U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

2025 Medicare Fee-for-Service Supplemental Improper Payment Data

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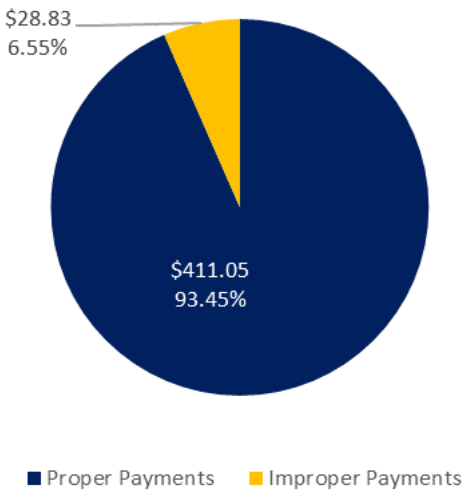
SUMMARY OF HIGH LEVEL FINDINGS

This document supplements improper payment information in the annual HHS AFR. PIIA requires improper payment reporting in the HHS AFR. The improper payment rate calculation complies with the requirements of OMB Circular A-123, Appendix C. CMS measures the Medicare FFS improper payment rate through the CERT program.

93.45 Percent Accuracy Rate and 6.55 Percent Improper Payment Rate[1,2,3]

Figure 1: Payment Accuracy (in Billions)



[1] HHS published the 2025 Medicare FFS improper payment rate in the Federal FY 2025 HHS AFR. 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. The FY 2025 Medicare FFS improper payment rate included claims submitted during the 12-month period from July 1, 2023 through June 30, 2024.

