack of documentation to support the services or supplies billed to Medicare. In other words, the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary.

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[3] The Part A to 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 Part A to B rebilling adjustment factor could only be applied to the high-level calculations (i.e., the overall, Part A Total, and Part A Hospital IPPS improper payment rates). This methodology is unchanged from 2012, 2013 and 2014.

Part A (excluding hospital Inpatient Prospective Payment System (IPPS))[4] services were the largest contributors to the 2015 improper payment rate. This category includes home health, hospital outpatient, skilled nursing facility, non-IPPS hospital (including inpatient rehabilitation facilities), and End-Stage Renal Disease services.

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

This report supplements information in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). The Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), (hereafter collectively referred to as IPERIA), requires improper payment reporting in the HHS AFR. The improper payment rate calculation complies with the requirements of Office of Management and Budget (OMB) Circular A-123, Appendix C.

This report highlights the Medicare FFS claim types that have the greatest impact on the 2015 improper payment rate, and describes CMS' corrective actions to prospectively reduce improper payments. The *Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payment Rate Report*, available on the CMS website: www.cms.gov/cert, provide additional detailed information. Table 1, below, summarizes the 2015 improper payment rates by claim type.

[4] Improper payment rate reporting for Part A (excluding hospital IPPS) providers is determined by the type of bill submitted to Medicare for payment. Providers, facilities, and suppliers that submit institutional claims via the electronic American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Health Care Claim: Institutional (837) or paper claim format Uniform Billing (UB)-04, are included in the Part A (excluding hospital IPPS) improper payment rate calculation. Examples of providers, facilities, and suppliers that bill using these formats include hospitals, skilled nursing facilities, home health and hospice providers, renal dialysis facilities, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. These institutional claims may include professional services that may be paid under Part A or Part B, yet are ultimately included in the CERT Part A (excluding hospital IPPS) improper payment rate measurement because they are submitted on the ASC X12 837 or UB-04.

**Table 1: 2015 Improper Payment Rates and Projected[5] Improper Payments by Claim Type (Dollars in Billions)[6]**

| Claim Type | Total Payment | Projected Improper Payment | Improper Payment Rate | 95% Confidence Interval |
|---|---|---|---|---|
| **Part A (Total)** | $260.0 | $28.7 | 11.0% | 10.2% - 11.8% |
| Part A (Excluding Hospital IPPS) | $147.4 | $21.7 | 14.7% | 13.4% - 16.0% |
| Part A (Hospital IPPS)[7] | $112.6 | $7.0 | 6.2% | 5.6% - 6.8% |
| **Part B** | $90.4 | $11.5 | 12.7% | 11.8% - 13.6% |
| **DMEPOS** | $8.0 | $3.2 | 39.9% | 35.5% - 44.4% |
| **Overall** | **$358.3** | **$43.3** | **12.1%** | **11.4% - 12.7%** |

[5] Projected amounts are based on the sample of claims actually reviewed.

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

[7] Adjusted for Medicare Part A to B rebilling of denied inpatient hospital claims.

## Disclaimers

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

Categories of improper payments in this report may not correspond exactly to categories (i.e., by Medicare Severity Diagnosis-Related-Groups (MS-DRGs), Berenson-Eggers Type of Service (BETOS) codes or Healthcare Common Procedure Coding System (HCPCS) codes) reported in the more detailed *Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payment Report*.

This report supplements information in the FY 2015 HHS AFR and reflects information available as of the date of release of the HHS AFR.

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

## Government Performance and Results Act Improper Payment Rate Goals

The Government Performance and Results Act of 1993 (GPRA), as modified by the Government Performance and Results Modernization Act of 2010, requires federal agencies to establish performance goals. One of the CMS' GPRA goals is to reduce the Medicare FFS improper payment rate. In addition, the IPIA as amended also required agencies to establish performance targets for reducing improper payments. The Medicare FFS GPRA performance goals and IPIA reduction targets are the same.

The 2015 improper payment rate was 12.1 percent, which is lower than the previously established goal of 12.5 percent. The CMS has many successful improper payment reduction strategies in place. However, the factors contributing to improper payments are complex and may change from year to year. As a result, the CMS examines and possibly revises these goals on an annual basis based on data analysis and policy changes. The IPERIA requires that these goals be realistic and ambitious.

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

- 11.5 percent by FY 2016
- 10.4 percent by FY 2017
- 9.4 percent by FY 2018

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

The CMS is committed to reducing improper payments in the Medicare FFS program. The CMS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. While CMS has fully implemented some corrective actions, others are still in the early stages of implementation. CMS believes these focused corrective actions will have a larger impact over time as they become operationalized.

Of particular importance are five corrective actions implemented in FY 2015 that CMS believes will have a considerable effect in preventing and reducing future improper payments.

- First, CMS continues to implement corrective actions to address program payment vulnerabilities related to home health services.
- Second, CMS proposed an update to the "Two Midnight" rule CMS-1633-P (70 FR Volume 80, Number 130, July 8, 2015) regarding when hospital admissions are appropriate for payment under Medicare Part A.

- Third, CMS issued a proposed rule that would build on a successful demonstration program to establish a Master List of Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization and potentially could be subject to prior authorization, as well as a Required Prior Authorization List of certain DMEPOS items that would be subject to a prior authorization process.
- Fourth, CMS expanded the use of prior authorization in the Medicare FFS program.
- Fifth, CMS implemented two demonstration projects to test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care for certain non-emergent services. These projects will also ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before rendering services and paying claims.

The HHS AFR includes additional information on these corrective actions.

## The Medicare FFS Program

### Features of the Medicare FFS Program

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

- Part A Excluding Hospital IPPS (including skilled nursing facility stays, home health services, and hospital outpatient services)
- Part A Hospital Inpatient Prospective Payment System (IPPS)
- Part B (including physician, laboratory, and ambulance services)
- DMEPOS

### Claim Payments in the Medicare FFS Program

Providers and suppliers submit claims to their respective MACs for Medicare FFS payment. MACs are responsible for preventing improper Medicare FFS payments through their claims payment decisions and processes. The primary goal of each MAC is to pay the correct amount for covered, medically necessary, and correctly coded services.

The MACs and other Medicare review contractors perform two main types of claim reviews. Contractors can perform these reviews either before or after payment is rendered (i.e., pre-payment or post-payment reviews).

- **Non-Complex Medical Review**: The Medicare review contractor makes a claim determination without clinical review of medical documentation submitted by the provider. This may include reviews that require some form of human intervention to verify claim information, and/or a review that is automated (i.e., done by computer).

Appropriate non-complex reviews increase the efficiency and consistency of payment decisions.

- **Complex Medical Review**: The Medicare review contractor makes a claim determination after reviewing additional documentation associated with the claim. Complex medical reviews for the purpose of making coverage determinations are performed by licensed nurses (Registered Nurses and Licensed Practical Nurses) or physicians, unless this task is delegated to other licensed health care professionals. During a complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians or physician specialists) for advice. The MACs cannot perform complex medical review on every claim submitted because of the large number of claims that they must process.

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

## Improper Payment Measurement in the Medicare FFS Program

### Statutory Background

The IPERIA requires federal agencies, including HHS, to review the programs they administer for improper payments every year. An improper payment is any payment made:

- In error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;
- To an ineligible recipient;
- For ineligible goods or services;
- For goods or services not received (except for such payments where authorized by law);
- That duplicates a payment;
- That does not account for credit for applicable discounts; or
- Without supporting documentation.; and
- Includes payments where documentation is missing or not available.

The IPERIA also requires the HHS to:

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

# The Comprehensive Error Rate Testing (CERT) Program

## CERT Program Objectives

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

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

## Calculation of the Medicare FFS Improper Payment Rate

### 1. Claims Selection

The first step in the CERT process is the selection of a stratified random sample of Medicare claims. Stratification ensures that the sample is representative of the population of claims submitted for Medicare payment. A portion of the claims sampled for the 2015 report period was unreviewable because the claim adjudication process was incomplete (e.g., the MAC returned the claim to the provider or supplier) (see Table 2 below). The final CERT sample is comprised of claims paid or denied by the MAC. This sampling methodology complies with all statutory requirements and OMB guidance.

**Table 2: Claim Counts by Type for the 2015 Improper Payment Rate Calculation**

| Claim Type | Claims |
|---|---|
| Part A (Excluding Hospital IPPS) | 7,415 |
| Part A (Hospital IPPS) | 12,864 |
| Part B | 18,317 |
| DMEPOS | 11,007 |
| **Total** | **49,603** |

### 2. Medical Record Requests

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

Should the CERT program receive no documentation within 75 days of its initial request, it scores the claim as an improper payment due to a "no documentation error" (explained below). Nevertheless, the CERT program still reviews late documentation received after the 75 days, and this review is counted in the final improper payment rate calculation, if it is received in time for the final calculations to be made.

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

Medical review professionals review the claim and submitted documentation to make a determination of whether the claim was paid or denied appropriately. These review professionals include nurses or physicians, unless this task is delegated to other licensed health care professionals. Before reviewing documentation, the CERT program examines the CMS claims systems to check for (1) Medicare beneficiary eligibility, (2) duplicate claims, and (3) Medicare as the primary insurer. When performing claim reviews, the CERT program checks for compliance with Medicare statutes and regulations, billing instructions, National Coverage

Determinations (NCDs),[8] Local Coverage Determinations (LCDs),[9] and provisions in the CMS instructional manuals.

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

**No Documentation**

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

**Insufficient Documentation**

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

**Medical Necessity**

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

**Incorrect Coding**

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

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[8] 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 an LCD.

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

**Other**

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

### 4. Tracking Appeals

Providers and suppliers have the right to appeal any improper payment determination made by the CERT program. There are five levels of appeals for the Medicare FFS claims, starting at the MAC level through federal court. Historically, a small number of CERT program claims appeals have gone beyond the first three levels. The first three levels are: (1) redeterminations at the MAC level, (2) reconsiderations at the Qualified Independent Contractor (QIC) level, and (3) administrative hearings by Federal Administrative Law Judges.[10]

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

### 5. Determining the Improper Payment Rate

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

### 6. Reporting the Results

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

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[10] A small number of claims go beyond these first three levels. The fourth level of appeal consists of a claims review by the HHS Departmental Appeals Board, while the fifth level of appeal is a judicial review by a federal district court. The federal district court jurisdiction is appropriate only for claims that exceed a specified dollar amount.

[11] 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.

[12] OMB issued guidance for IPIA of 2002 implementation requirements, including attaining statistical validity, through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011 and October 20, 2014.

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

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

## 7. Reconciliation of Improper Payments

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

MACs recover most of the overpayments identified on claims sampled by the CERT program. Overpayments on claims sampled during the 2015 report period were $39,710,413. As of the publication date of the FY 2015 HHS AFR, actual MAC collections for these overpayments were $30,684,728 or 77 percent of the actual overpayment dollars identified. MACs do not collect overpayments if they cannot locate providers or suppliers who have gone out of business. MACs also do not collect overpayments when a claim decision is overturned on appeal. When active Medicare providers or suppliers fail to respond to requests for repayment and do not appeal, MACs may recoup overpayments by offsetting future payments.

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

# ANALYSIS AND SUMMARY OF RESULTS

All rates and amounts in the detailed analysis are unadjusted for the impact of Part A to B rebilling (see page 24 for an explanation of Part A to Part B rebilling).

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

### Excluding Hospital IPPS Services[14]

### Home Health Services[15]

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

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

The improper payment rate for home health services was 59.0 percent, accounting for 22.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during the 2015 report period was $10.1 billion.