[2] CMS adjusted the improper payment rate by 0.20 percentage points ($878.94 million) from 6.75 percent to 6.55 percent to account for the effect of rebilling inpatient hospital claims denied under Medicare Part A (Part A to B rebilling). 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 through 2025.

[3] For purposes of this report, correct payments are considered total Medicare FFS payments minus payments considered an improper payment as identified through CERT. Please note that instances of fraud or other problems not discerned during the CERT review could still be present.

Common Causes of Improper Payments

Figure 2: Improper Payment Rate Error Categories by Percentage of 2025 National Improper Payments[4]

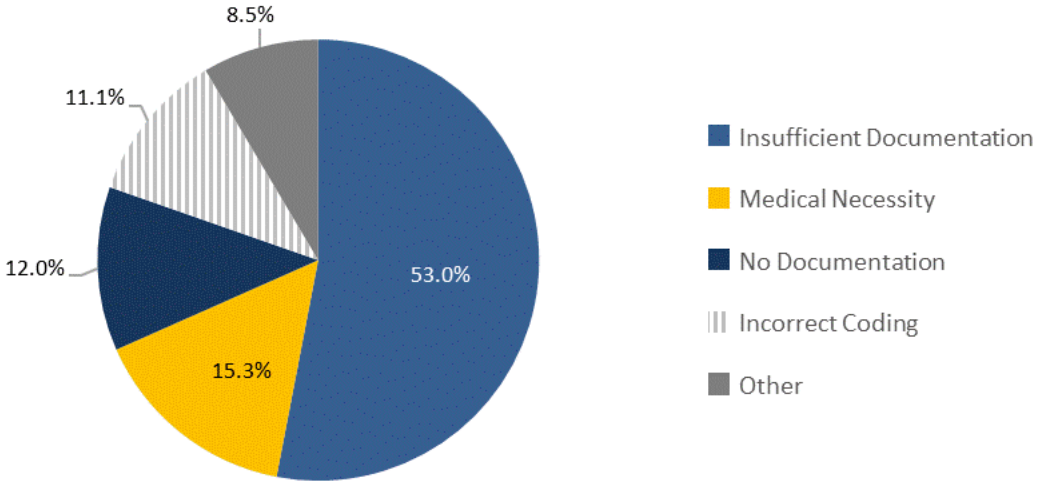
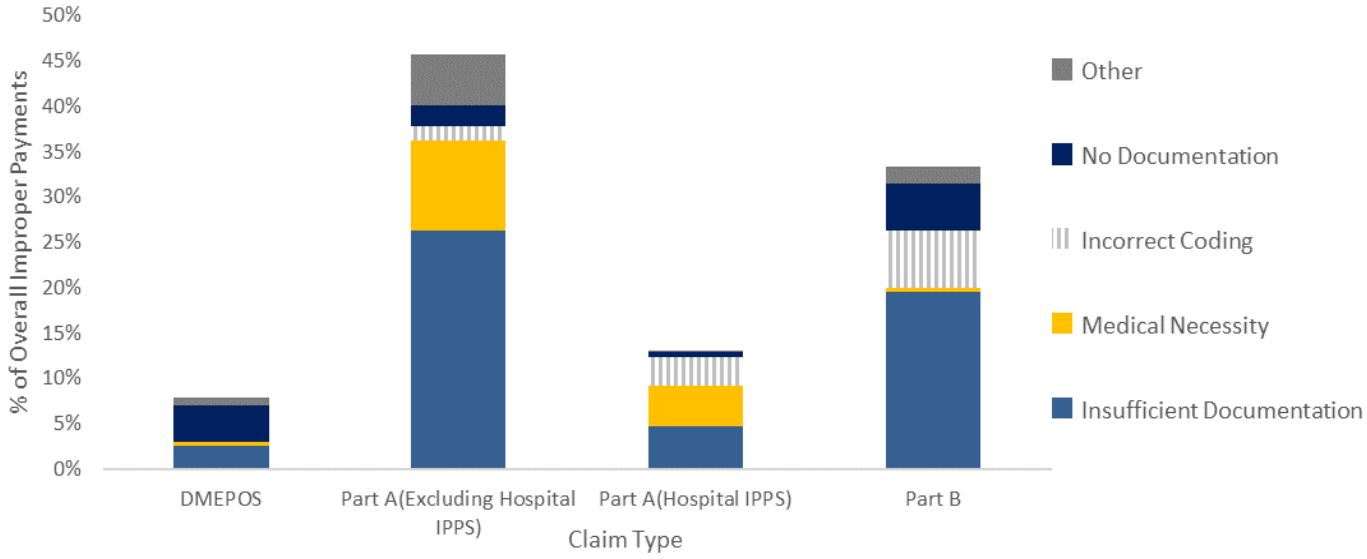