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

- Physician certification/recertification of "confined to home" status and the need for home health services
- Face-to-face encounter documentation
- Therapy notes

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[14] Improper payment rate reporting for Part A (excluding hospital IPPS) providers is determined by the type of bill submitted to Medicare for payment. Providers, facilities, and suppliers that submit institutional claims via the electronic American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Health Care Claim: Institutional (837) or paper claim format Uniform Billing (UB)-04, are included in the Part A (excluding hospital IPPS) improper payment rate calculation. Examples of providers, facilities, and suppliers that bill using these formats include hospitals, skilled nursing facilities, home health and hospice providers, renal dialysis facilities, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. These institutional claims may include professional services that may be paid under Part A or Part B, yet are ultimately included in the CERT Part A (excluding hospital IPPS) improper payment rate measurement because they are submitted on the ASC X12 837 or UB-04.

[15] Home Health Services is defined as all services with a provider type of Home Health Agency.

- A comprehensive assessment of the beneficiary.

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

*Example*

A home health agency submitted a claim without a signed home health plan of care/certification for a subsequent episode (i.e., not the initial episode) of home health services. Prior to claim submission, a physician must sign and date the home health plan of care/certification. The submitted documentation did not include a copy of the original certification (signed and dated by the physician) for home health services for the initial episode. Certification also requires a face-to-face encounter with the beneficiary. In response to additional requests for documentation, the HHA sent a plan of care/certification signed and dated by the physician four months after the claim submission date. For this beneficiary, the home health nurse performed straight urinary catheterizations. The beneficiary also attended outpatient physical therapy in order to use equipment not available in the home (i.e., a standing frame). The physician sent a copy of a face-to-face encounter document that did not support homebound status because the medical condition section was blank. The CERT program scores a subsequent episode claim as an improper payment if the original certification is missing or is inadequate. The CERT program scored the claim as an improper payment due to insufficient documentation.

## Skilled Nursing Facility Services[16]

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

The improper payment rate for SNF services was 11.0 percent, accounting for 8.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2015 report period was $4.0 billion.

The majority of improper payments for SNF services were due to insufficient documentation. Providers of SNF services are required to submit medical records to support the medical necessity of SNF services provided. For example, documents required in the medical record include, but are not limited to the following.

- A certification that the beneficiary needed daily skilled care that could only be provided in a SNF setting
- An authenticated plan of care

[16] Skilled Nursing Facility is defined as all services with a provider type of SNF.

- The time (in minutes) for the therapy service provided

*Example*

A SNF submitted a claim for skilled services provided to a beneficiary. The submitted documentation did not include the physician's certification for SNF care or orders for provided respiratory treatments. The submitted documentation included admission orders and a statement that the beneficiary required "skilled nursing treatment for pain control and physical therapy for 1-2 weeks." This does not meet the requirement for certification of the need for skilled services for physical and occupational therapy, nor does it meet the requirements for an order for physical therapy. The CERT program scored the claim as an improper payment due to insufficient documentation.

## Hospital Outpatient Services

Medicare FFS Part A provides coverage for some services provided in the outpatient hospital setting. Covered services include, but are not limited to the following.

- Medication administration
- Laboratory and other diagnostic testing
- Therapy services.

The improper payment rate for outpatient services was 4.9 percent, accounting for 5.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for outpatient services during the 2015 report period was $2.5 billion.

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

*Example*

A hospital outpatient department billed for laboratory tests and other services for therapeutic apheresis for two service dates. The laboratory tests were a Complete Metabolic Panel, a Complete Blood Count, and a Hepatitis B surface antigen. The other services included the administration of calcium gluconate, iron sucrose, human albumin, and diphenhydramine. The submitted documentation included an order for the medications, medication administration records for the billed dates of service, laboratory testing orders, apheresis treatment records, medication administration records, lab reports, and nursing records. However, the submitted documentation did not include any clinical documentation to support medical necessity for these procedures. The CERT program scored the claim as an improper payment due to insufficient documentation.

## Hospital Inpatient (Part A non-Diagnosis-related group)

The category of providers identified as Hospital Inpatient (Part A non-Diagnosis-related group (DRG)) includes Inpatient Rehabilitation Hospitals and Inpatient Rehab Units.

The improper payment rate for Hospital Inpatient (Part A non-DRG) was 29.7 percent, accounting for 4.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for Hospital Inpatient (Part A non-DRG) during the 2015 report period was $1.8 billion. Most of the improper payments for Hospital Inpatient (Part A non-DRG) were due to insufficient documentation.

## Inpatient Rehabilitation Facility Services[17]

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

The improper payment rate for IRFs was 45.5 percent, accounting for 3.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for IRFs during the 2015 report period was $1.7 billion. Most of the improper payments for IRFs were due to insufficient documentation.

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

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

### *Example - Inpatient Rehabilitation Hospitals*

A provider admitted a beneficiary to an IRF after several recent hospitalizations for treatment of multiple medical problems, including a pseudoaneurysm, hypotension, hypoxia, bilateral pleural effusions, and respiratory distress requiring intubation. The submitted documentation did not include the required evidence of close supervision by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation. There was only one note written by a rehabilitation physician that showed a face-to-face encounter. There were

[17] Inpatient Rehabilitation Facility is defined as any service with a provider type of either Inpatient Rehabilitation Hospitals or Inpatient Rehabilitation Unit.

multiple notes documenting services performed by a nurse practitioner and a physician's assistant. The individual plan of care did not specify the frequency, duration, or intensity of therapy as required. Therefore, the CERT program scored this claim as an improper payment due to a medical necessity error.

*Example - Inpatient Rehabilitation Unit*

An acute care facility discharged a beneficiary and transferred her to an IRF unit for continued treatment of a right temporal lobe cerebrovascular accident. The documentation showed the beneficiary received the required level of intensity of rehabilitative services. However, there was no IRF Patient Assessment Instrument submitted. Also missing were the overall plan of care synthesized by the treating physician, and team conference notes led by the treating physician. Without these documents, the CERT Program was unable to determine whether the IRF stay was medically necessary. The CERT program scored this claim as an improper payment due to insufficient documentation.

## Non-Hospital-Based Hospice Services

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

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

The improper payment rate for hospice services was 10.7 percent, accounting for 3.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for hospice services during the 2015 report period was $1.4 million. Most of the improper payments for hospice services were due to insufficient documentation.

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

- Certification that the beneficiary is terminally ill with a prognosis of six months or less if the terminal illness runs its normal course;
- Clinical findings and other documentation that support a life expectancy of six months or less;
- A brief narrative explanation of the clinical findings, composed by the physician, that supports a life expectancy of six months or less;

- The signature of the physician and the date the certification was signed; and
- The benefit period dates to which the certification applies.

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

*Example*

A beneficiary elected hospice care, and her physician admitted her to a hospice with a diagnosis of Congestive Heart Failure. The submitted medical records documented that the beneficiary used supplemental oxygen on an "as needed" basis in the evenings, continued to smoke 1-3 packs of cigarettes per day, and had intermittent chest pain relieved with sublingual nitroglycerine. The medical records showed that while receiving hospice care, she was able to cook meals, and when she became tired, sitting down relieved her fatigue. A progress note recorded that the beneficiary said she was doing well and did not need hospice. Further documentation noted that the daughter of the beneficiary stated, "she has improved a lot." The medical record showed that the beneficiary improved while in hospice and that there was not a reasonable expectation of continued decline with a life expectancy of less than six months. Therefore, hospice care was not medically necessary. The CERT program scored this claim as an improper payment due to a medical necessity error.

## End-Stage Renal Disease Services

Medicare provides End-Stage Renal Disease (ESRD) benefits for all renal dialysis services for outpatient maintenance dialysis. Medicare-certified ESRD facilities or special purpose dialysis facilities are responsible for furnishing all renal dialysis services to ESRD beneficiaries either directly or under arrangement with other providers or suppliers. The most common elements of dialysis treatment are:

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

The improper payment rate for ESRD services was 7.9 percent, accounting for 2.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for ESRD services during the 2015 report period was $880.1 million.

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

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

*Example*

An ESRD unit (i.e., dialysis facility) submitted documentation for a claim for four sessions of hemodialysis per week. There was no documentation to support the medical necessity of four sessions of hemodialysis per week and there was no physician's order for four sessions per week. The medication dosing protocols signed by a physician and the Medication Administration Record to support the medications billed were also missing. The CERT program scored this claim an improper payment due to insufficient documentation.

## Hospital IPPS Services

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates known as the inpatient prospective payment system (IPPS). The IPPS categorizes patient care into a Medicare Severity (MS)-DRG based upon the procedures performed, the severity of the beneficiary's condition, and other factors. Each MS-DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that MS-DRG. Hospitals must meet all documentation requirements specified in Medicare policy to receive Medicare payment for an inpatient hospital stay.

The CMS implemented two policies in the CMS 1599-F (78 FR 50495, issued on August 2, 2013 and effective on October 1, 2013) pertaining to inpatient hospital claims to reduce improper payments:

- The CMS allowed all hospitals participating in Medicare to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient.
- The CMS clarified and modified the policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A and how Medicare review contractors assess inpatient hospital claims for payment purposes.

These policy changes applied to most claims reviewed for the 2015 Medicare FFS Improper Payments Report. As a result, the Hospital IPPS improper payment rate (unadjusted for Part A to B rebilling) decreased from 12.2 percent for the 2014 report period to 7.4 percent for the 2015 report period. In addition, the improper payment rate for inpatient hospital stays of one day or less decreased from 37.1 percent for the 2014 report period to 27.8 percent for the 2015 report period.

The 2015 improper payment rate for hospital IPPS services was 6.2 percent (adjusted for Part A to B rebilling), accounting for 15.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for hospital IPPS services during the 2015 report period was $7.0 billion (adjusted for Part A to B rebilling).

The 2015 hospital IPPS improper payment rate and amount are adjusted for Part A to B rebilling. This adjustment accounts for the difference between the improper inpatient payment made under Medicare Part A and the amount that would have been payable if the hospital claim was rebilled as a Medicare Part B claim. The Part A to B rebilling adjustment only applies to the overall improper payment rate for Part A inpatient services and not to procedure-specific rates.[18]

The majority of hospital IPPS improper payments are due to the admission of a Medicare beneficiary as an inpatient when the medical record supports the provision of care in an outpatient or other non-hospital based setting. The CERT program categorizes these situations as "medical necessity errors." The CERT program denied 1,635 claims for this reason during the 2015 report period. These sampled errors totaled $17.5 million in actual overpayments, which projected to $4.6 billion in overpayments for the universe of Medicare FFS claims (not adjusted for Part A to B rebilling). These errors are more likely to occur when the length of stay is shorter and when there is an elective surgical procedure. Sometimes, providers admit beneficiaries as inpatients post-operatively for overnight monitoring and discharge them the next day. Even if the procedure itself was reasonable and necessary, the post-operative inpatient admission for monitoring may not be medically necessary.

[18] The Part A to 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 Part A to B rebilling adjustment factor could only be applied to the high-level calculations (i.e., the overall, Part A Total, and Part A Hospital IPPS improper payment rates). This methodology is unchanged from 2012, 2013 and 2014.

**Table 3: Projected Improper Payments by Length of Stay (Dollars in Billions)[19]**

| Part A Hospital IPPS<br>Length of Stay | Improper Payment Rate | Projected Improper Payment | Proportion of Overall CERT Error |
|---|---|---|---|
| **All CERT** | **12.5%** | **$44.7** | **100.0%** |
| **Overall Hospital IPPS** | **7.4%** | **$8.3** | **18.6%** |
| 0 or 1 day | 27.8% | $2.1 | 4.8% |
| 2 days | 11.2% | $1.4 | 3.0% |
| 3 days | 8.7% | $1.4 | 3.1% |
| 4 days | 6.0% | $0.7 | 1.5% |
| 5 days | 6.5% | $0.6 | 1.3% |
| More than 5 days | 3.9% | $2.2 | 4.9% |

The three examples below illustrate improper payments for MS-DRG groups during the 2015 reporting period.

### Psychoses: MS-DRG 885

A provider admitted a beneficiary to an inpatient psychiatric facility because of increased depression, confusion, and anxiety due to tapering off benzodiazepines. The beneficiary had no comorbid conditions. His symptoms improved after changes to his medications. Although the beneficiary continued to have depression and anxiety, he was medically stable and not a danger to himself or others. The medical record documentation did not support billing for an MS-DRG; instead, it should have been billed as outpatient services. Therefore, the CERT program scored this claim as an improper payment due to a medical necessity error.

The majority of errors for MS-DRG 885 are the type of medical necessity error illustrated above. In addition, CERT identifies improper payments because of failure to meet certification and/or

[19] Unadjusted for Part A to B rebilling

recertification requirements. The medical record must clearly state the need for active treatment and all documentation must meet the content and timing requirements of 42 CFR 424.14 (e.g., diagnostic study, intensive treatment services, inpatient admission, and related services). If this required documentation and/or the physician's signature are not present in the medical records, then the payment is improper.

The improper payment rate for MS-DRG 885 was 8.4 percent, accounting for 0.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2015 report period was $351.3 million (without the Part A to B rebilling adjustment).

### Major Joint Replacement or Reattachment of Lower Extremity: MS-DRGs 469 and 470

A provider admitted a beneficiary for an elective (i.e., planned, non-emergent) total hip replacement performed on the day of admission without complication. On the operative report, the beneficiary's pre-operative diagnosis was avascular necrosis of the left hip. CERT requested supporting documentation such as the surgeon's preoperative office notes and preoperative imaging reports. There was no response to the additional documentation request. The CERT program scored this claim as an improper payment due to insufficient documentation.

The improper payment rate for MS-DRGs 469 and 470 (combined) was 5.5 percent, accounting for 0.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2015 report period was $359.1 million (without the Part A to B rebilling adjustment).

### Kidney & Urinary Tract Infections: MS-DRGs 689 and 690

A beneficiary with a past medical history of dementia and anemia presented to the hospital Emergency Room with weakness, chills, and fever. Laboratory results were normal with the exception of positive nitrates and bacteria in the urine. The beneficiary received rehydration and one dose of an antibiotic intravenously. The medical record documentation did not support billing for an MS-DRG; instead, it should have been billed as outpatient services. Therefore, the CERT program scored this claim as an improper payment due to a medical necessity error.

The improper payment rate for MS-DRGs 689 and 690 (combined) was 19.1 percent, accounting for 0.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2015 report period was $240.7 million (without the Part A to B rebilling adjustment).

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

### Part B Excluding DMEPOS

Medicare provides coverage for medically necessary services, such as laboratory tests, physician services, ambulance services, and procedures, under the Part B benefit. Medicare pays for these services only if the beneficiary's medical record contains sufficient documentation of the

patient's medical condition to support the need for the services. In addition, all documentation requirements outlined in Medicare policies must be present for the claim to be paid.

The improper payment rate for Part B (excluding DMEPOS) was 12.7 percent, accounting for 25.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for Part B (excluding DMEPOS) during the 2015 report period was $11.5 billion. Insufficient documentation errors caused the vast majority (68.2 percent) of improper payments for Part B (excluding DMEPOS). In these cases, the supplier or provider did not submit a complete medical record or the record did not adequately support the supplies or services billed. Other insufficient documentation errors were found when the medical record lacked required documentation elements, such as a documented face-to-face physician evaluation within a specified timeframe or a physician signature on a supplier form.

### Laboratory Tests - Other

This is a very broad category of Part B services, which includes HCPCS (Healthcare Common Procedure Coding System) codes for pathology and laboratory services. The category is BETOS (Berenson-Eggers Type of Service) Code category T1H "Lab tests - other (non-Medicare fee schedule)". Examples of these services are urine drug screening, medication assays, genetic tests, tissue examination, blood tests, and others.

The improper payment rate for "lab tests – other" was 39.0 percent, accounting for 2.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $1.2 billion.

The majority of improper payments for "lab tests – other" were due to insufficient documentation. All lab tests require documentation in the beneficiary's medical record indicating the intent to order the test and to support the medical necessity for the test. The treating physician or non-physician practitioners (NPP) must sign medical record documentation showing the intent to order the test (e.g., including office visit notes, progress notes, or testing protocols). Some specialized lab tests have precise documentation requirements and coverage criteria.

Routine screening tests (unless specifically covered by Medicare) or tests for quality assurance or quality control are not considered medically reasonable and necessary.

The ordering and referring provider specialties of Internal Medicine, Family Practice, and Cardiology comprise 62.4 percent of improper payments for "laboratory tests – other." In order to reduce the improper payment rate for "lab tests – other" the referring providers must respond to requests for documentation.

#### *Example*

A laboratory billed for a lipid panel, hemoglobin A1C, and urinalysis (without microscopy). The submitted documentation included only the laboratory results reports. The submitted documentation was missing the physician's order and there was no clinical documentation to

support the intent to order the billed lab tests. Nor was there an authenticated clinical documentation to support medical necessity for the billed lab tests. A valid diagnostic code unsupported by the medical record is insufficient to establish medical necessity. There was no response to an additional request for documentation. The submitted documentation did not meet the criteria for coverage based on Medicare guidelines. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Evaluation and Management Services

Evaluation and Management (E&M) services are visits and consultations by physicians and other qualified NPPs to Medicare beneficiaries.

The improper payment rate for E&M services was 14.6 percent, accounting for 10.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $4.6 billion.

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

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

Incorrect coding and insufficient documentation caused most of the improper payments for E&M services during the 2015 report period. Often the physician submitted medical documentation that supported a different E&M code than the one billed. Many other claims were found to have insufficient documentation because the submitted records lacked a physician signature. For other claims, physicians provided services in settings other than their own offices and did not submit records maintained by hospitals or other facilities.

### Non-Physician Practitioners (NPPs)

The CERT program identified many improper payments for E&M services billed using physicians' National Provider Identifiers (NPIs) but provided solely by NPPs. For certain E&M visits and settings, if a physician and a qualified NPP each perform and document a substantive part of an E&M visit face-to-face with the same beneficiary on the same date of service, then the physician can bill this visit under his or her NPI. NPPs must bill under their own NPIs if they provide an E&M service (in person) for a physician's patient in a hospital and the physician

does not also perform (and document) a substantive part of an E&M visit face-to-face with the same beneficiary on the same date of service.

### E&M: Hospital Visit – Initial

The improper payment rate for initial hospital visits was 30.2 percent, accounting for 2.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $888.9 million.

The majority of improper payments for initial hospital visits were due to incorrect coding. In addition, CERT identified improper payments due to insufficient documentation.

The servicing provider specialties of Internal Medicine and Cardiology comprise 41.6 percent of improper payments for initial hospital visits. In order to reduce the improper payment rate for initial hospital visits, the referring providers must respond to requests for documentation.

*Example*

A provider billed HCPCS 99223 (initial hospital care, per day, which requires three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity). The submitted documentation included an unsigned visit note for a date of service other than the billed date of service. The CERT reviewer requested documentation for the billed date of service and received an attestation statement for the previously submitted visit note (i.e., not for the billed date of service). The CERT program scored this claim as an improper payment due to insufficient documentation.

### E&M: Hospital Visit – Subsequent

The improper payment rate for subsequent hospital visits was 19.1 percent, accounting for 2.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $1.0 billion.

The majority of improper payments for subsequent hospital visits were due to incorrect coding.

The servicing provider specialty Internal Medicine comprises 36.4 percent of improper payments for subsequent hospital visits. In order to reduce the improper payment rate for subsequent hospital visits, the referring providers must respond to requests for documentation.

*Example*

A provider billed HCPCS 99233 (subsequent hospital care, per day, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity). The submitted documentation did not meet the requirements for 99233 but did meet the requirements for 99232. HCPCS 99232 requires two of three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. The beneficiary was stable; the provider ordered laboratory tests and made no changes in treatment. The CERT

program downcoded the claim and scored it as an improper payment due to an "incorrect coding error."

### E&M: Office Visits – Established

The improper payment rate for office visits with established patients was 7.7 percent, accounting for 2.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $1.1 billion.

The majority of improper payments for office visits with established patients were due to incorrect coding.

The servicing provider specialties of Internal Medicine, Family Practice, and Cardiology comprise 40.1 percent of improper payments for office visits with established patients. In order to reduce the improper payment rate for office visits with established patients, the referring providers must respond to requests for documentation.

#### *Example*

A provider billed for HCPCS 99215 (office or other outpatient visit requiring two of three key components: comprehensive history, comprehensive examination, and medical decision making of high complexity). The submitted documentation did not meet the requirements for 99215 but met the requirements for 99214. HCPCS 99214 requires two of three key components: detailed history; detailed examination; medical decision making of moderate complexity. The CERT program downcoded the claim and scored it as an improper payment due to an "incorrect coding error."

### Ambulance Services

The improper payment rate for ambulance services was 15.7 percent, accounting for 1.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $734.1 million.

Medicare covers ambulance services only for beneficiaries whose medical condition is such that use of any other means of transportation is contraindicated. The beneficiary's condition at the time of transport determines whether the service is medically necessary.

The majority of improper payments for ambulance services were due to insufficient documentation. For Medicare coverage, in addition to other requirements, the documentation must support the medical necessity for ambulance services, include details of the beneficiary's condition, and explain the need for special items or services. In order for an ambulance supplier or provider to submit a claim to Medicare for ambulance services, Medicare requires the signature of the beneficiary, or that of a person authorized to sign the claim form on behalf of the beneficiary.

*Example*

The ambulance supplier billed for Basic Life Support, emergency ambulance service, with modifiers NH (i.e., transportation from a Skilled Nursing Facility to a Hospital). The submitted documentation included the beneficiary care record for the billed date of service without provider signatures, without a beneficiary signature (or other acceptable signature if the beneficiary is incapable), and without documentation of the medical necessity for ambulance transportation. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Minor Procedures - Other (Medicare Fee Schedule)

This is a very broad category of Part B services, which includes HCPCS codes for specific therapy services, minor excisions, procedures, diagnostic studies, and treatments. The category is BETOS Code category P6C "Minor procedures – other (Medicare fee schedule)."

The improper payment rate for "minor procedures – other (Medicare fee schedule)" was 20.1 percent, accounting for 1.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2015 report period was $593.6 million.

The majority of improper payments for "minor procedures – other (Medicare fee schedule)" were due to insufficient documentation. For Medicare coverage, the beneficiary's medical record must contain documentation of the service provided including relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The ordering and referring provider specialties of General Surgery, Family Practice, and Internal Medicine comprise 69.9 percent of improper payments for "Minor procedures – other (Medicare fee schedule)." In order to reduce the improper payment rate for "Minor procedures – other (Medicare fee schedule)", the referring providers must respond to requests for documentation.

*Example*

A provider billed for a vitamin B-12 injection. The submitted documentation included a screen print supporting the administration of the billed medication to the beneficiary in the left deltoid. The CERT reviewer requested additional documentation such as the physician's order for the medication, clinical documentation supporting the plan/intent for the billed medication, and documentation supporting the medical necessity of the vitamin B12 injection. Following the request for additional documentation, the provider sent duplicate documentation and records from 2005. The CERT program scored this claim as an improper payment due to insufficient documentation.

*Example*

A provider billed for HCPCS 97112 (therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes), with GP modifier (Services Delivered Under an Outpatient Physical Therapy Plan of Care); 2 units of service. The submitted documentation included the therapy daily progress note supporting 28 minutes of massage therapy (which does not support a

bill for HCPCS 97112) and the physician's order to evaluate and treat. The CERT reviewer requested additional documentation; however, the provider failed to send a therapy plan of care or support for the billed service. An order to evaluate and treat does not meet the requirements of a therapy plan of care. The CERT program scored this claim as an improper payment due to insufficient documentation.

## DMEPOS

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

The improper payment rate for DMEPOS decreased from 53.1 percent during the 2014 report period to 39.9 percent during the 2015 report period. The percent of the overall Medicare FFS improper payment rate attributed to DMEPOS decreased from 10.4 percent during the 2014 report period to 7.1 percent during the 2015 report period. The projected improper payment amount for DMEPOS decreased from $5.1 billion during the 2014 report period to $3.2 billion during the 2015 report period. These decreases are attributed to corrective actions implemented over a six year period. Examples of corrective actions include the DMEPOS Accreditation Program, DMEPOS MAC onsite visits to large suppliers, DMEPOS competitive bidding, and prior authorization of Power Mobility Devices.