Figure 3: Improper Payment Rate Error Categories by Percentage of 2025 National Improper Payments by Claim Type (Adjusted for Impact of A/B Rebilling)[5]

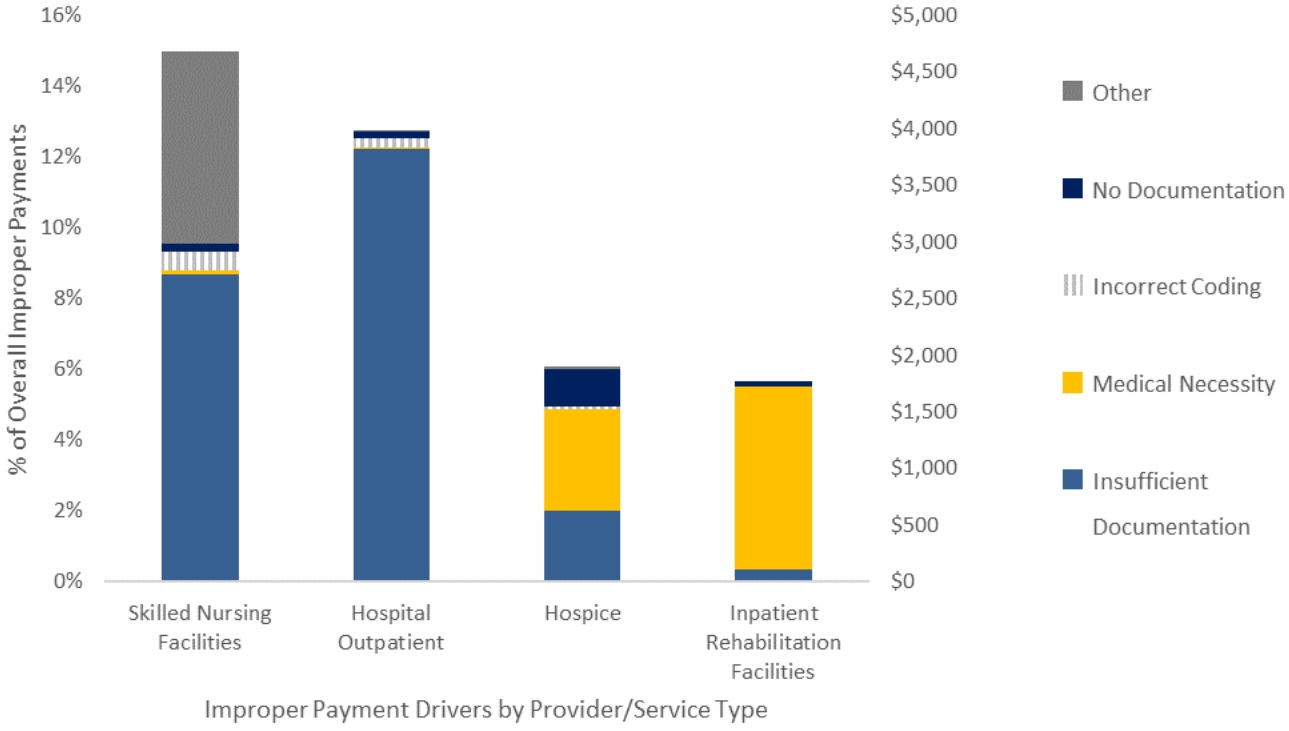


[4] The percentages in this pie chart may not add up to 100 percent due to rounding.

[5] 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 ANSI ASC X12 Health Care Claim: Institutional (837) or paper claim format 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.

Improper payment drivers are service types or provider types that make up the largest proportions of the overall CERT improper payments. For the 2025 reporting period, the Medicare FFS improper payment drivers are: Skilled Nursing Facilities, Hospital Outpatient, Inpatient Rehabilitation Facilities, and Hospice. The following figure and tables will provide additional information about the improper payment drivers. Root causes associated with fewer than 5 sampled claims are excluded in Tables 1 through 13. Prior to the 2024 reporting period, root causes in Tables 1 through 13 were associated with the primary error listed on the claim or line. Starting with the 2024 reporting period, root causes not associated with the primary error on the claim or line may also be included in these tables.

Figure 4: Improper Payment Rate Error Categories by Percentage of 2025 National Improper Payments and Improper Payments (in Millions) by Improper Payment Drivers



Skilled Nursing Facility

Skilled nursing facilities (SNF) is defined as all services with a provider type of SNF, including SNF inpatient, SNF outpatient, and SNF inpatient Part B. The projected improper payment amount for SNF services during the 2025 report period was $4.3 billion, resulting in an improper payment rate of 11.8 percent.

Table 1: Top Root Causes for Skilled Nursing Facility

Root Cause Description	Error Category	Sample Claim Count[6]
HIPPS level changed based on documentation submitted*	Insufficient Documentation	327
Case Mix Group (CMG) component documentation - Inadequate	Insufficient Documentation	176
Order - Missing	Insufficient Documentation	160
Documentation to support primary diagnosis and/or active diagnosis as reported on MDS - Missing	Insufficient Documentation	145
Case Mix Group (CMG) component documentation - Missing	Insufficient Documentation	125
Documentation to support the PT/OT and/or Nursing Functional Scores - Missing	Insufficient Documentation	98
Documentation to support the PT/OT and/or Nursing Functional Scores - Inadequate	Insufficient Documentation	94
Physician/NPP's Certification/Recertification, as applicable - Inadequate	Insufficient Documentation	66
Other	Other	63
HIPPS code in the repository does not match the HIPPS code billed	Other	38

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

[6] The root cause and error category with the highest sample claim count in Tables 1 through 4 may not correspond with the top error category of improper payments for the drivers in Figure 4.

Hospital Outpatient

Hospital Outpatient services is defined as all services billed with type of bill 12x through 19x (e.g., Hospital OPPS, Laboratory, and Others). The projected improper payment amount for Hospital Outpatient services during the 2025 report period was $3.7 billion, resulting in an improper payment rate of 4.4 percent.