Insufficient documentation errors caused the vast majority (83.0 percent) of improper payments for DMEPOS. In these cases, the supplier or provider did not submit a complete medical record or the record did not adequately support the supplies or services billed. Other insufficient documentation errors occurred when the medical record lacked required documentation elements such as a documented face-to-face physician evaluation within a specified timeframe or a physician signature on a supplier form.

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

The five DMEPOS categories with the highest improper payments were (in order):

- Oxygen supplies and equipment

- Positive airway pressure devices and supplies for beneficiaries with obstructive sleep apnea,
- Nebulizers and related drugs
- Glucose monitors and testing supplies
- Lower limb prosthetics

These five DMEPOS groups combined accounted for 37.1 percent of the DMEPOS improper payments in the 2015 report period.

### Oxygen Supplies and Equipment

Medicare FFS provides coverage for home and portable oxygen supplies and equipment for beneficiaries with severe lung disease or conditions related to low oxygen levels that improve with oxygen therapy.

The improper payment rate for oxygen supplies and equipment was 48.5 percent, accounting for 1.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for oxygen supplies and equipment during the 2015 report period was $541.1 million.

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

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

- The order for the oxygen supplies and equipment
- The most recent Certificate of Medical Necessity (CMN) documenting the beneficiary's condition
- Oxygen saturation results
- Physician's notes demonstrating that the beneficiary was seen by a physician within the appropriate timeframes for certification or recertification of the need for oxygen supplies and equipment
- Physician's notes supporting monitoring of the beneficiary's continued medical necessity for oxygen supplies
- The ordering and referring provider specialties of Internal Medicine and Family Practice comprise 80.5 percent of improper payments for Oxygen Supplies and Equipment. In order to reduce the improper payment rate for oxygen supplies and equipment, the referring providers must respond to requests for documentation.

*Example*

A supplier submitted a claim for the monthly charge for stationary oxygen contents and portable oxygen contents. The CERT reviewer received an initial CMN, an order for oxygen, and a recertification CMN all dated on the same day in June 1997. The only difference between the initial CMN and the recertification CMN was that a box was checked indicating a recertification; it included the same physician signature date as the initial CMN. The date on the delivery slip was in April 1997. The CERT reviewer requested timely documentation supporting the continued medical need for the oxygen as required by the LCD, but received no additional documentation. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Positive Airway Pressure Devices

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

The improper payment rate for CPAP/BPAP devices and supplies was 40.4 percent, accounting for 0.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for CPAP/BPAP supplies during the 2015 report period was $248 million.

For Medicare coverage of CPAP/BPAP devices for a diagnosis of obstructive sleep apnea the beneficiary's medical record must contain a sleep test that meets the Medicare coverage criteria in effect for the date of service. The initial coverage period is for three months. For coverage beyond three months, the treating physician must perform a re-evaluation within a specified timeframe. Documentation must show that the beneficiary is benefitting from the therapy and adhering to the usage guidelines.

To be covered, the medical record must include documentation of the qualifying sleep test, the physician's evaluation of the beneficiary's sleep apnea, the supplier's instruction on the proper use and care of the equipment, and the ineffectiveness of CPAP (when a BPAP device is ordered).

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

- The signed and dated order for the CPAP/BPAP device and each accessory billed
- Physician evaluation performed prior to the sleep test, assessing the beneficiary for sleep apnea
- Physician re-evaluation performed within the required timeframe to support that the beneficiary benefits from the therapy and adheres to specified usage guidelines
- Qualifying sleep test that meets Medicare requirements
- The ordering and referring provider specialties of Internal Medicine and Family Practice comprise 71.7 percent of improper payments for CPAP/BPAP devices and supplies. In

order to reduce the improper payment rate for CPAP/BPAP devices and supplies, the referring providers must respond to requests for documentation.

*Example*

A supplier submitted a claim for tubing for a CPAP device. The submitted documentation was missing the referring physician's order for the tubing. It was also missing timely documentation supporting the continued medical necessity for the CPAP device. The documentation was not timely because it was dated more than 12 months before the billed dated of service. The CERT reviewer requested additional documentation, such as a detailed written order and timely documentation supporting continued medical necessity for the CPAP device. The submitted additional documentation included duplicates of the previously received clinical records. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Nebulizer Machines and Related Medications

Medicare provides coverage for medically necessary nebulizer machines and related medications for those beneficiaries with respiratory problems such as asthma. A nebulizer machine is a device that uses pressurized air to convert liquid medicine into an easily inhaled fine mist.

The improper payment rate for nebulizer machines and related medications was 11.0 percent, accounting for 0.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for nebulizer machines and related medications during the 2015 report period was $125 million.

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

The ordering and referring provider specialties of Internal Medicine and Family Practice comprise 91.0 percent of improper payments for nebulizer machines and related medications. In order to reduce the improper payment rate for nebulizer machines and related medications, the referring providers must respond to requests for documentation.

*Example*

A supplier billed for administration sets for use with small disposable nebulizers. The submitted documentation was missing a Detailed Written Order (DWO) for the nebulizer and timely documentation to support medical necessity for the nebulizer. The submitted documentation included an order from a physician who was not the treating physician, and the order did not meet the requirements of a DWO. The CERT reviewer made an additional request for a DWO and timely documentation supporting the continued medical necessity for the nebulizer. The additional documentation received included duplicates of the previously received clinical records. Submitted documentation did not meet the criteria for coverage based on the LCD or

Medicare guidelines. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Glucose Monitors and Testing Supplies

Medicare provides coverage for glucose monitors and supplies (e.g., test strips and lancets) for Medicare beneficiaries with diabetes at a frequency of testing that is medically necessary.

The improper payment rate for glucose testing supplies was 42.9 percent, accounting for 0.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for glucose testing supplies during the 2015 report period was $139.8 million.

For Medicare coverage, the beneficiary's medical record must contain timely documentation of the beneficiary's medical condition to support the continued medical necessity for the type and quantity of items ordered. Documentation must include such elements as a physician's order for the glucose testing supplies, evaluations demonstrating physician oversight of the beneficiary, and the need for glucose testing supplies.

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

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

The ordering and referring provider specialties of Internal Medicine and Family Practice, along with Nurse Practitioners comprise 90.7 percent of improper payments for glucose monitors and testing supplies. In order to reduce the improper payment rate for glucose monitors and supplies, the referring providers must respond to requests for documentation.

#### *Example*

A supplier billed for blood glucose test strips (qty. 100) and lancets (qty. 100), for a 3-month period, with a KS modifier to indicate treatment without insulin. Per the LCD for Glucose Monitors, documentation supporting continued medical necessity is required as well as the detailed written order for the item billed. The submitted documentation was missing the treating physician's signed and dated DWO, and timely documentation from the treating physician supporting the medical necessity for the items. The submitted documentation included a referral form, an order for diabetic supplies signed by a nurse, dietitian's notes, and a glucose testing log. The CERT reviewer made an additional request for the physician's DWO and timely clinical documentation to support the continued medical necessity for the items. The additional documentation received included duplicates of the previously received clinical records.

Submitted documentation did not meet the criteria for coverage based on the LCD or Medicare guidelines. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Lower Limb Prosthetics

The improper payment rate for lower limb prosthetics was 23.7 percent, accounting for 0.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for lower limb prostheses during the 2015 report period was $127.3 million.

The majority of improper payments for lower limb prosthetics are due to insufficient documentation. Critical documentation that was often missing from the submitted records included:

- The order for the prosthesis/prosthesis replacement;
- Physician's documentation to support the functional level; and
- Documentation of the reason for the replacement; this may be documented by the ordering physician either on the order or in the medical record and must fall under one of the following:

1. A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes.

2. An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement.

3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of replacement device, or, as the case may be, of the part being replaced.

The ordering and referring provider specialties of Internal Medicine, Family Practice, and General Surgery comprise 72.0 percent of improper payments for lower limb prosthetics. In order to reduce the improper payment rate for lower limb prosthetics, the referring providers must respond to requests for documentation.

#### *Example*

A supplier billed for a replacement below knee (BK) lower limb prosthesis and its related components. According to section 1834(h)(1)(G)(i) of the Act, an ordering physician determines the reason for the replacement and the reason must fall under one of three circumstances. Per the LCD for lower limb prostheses, each item requires a DWO. The submitted documentation included proof of delivery, an order for a BK LLP (without specifics for the billed components and without the reason for the replacement), authenticated notes signed by a certified prosthetist, an operative report from 2 years prior to the billed date of service, and a physician's signature log. The CERT reviewer requested the DWO and documentation from the physician supporting

the reason for the replacement. The additional documentation included a note from the treating physician indicating that the beneficiary was ambulating well with a left BK LLP. Submitted documentation did not meet the criteria for coverage based on the Act or the LCD. The CERT program scored this claim as an improper payment due to insufficient documentation.

### Resources for Providers and Suppliers

The following links provide information that is available for providers and suppliers to educate them on the CERT process; major drivers of improper payments and corrective actions; and other improper payment efforts.

### Medicare Quarterly Provider Compliance Newsletter

This newsletter is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Fee-For- Service (FFS) Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf

### Payment Accuracy Website

This website provides an overview of improper payments measurements across the federal government.

https://paymentaccuracy.gov/

## Corrective Actions to Improve the Accuracy Rate

In addition to the five major initiatives discussed on pages 9 - 10 above, CMS has implemented additional efforts in specific areas to reduce improper payments in the Medicare FFS program as outlined below.

**Corrective Actions to Address Root Causes:**

***Root Cause: Administrative or Process Errors Made by Other Party***

- Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of individual claims, CMS relies on automated edits to identify many inappropriate claims. CMS designed its systems to detect anomalies on the face of the claims. Through these efforts, CMS correctly pays submitted claims nearly 100 percent of the time. For example, CMS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. This program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The use of the NCCI edits saved the Medicare program $681.9 million in FY 2014.
- The *Affordable Care Act* required CMS to revalidate all existing Medicare providers and suppliers. All Medicare providers and suppliers already enrolled prior to the new screening requirements were sent revalidation notices by March 23, 2015. CMS has completed the revalidation of all 1.6 million existing Medicare providers to ensure that only qualified and legitimate providers and suppliers can deliver health care items and services to Medicare beneficiaries. These revalidation efforts alone resulted in the deactivation of more than 307,388 provider and supplier practice locations as well as the revocation of 17,655 providers' and suppliers' billing privileges.
- CMS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including federal and state partners, private payers, associations, and law enforcement, exchange data and anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.
- CMS and its contractors develop medical review strategies using improper payment data to ensure the areas of highest risk and exposure are targeted. CMS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) claims.

***Root Cause: Medical Necessity and Insufficient Documentation to Determine***

- CMS contracted with a Supplemental Medical Review/Specialty Contractor (SMRC) to perform medical reviews focused on vulnerabilities identified by CMS internal data analysis, the CERT program, professional organizations, and federal oversight agencies. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing

rules. In FY 2015, the SMRC performed post payment reviews on certain durable medical equipment items, such as continuous positive airway pressure devices, portable oxygen concentrators, and nebulizer medications and equipment. The SMRC also reviewed high cost diagnostic imaging and blepharoplasty procedures. The results of these reviews are used to improve billing accuracy.

- CMS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. In February 2014, CMS announced a number of changes to the Medicare FFS RAC program that will take effect with the new contract awards as a result of stakeholder feedback. CMS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. For further information on these changes, refer to the Recovery Audit Program website.
- CMS issues Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the state and across the nation.
- CMS published CMS-6010-F, "Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements and Changes in Provider Agreements" (77 FR 25283), on April 27, 2012. Effective January 6, 2014, this rule requires physicians and other professionals who order and certify certain covered items and services for Medicare beneficiaries, including the following: home health, clinical laboratory, imaging and DMEPOS, to be a Medicare participating provider. Finally, it establishes document retention and access to documentation requirements for providers and suppliers that order and certify certain items and services for Medicare beneficiaries.

## Acronyms

| Acronyms | Definition |
|---|---|
| AFR | Agency Financial Report |
| BPAP | Bi-Level Positive Airway Pressure |
| CBRs | Comparative Billing Reports |
| CERT | Comprehensive Error Rate Testing |
| CMN | Certificate of Medical Necessity |
| CMS | Centers for Medicare & Medicaid Services |
| CPAP | Continuous Positive Airway Pressure |
| DMEPOS | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies |
| DRG | Diagnosis Related Group |
| DWO | Detailed Written Order |
| E&M | Evaluation and Management |
| ESRD | End Stage Renal Disease |
| FFS | Fee-For-Service |
| GPRA | Government Performance and Results Act of 1993 |

| Acronyms | Definition |
|---|---|
| HCPCS | Healthcare Common Procedure Coding System |
| HFPP | Healthcare Fraud Prevention Partnership |
| HHS | Department of Health and Human Services |
| IPERIA | Improper Payments Elimination and Recovery Improvement Act of 2012 |
| IPIA | Improper Payments Information Act of 2002 |
| IPPS | Inpatient Prospective Payment System |
| IRF | Inpatient Rehabilitation Facility |
| LCD | Local Coverage Determination |
| MAC | Medicare Administrative Contractor |
| MS-DRG | Medicare Severity Diagnosis Related Group |
| NCCI | National Correct Coding Initiative |
| NCD | National Coverage Determination |
| NPI | National Provider Identifier |
| NPP | Non-Physician Practitioner |
| OMB | Office of Management and Budget |

| Acronyms | Definition |
|---|---|
| PAP | Positive Airway Pressure |
| SMRC | Supplemental Medical Review/Specialty Contractor |
| SNF | Skilled Nursing Facility |

# Appendix

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

| Fiscal Year and Rate Type (Net/Gross) | | No Document Errors | Insufficient Document Errors | Medical Necessity Errors | Incorrect Coding Errors | Other Errors | Improper Payment Rate | Correct Payment Rate |
|---|---|---|---|---|---|---|---|---|
| 1996[20] | 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% | 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[21] | 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[22] | Gross | 0.2% | 5.0% | 3.4% | 1.2% | 0.1% | **9.9%** | 90.1% |
| 2012[23] | Gross | 0.2% | 5.0% | 2.6% | 1.3% | 0.1% | **9.3%** | 90.7% |
| 2013[23] | Gross | 0.2% | 6.1% | 2.8% | 1.5% | 0.2% | **10.7%** | 89.3% |
| 2014[23] | Gross | 0.1% | 8. 2% | 3.6% | 1.6% | 0.2% | **13.6%** | 86.4% |
| 2015[23] | Gross | 0.2% | 8.2% | 2.5% | 1.3% | 0.4% | **12.5%** | 87.5% |

[20] FY 1996-2003 Improper payments were calculated as Overpayments – Underpayments.
[21] FY 2004-2014 Improper payments were calculated as Overpayments + absolute value of Underpayments.
[22] The FY 2011 improper payment rate reported in the HHS Agency Financial Report was 8.6 percent, which was adjusted for the prospective impact of late appeals and documentation. Because this adjustment could not be applied on a lower level than the overall improper payment rate, the FY 2011 rates in this table are unadjusted.
[23] The FY 2012, 2013, 2014, and 2015 improper payment rates reported in the HHS Agency Financial Report were 8.5 percent, 10.1 percent, 12.7 percent, and 12.1 percent, respectively. These rates represented the rate that was adjusted for the impact of denied Part A inpatient claims under Part B. Because this adjustment could not be applied on a lower level than the overall and the Part A improper payment rates, the FY 2012, 2013, 2014, and 2015 rates in this table are unadjusted.

### Table 5: Comparison of 2014 and 2015 National Improper Payment Rates[24]

| Error Category | 2014 | 2015 | | | | |
|---|---|---|---|---|---|---|
| | Total | Total | Part A Excl. Hospital IPPS | Part A Hospital IPPS | Part B | DMEPOS |
| No Documentation | 0.1% | 0.2% | 0.0% | 0.0% | 0.1% | 0.0% |
| Insufficient Documentation | 8.2% | 8.2% | 4.9% | 0.3% | 2.2% | 0.7% |
| Medical Necessity | 3.6% | 2.5% | 0.8% | 1.6% | 0.1% | 0.0% |
| Incorrect Coding | 1.6% | 1.3% | 0.1% | 0.4% | 0.8% | 0.0% |
| Other | 0.2% | 0.4% | 0.2% | 0.0% | 0.1% | 0.1% |
| **Total** | **13.6%** | **12.5%** | **6.1%** | **2.3%** | **3.2%** | **0.9%** |

[24] 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 Part A to B rebilling.

### Table 6: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions)[25]

| Claim Type | Overall Improper Payments | | | Overpayments | | Underpayments | |
|---|---|---|---|---|---|---|---|
| | Total Amount Paid | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate |
| **Part A (Total)** | $260.0 | $30.0 | 11.5% | $29.1 | 11.2% | $0.9 | 0.4% |
| Part A (Excluding Hospital IPPS) | $147.4 | $21.7 | 14.7% | $21.6 | 14.7% | $0.1 | 0.0% |
| Part A (Hospital IPPS) | $112.6 | $8.3 | 7.4% | $7.5 | 6.6% | $0.9 | 0.8% |
| **Part B** | $90.4 | $11.5 | 12.7% | $11.2 | 12.4% | $0.3 | 0.3% |
| **DMEPOS** | $8.0 | $3.2 | 39.9% | $3.2 | 39.9% | $0.0 | 0.0% |
| **Total** | **$358.3** | **$44.7** | **12.5%** | **$43.4** | **12.1%** | **$1.3** | **0.4%** |

[25] 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 Part A to B rebilling.

### Table 7: 2015 Projected Improper Payments (Dollars in Billions) by Type of Error and Clinical Setting[26]

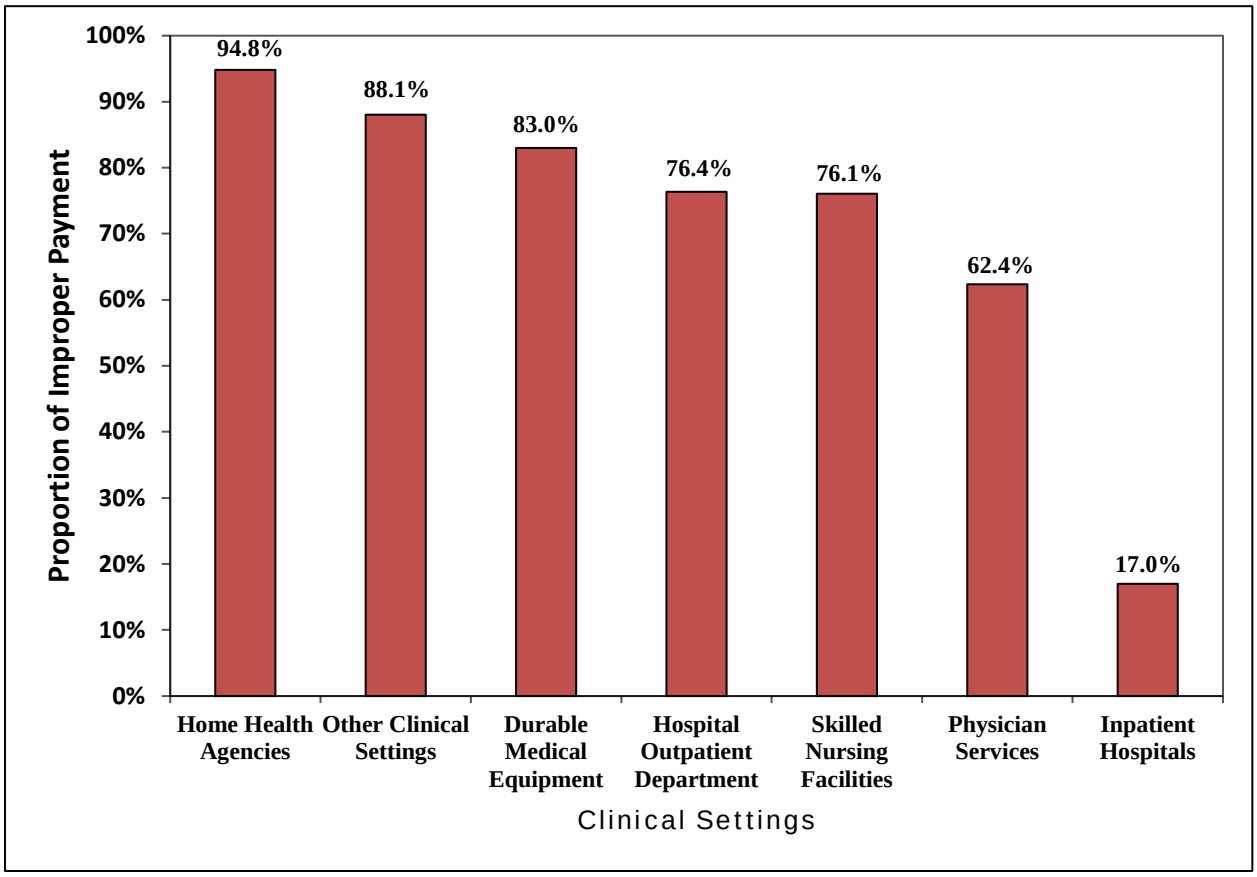
Examining the types of CERT errors and their impact on improper payments is a crucial step toward reducing the improper payment rate in the Medicare FFS program. Improper payments vary by clinical setting. Insufficient documentation errors and medical necessity errors are the main drivers of projected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

| Error Category | DMEPOS | Home Health Agencies | Hospital Outpatient Departments | IPPS Hospitals | Physician Services (All Settings) | Skilled Nursing Facilities | Other Clinical Settings | Overall |
|---|---|---|---|---|---|---|---|---|
| No Documentation | $0.1 | $0.0 | $0.0 | $0.0 | $0.4 | $0.0 | $0.1 | $0.6 |
| Insufficient Documentation | $2.6 | $9.6 | $4.4 | $1.7 | $5.5 | $3.0 | $2.4 | $29.2 |
| Medical Necessity | $0.1 | $0.4 | $1.0 | $7.0 | $0.1 | $0.1 | $0.1 | $8.8 |
| Incorrect Coding | $0.0 | $0.0 | $0.2 | $1.3 | $2.7 | $0.3 | $0.1 | $4.7 |
| Other | $0.4 | $0.1 | $0.2 | $0.1 | $0.2 | $0.5 | $0.0 | $1.4 |
| **Total** | **$3.2** | **$10.1** | **$5.8** | **$10.2** | **$8.9** | **$4.0** | **$2.7** | **$44.7** |

[26] 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 Part A to B rebilling.

## Figure 1: Proportion of Improper Payments Attributed to Insufficient Documentation in 2015, by Clinical Setting

Insufficient documentation errors accounted for the greatest proportion of improper payments during the 2015 report period.