Table 2: Top Root Causes for Hospital Outpatient

Root Cause Description	Error Category	Sample Claim Count
Documentation to support medical necessity - Missing	Insufficient Documentation	30
Documentation for the billed date of service - Missing	Insufficient Documentation	23
Order - Missing	Insufficient Documentation	20
Physical/Occupational/Speech Therapy - Certification/Recertification - Missing	Insufficient Documentation	18
Provider's intent to order (for certain services) - Missing	Insufficient Documentation	18
Service code billed is changed to the service provided and/or ordered*	Incorrect Coding	13
NCD requirement(s), other documentation required for payment - Missing	Insufficient Documentation	13
Documentation for the associated diagnostic lab test(s) - Inadequate	Insufficient Documentation	12
LCD/LCA requirements, other documentation required for payment - Missing	Insufficient Documentation	12
LCD/LCA requirements, other documentation required for payment - Inadequate	Insufficient Documentation	11

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Hospice

Hospice services is defined as all services with a provider type of Hospice, including Hospital Based Hospice and Non-Hospital Based Hospice. The projected improper payment amount for Hospice during the 2025 report period was $1.7 billion, resulting in an improper payment rate of 6.1 percent.

Table 3: Top Root Causes for Hospice

Root Cause Description	Error Category	Sample Claim Count
Documentation does not support medical necessity for the service or item billed	Medical Necessity	23
Physician/NPP's Certification/Recertification, as applicable - Inadequate	Insufficient Documentation	18
Service intensity add-on (SIA) services documentation – Missing*	Insufficient Documentation	14
Units of service (UOS) incorrectly coded Documentation supports lower UOS than billed*	Incorrect Coding	7
Units of service (UOS) incorrectly coded related to required physician certification/recertification	Insufficient Documentation	7
No response	No Documentation	7
Face to face documentation - Missing	Insufficient Documentation	6
Physician narrative as part of the certification/recertification supporting terminal illness - Missing	Insufficient Documentation	6
Physician/NPP's Certification/Recertification, as applicable - Missing	Insufficient Documentation	6
Units of service (UOS) incorrectly coded Documentation supports higher UOS than billed*	Incorrect Coding	6

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Inpatient Rehabilitation Facilities

Inpatient Rehabilitation Facilities (IRF) is defined as all services with a provider type of Inpatient Rehabilitation Hospitals or Inpatient Rehab Unit. The projected improper payment amount for IRF services during the 2025 report period was $1.6 billion, resulting in an improper payment rate of 21.5 percent.

Table 4: Top Root Causes for Inpatient Rehabilitation Facilities

Root Cause Description	Error Category	Sample Claim Count
Documentation does not support medical necessity for the service or item billed	Medical Necessity	109
Interdisciplinary team (IDT) meeting notes/records - Missing	Insufficient Documentation	10
Preadmission screening - Missing	Insufficient Documentation	7

Part B

The following tables show the top root causes of improper payments for the three service types in Part B with the highest projected improper payments.

Table 5: Top Root Causes for Lab tests - other (non-Medicare fee schedule)

Root Cause Description	Error Category	Sample Claim Count
Documentation to support medical necessity - Missing	Insufficient Documentation	116
Result of the diagnostic or laboratory test - Missing	Insufficient Documentation	70
Provider's intent to order (for certain services) - Missing	Insufficient Documentation	50
No response	No Documentation	43
Order - Missing	Insufficient Documentation	40
Risk assessment for urine drug screen - Missing	Insufficient Documentation	29
LCD/LCA requirements, other documentation required for payment - Inadequate	Insufficient Documentation	29
LCD/LCA requirements, other documentation required for payment - Missing	Insufficient Documentation	29
NCD requirement(s), other documentation required for payment - Missing	Insufficient Documentation	22
Level of risk for urine drug screen - Missing	Insufficient Documentation	20

Table 6: Top Root Causes for Minor procedures - other (Medicare fee schedule)

Root Cause Description	Error Category	Sample Claim Count
Physical/Occupational/Speech Therapy - Certification/Recertification - Missing	Insufficient Documentation	62
Physical/Occupational/Speech Therapy - Reason for the delayed physician certification/recertification - Missing	Insufficient Documentation	28
Physical/Occupational/Speech Therapy - Plan of care - Missing	Insufficient Documentation	20
Documentation to support the services were provided or other documentation required for payment of the code - Missing	Insufficient Documentation	13
No response	No Documentation	13
Physical/Occupational/Speech Therapy - Required progress report, performed at least once every 10 treatment days - Missing	Insufficient Documentation	12
Units of service (UOS) incorrectly coded Documentation supports higher UOS than billed*	Incorrect Coding	12
Physical/Occupational/Speech Therapy - Plan of care - Inadequate	Insufficient Documentation	11
Physical/Occupational/Speech Therapy - Therapy minutes - Missing	Insufficient Documentation	10
Documentation to support medical necessity - Missing	Insufficient Documentation	9