## Table 8: Projected Improper Payments, Overpayments and Underpayments by Top 10 States (Dollars in Millions)[27]

| State | Overall | | Overpayments | | Underpayments | |
|---|---|---|---|---|---|---|
| | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate |
| CA | $4,659.8 | 14.1% | $4,505.6 | 13.6% | $154.2 | 0.5% |
| TX | $4,393.8 | 17.6% | $4,310.7 | 17.3% | $83.1 | 0.3% |
| FL | $3,569.9 | 13.1% | $3,449.0 | 12.7% | $120.9 | 0.4% |
| NY | $2,411.4 | 11.1% | $2,268.2 | 10.5% | $143.2 | 0.7% |
| IL | $2,392.8 | 15.0% | $2,353.6 | 14.7% | $39.2 | 0.2% |
| PA | $1,995.6 | 14.0% | $1,936.0 | 13.6% | $59.6 | 0.4% |
| NJ | $1,823.4 | 14.0% | $1,782.9 | 13.7% | $40.5 | 0.3% |
| OH | $1,802.9 | 13.7% | $1,791.7 | 13.7% | $11.2 | 0.1% |
| GA | $1,627.3 | 16.7% | $1,609.5 | 16.5% | $17.8 | 0.2% |
| MI | $1,523.8 | 11.3% | $1,491.0 | 11.1% | $32.8 | 0.2% |
| **Overall** | **$44,697.0** | **12.5%** | **$43,437.7** | **12.1%** | **$1,259.3** | **0.4%** |

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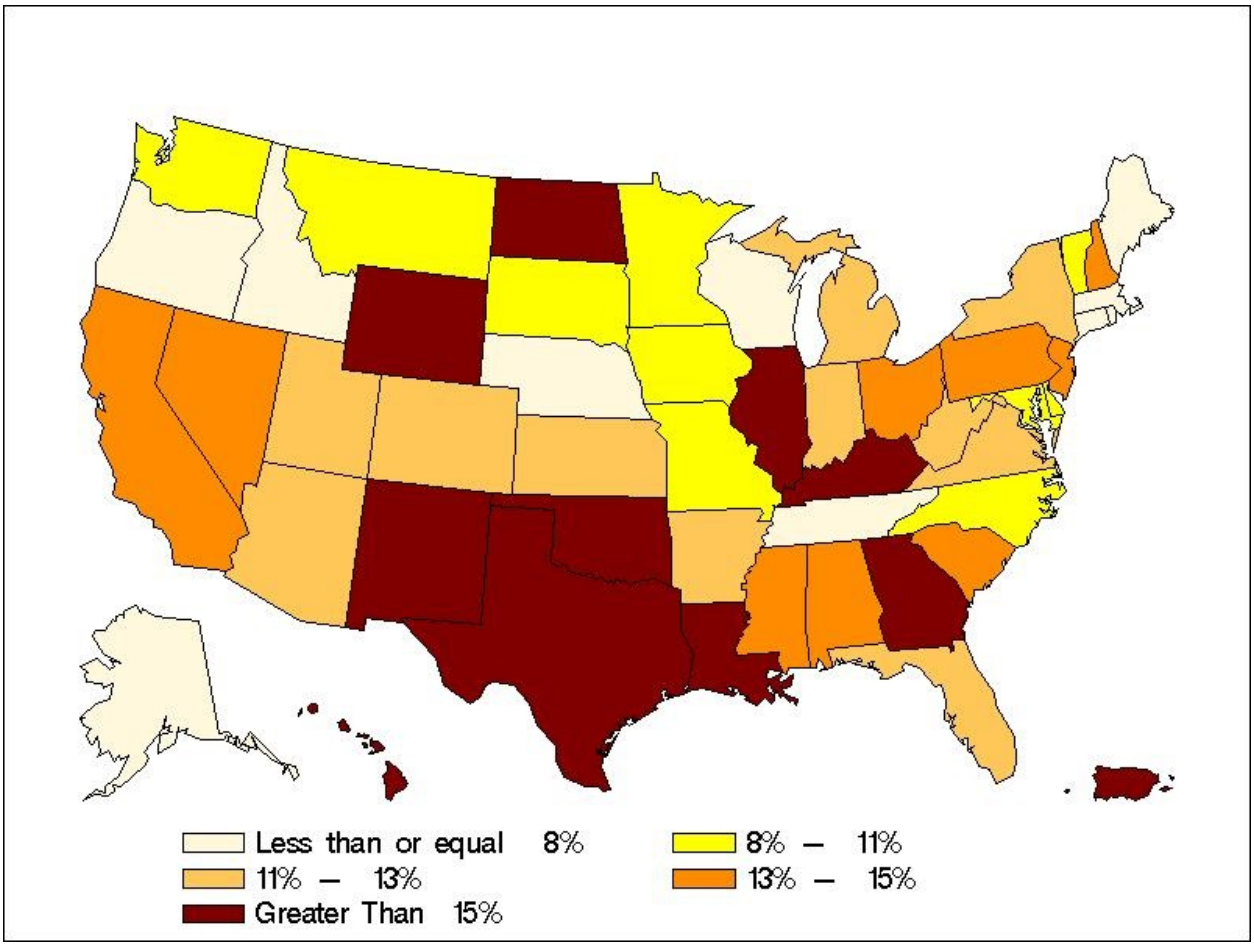
[27] Some columns and/or rows may not sum correctly due to rounding. The improper payment rates in this table are unadjusted for the impact of Part A to B rebilling.

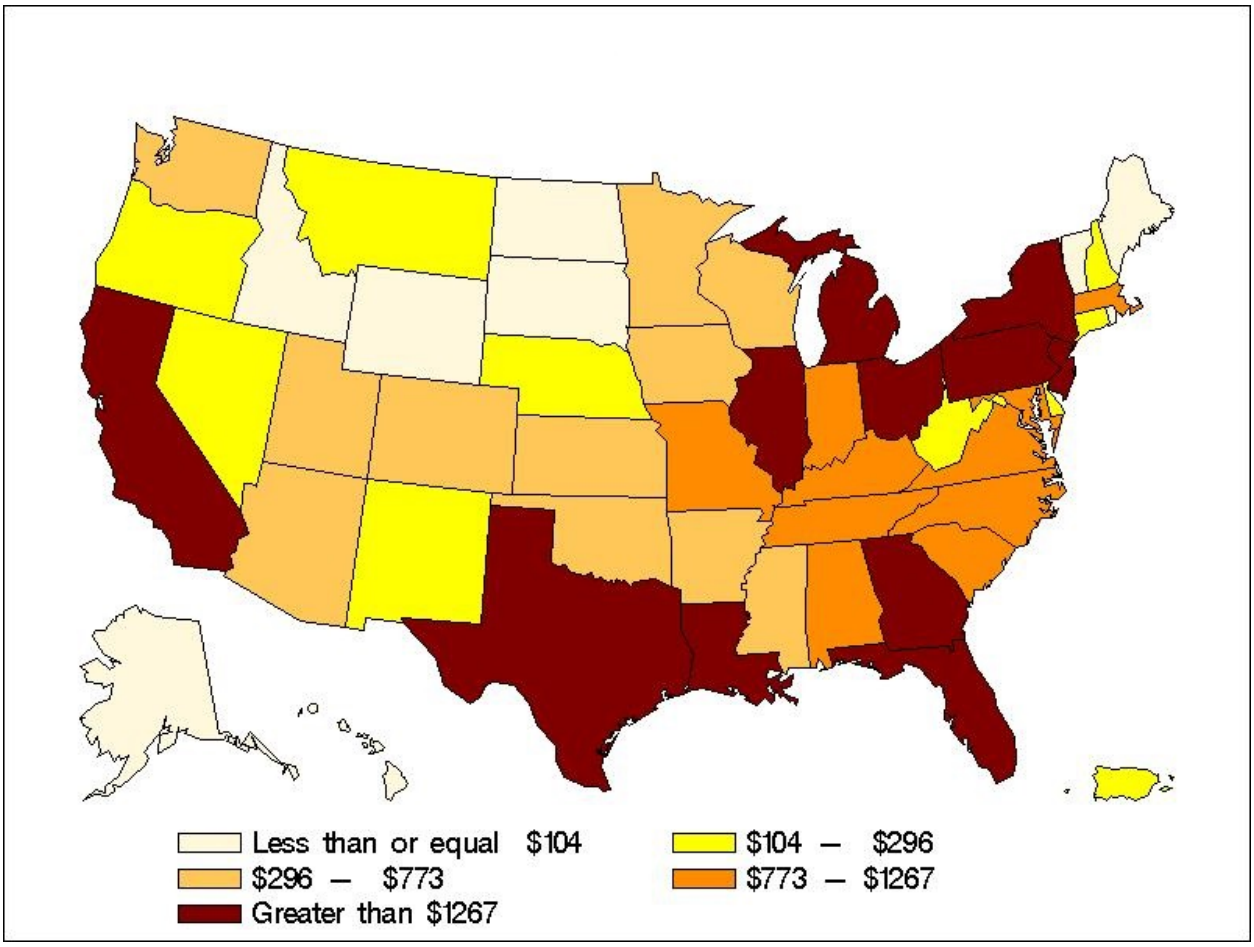
## Geographic Trends[28]

### Figure 2: 2015 Improper Payment Rates by State




[28] Cut points and colors for maps are assigned using quintiles. Part A Inpatient Hospital maps are unadjusted for Part A to B rebilling; the adjustment does not apply to Part A Excluding IPPS, DMEPOS, and Part B

**Figure 3: 2015 Improper Payment Amounts by State (Dollars in Millions)**



## Figure 4: Part A (Hospital IPPS) Improper Payment Rates by State

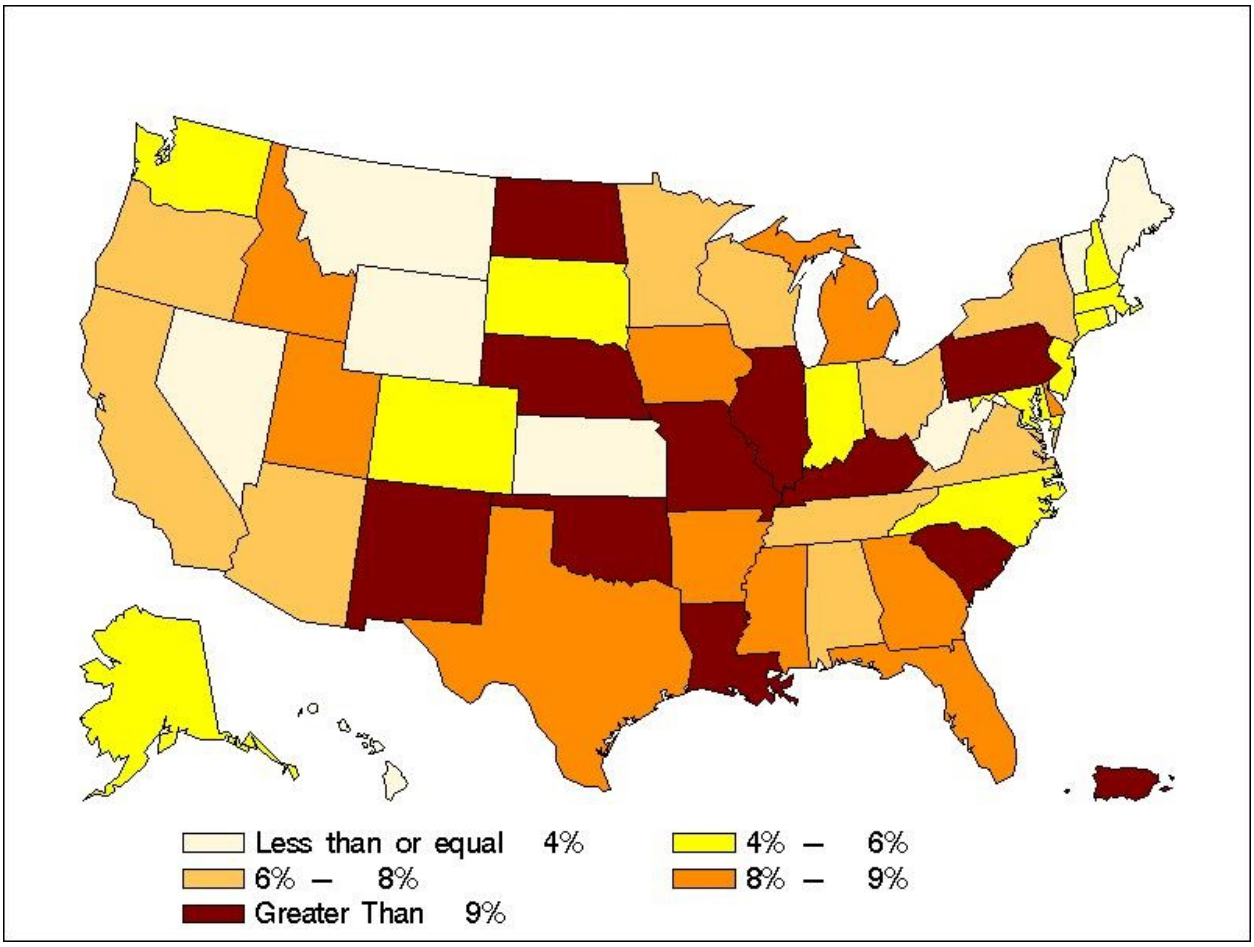
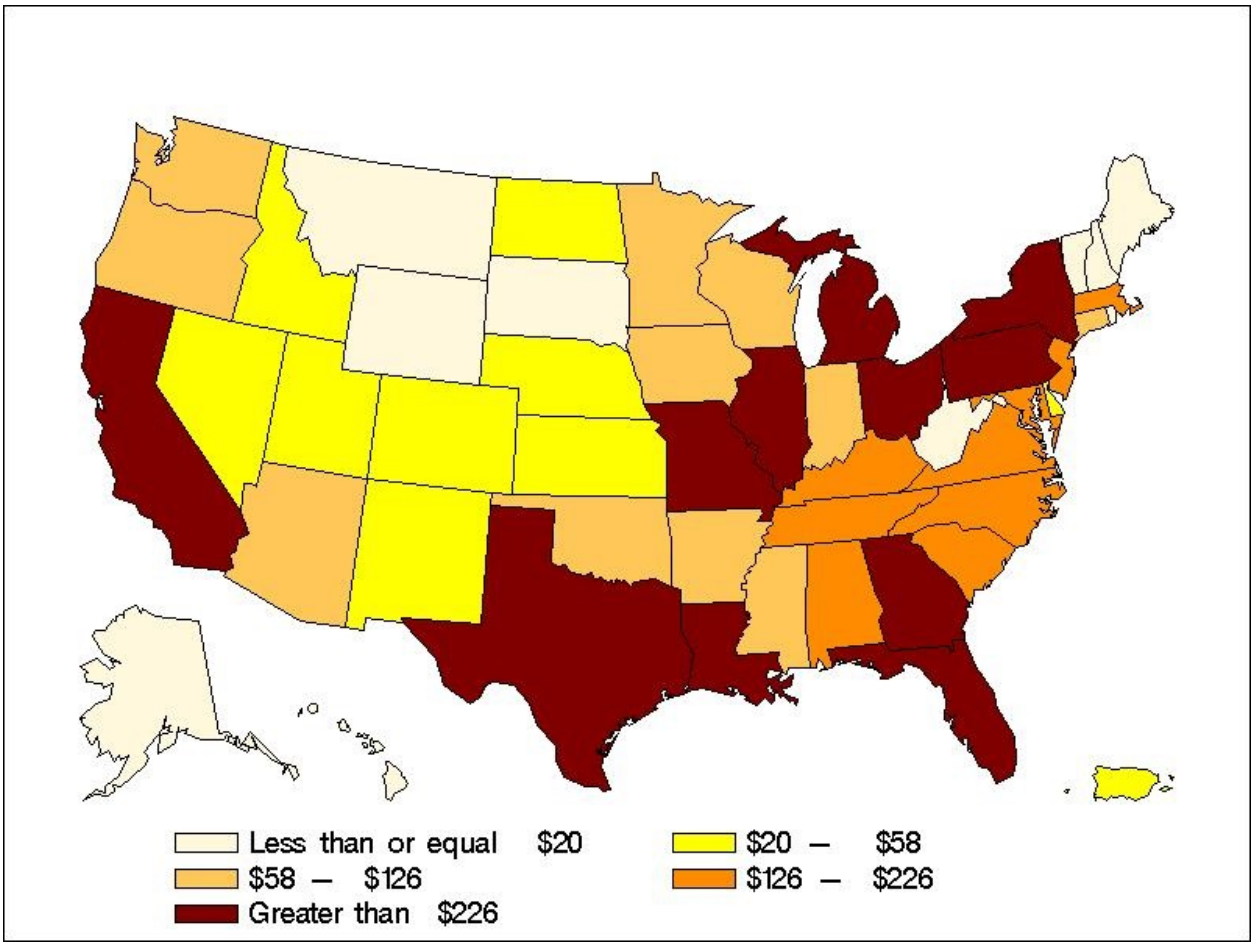


**Figure 5: Part A (Hospital IPPS) Improper Payment Amounts by State (Dollars in Millions)**



## Figure 6: Part A (Excluding Hospital IPPS) Improper Payment Rates by State

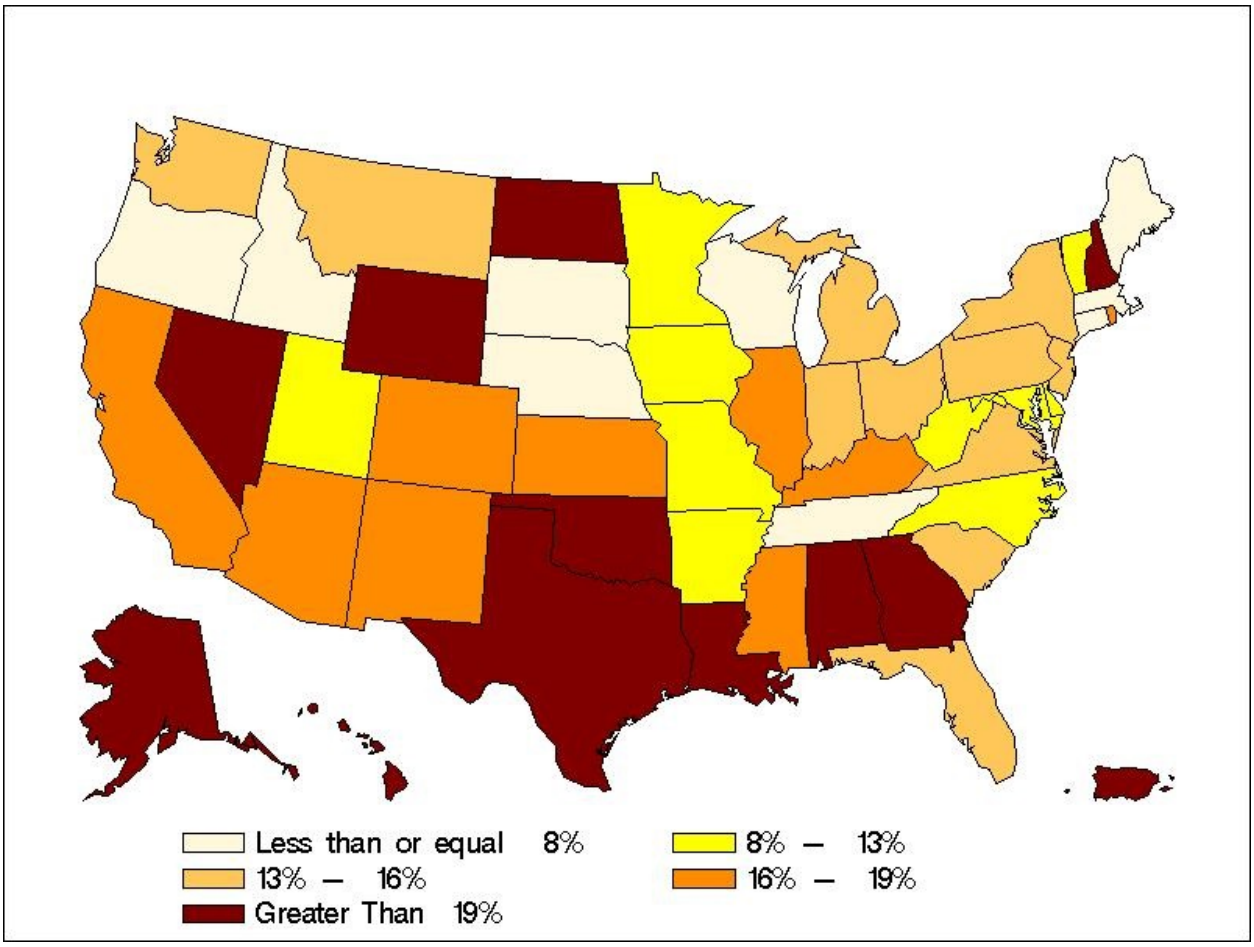
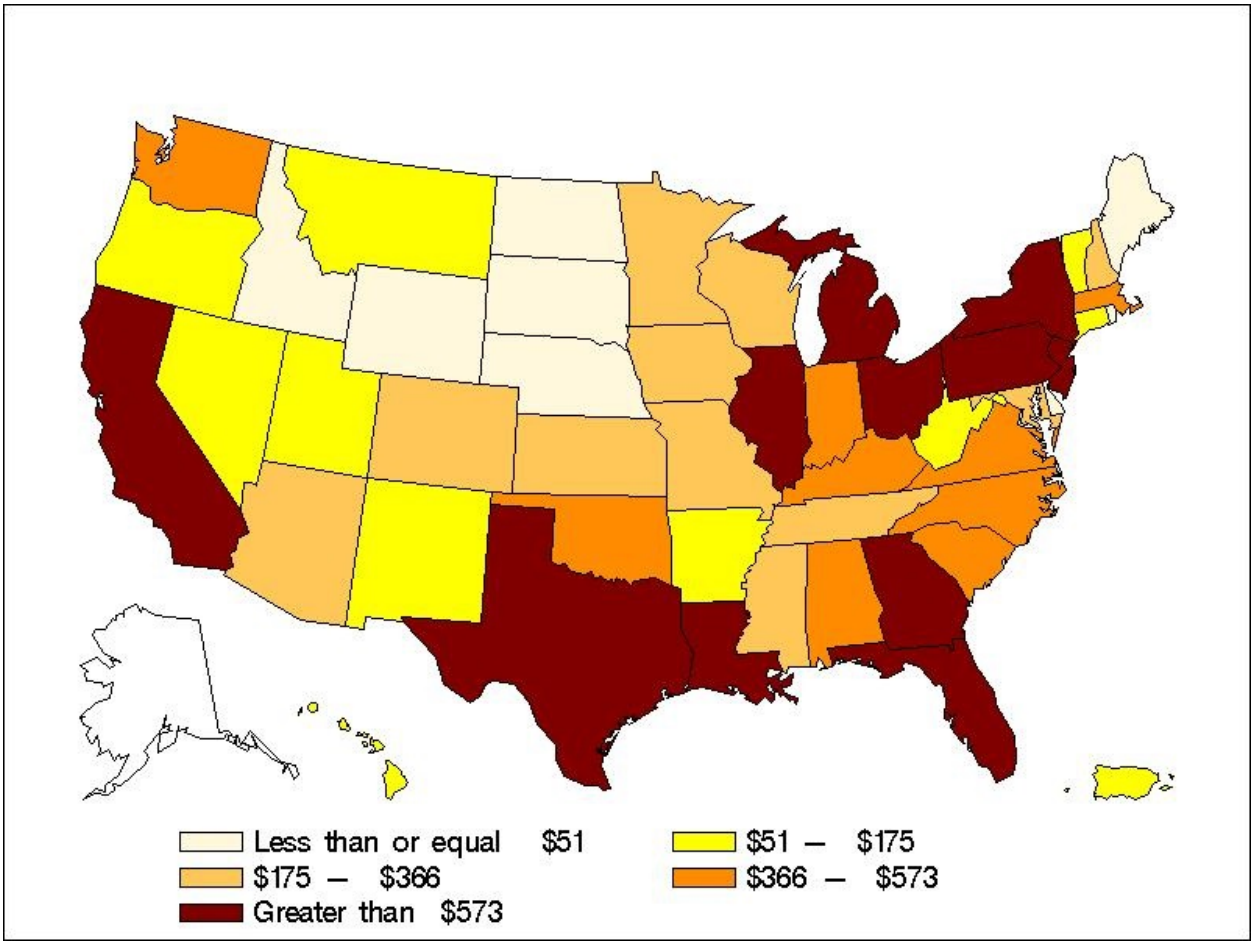
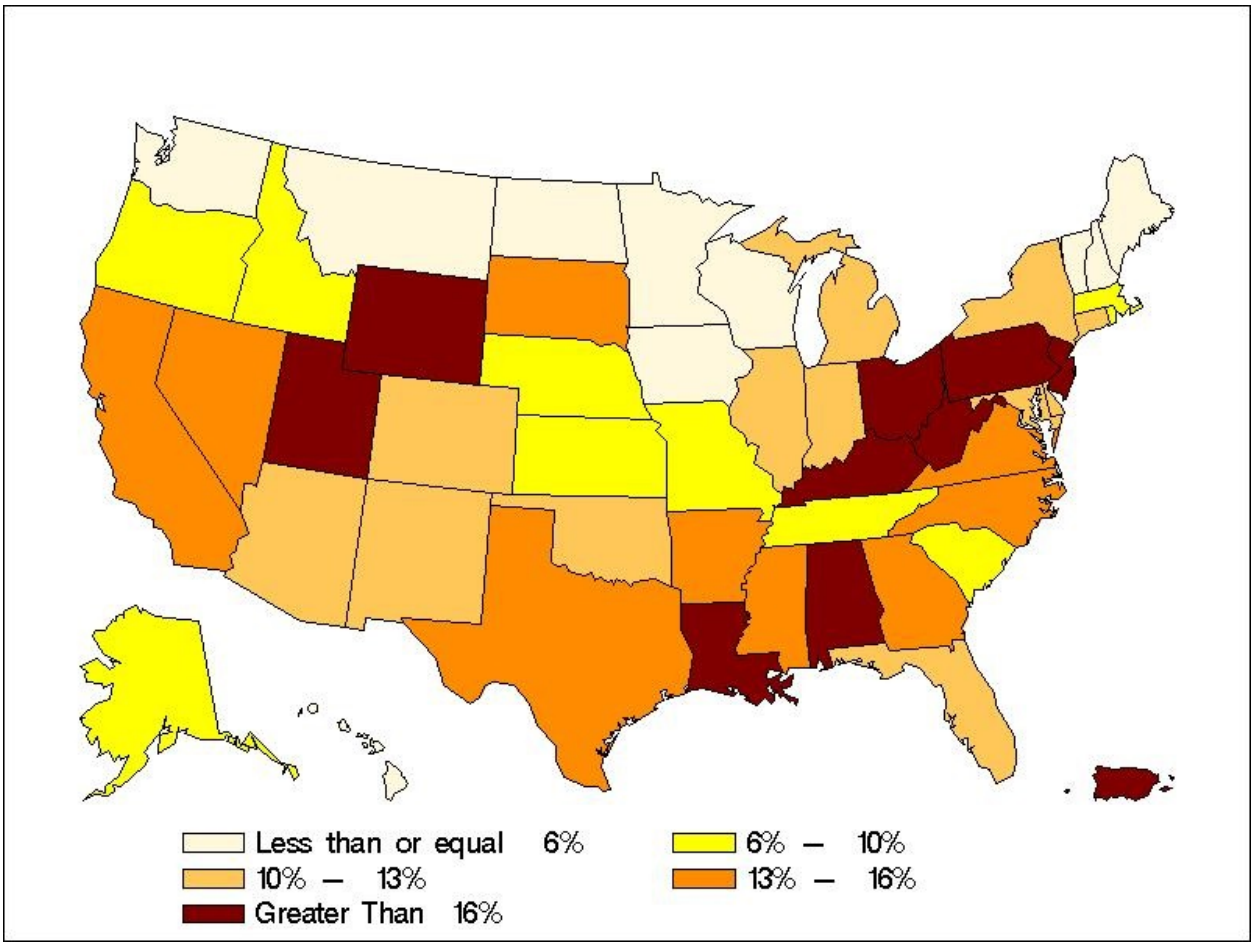


**Figure 7: Part A (Excluding Hospital IPPS) Improper Payment Amounts by State (Dollars in Millions)**



## Figure 8: Part B Improper Payment Rates by State



## Figure 9: Part B Improper Payment Amounts by State

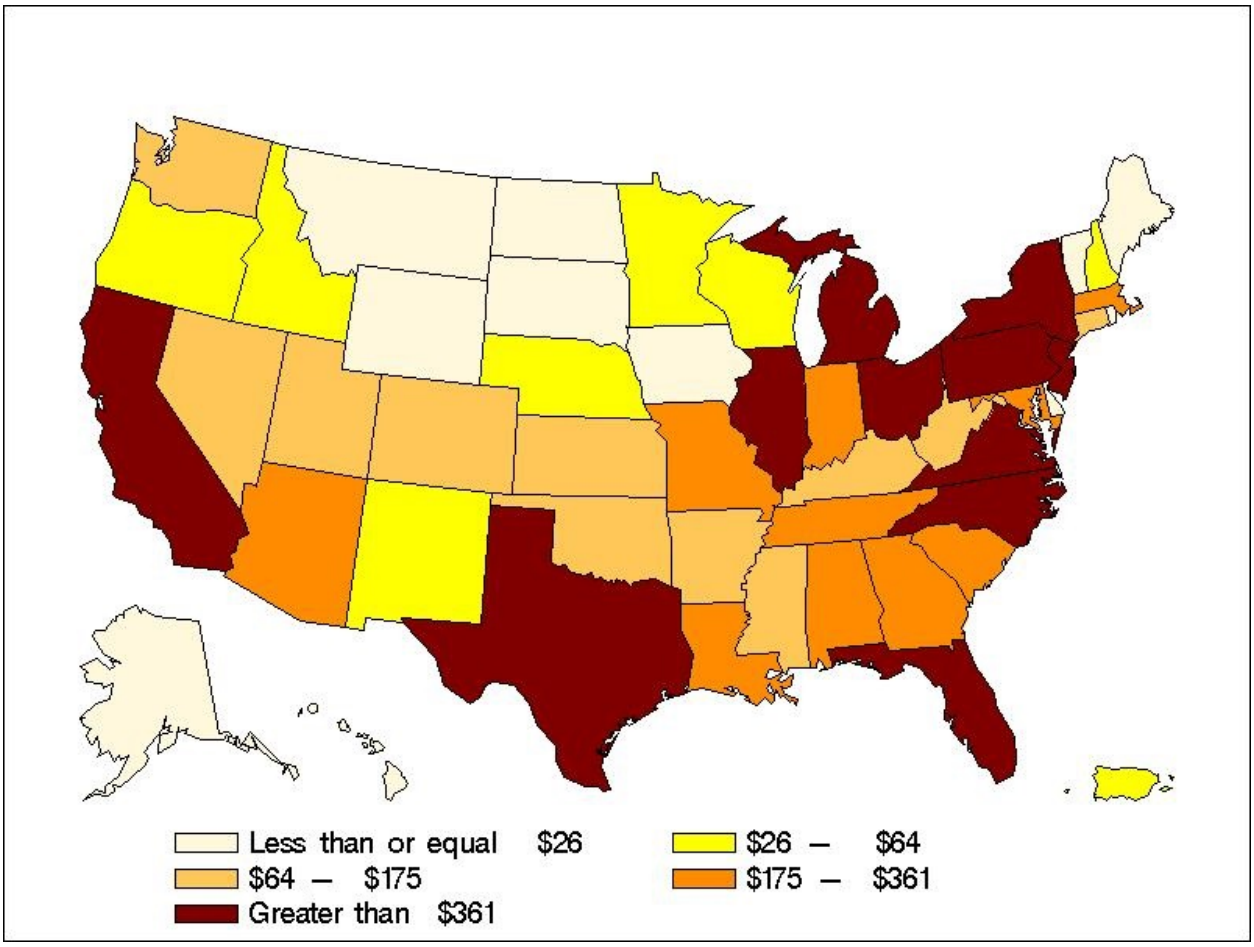


**Figure 10: DMEPOS Improper Payment Rates by State**

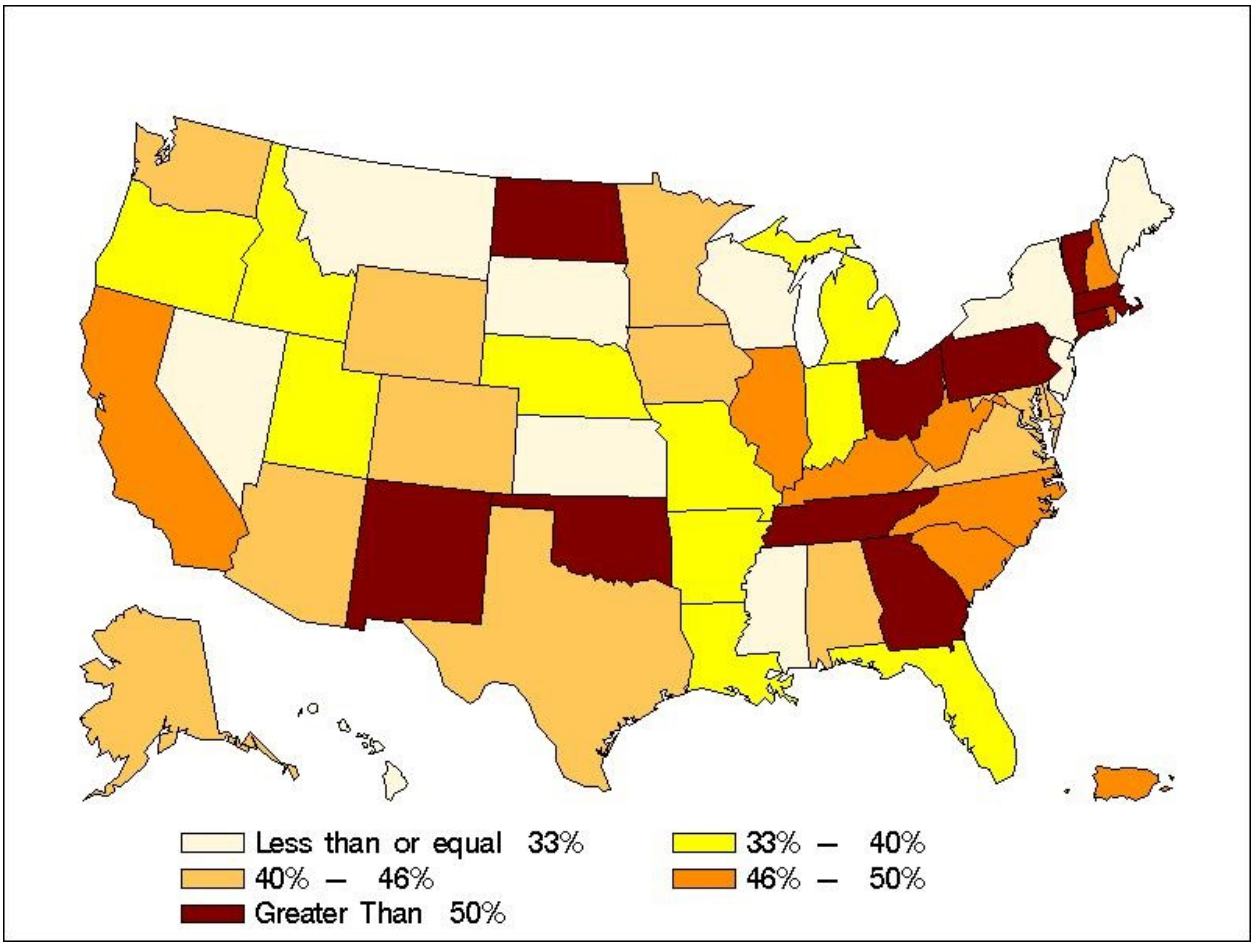


**Figure 11: DMEPOS Improper Payment Amounts by State (Dollars in Millions)**