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Table 7: Top Root Causes for Office visits - established

Root Cause Description	Error Category	Sample Claim Count
Documentation supports lower level of E/M service than what was billed*	Incorrect Coding	120
No response	No Documentation	12
Documentation for the billed date of service - Missing	Insufficient Documentation	10
Separately identifiable E/M service documentation - Inadequate	Insufficient Documentation	7
Documentation supports higher level of E/M service than what was billed*	Incorrect Coding	7
Incident to - Documentation to support physician supervision - Missing	Insufficient Documentation	6
Documentation to support the services were provided or other documentation required for payment of the code - Inadequate	Insufficient Documentation	5
Documentation to support the services were provided or other documentation required for payment of the code - Missing	Insufficient Documentation	5

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

DMEPOS

The following tables show the top root causes of improper payments for the three service types in DME with the highest projected improper payments.

Table 8: Top Root Causes for Urological Supplies

Root Cause Description	Error Category	Sample Claim Count
No response+	No Documentation	73
Documentation to support coverage criteria - Inadequate	Insufficient Documentation	17
Refill request - Missing	Insufficient Documentation	11
Documentation to support coverage criteria - Missing	Insufficient Documentation	8
Order - Missing	Insufficient Documentation	8
Proof of delivery - Inadequate	Insufficient Documentation	7
No documentation due to extenuating circumstances+	No Documentation	7
Proof of delivery - Missing	Insufficient Documentation	6
Base item on the claim is denied therefore the related addition to the base, accessory, or supply fee is denied	Medical Necessity	5

Note: Many of these errors were associated with claims under a payment suspension for Operation Gold Rush and are therefore zero dollar errors that do not contribute to the improper payment rate. These errors are identified with a plus sign.

Table 9: Top Root Causes for Surgical Dressings

Root Cause Description	Error Category	Sample Claim Count
Wound management documentation - Inadequate	Insufficient Documentation	95
No response	No Documentation	29
Wound management documentation - Missing	Insufficient Documentation	23
Proof of delivery - Missing	Insufficient Documentation	19
Order - Missing	Insufficient Documentation	18
Submitted order not written by provider listed on the claim as ordering/referring provider	Other	15
Units of service (UOS) ordered does not support the units of service (UOS) provided and billed*	Insufficient Documentation	15
Proof of delivery - Inadequate	Insufficient Documentation	14
The date of service billed was not supported by the submitted documentation	Other	12
Order - Inadequate	Insufficient Documentation	10

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Table 10: Top Root Causes for Glucose Monitor

Root Cause Description	Error Category	Sample Claim Count
Documentation to support medical necessity of diabetic testing supplies - Missing	Insufficient Documentation	49
The date of service billed was not supported by the submitted documentation	Other	17
Proof of delivery - Inadequate	Insufficient Documentation	15
Proof of delivery - Missing	Insufficient Documentation	11
No response	No Documentation	10
Modifier changed due to missing documentation*	Insufficient Documentation	10
Documentation to support medical necessity of diabetic testing supplies - Inadequate	Insufficient Documentation	9
Order - Missing	Insufficient Documentation	9
Documentation to support medical necessity of high utilization of diabetic testing supplies - Missing	Insufficient Documentation	6
Incorrect modifier billed*	Incorrect Coding	6

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Part A (Excluding Hospital IPPS)

The provider types in Part A (Excluding Hospital IPPS) with the highest projected improper payments are also the top overall improper payment drivers. Please refer to Tables 1-4 for the top root causes of improper payments for Part A (Excluding Hospital IPPS) provider types.

Part A (Hospital IPPS)

The following tables show the top root causes of improper payments for the three service types in Part A (Hospital IPPS) with the highest projected improper payments.

Table 11: Top Root Causes for Percutaneous Intracardiac Procedures (273, 274)

Root Cause Description	Error Category	Sample Claim Count
NCD requirement(s), other documentation required for payment - Inadequate	Insufficient Documentation	103
Discharge status incorrectly coded*	Incorrect Coding	14
NCD requirement(s), other documentation required for payment - Missing	Insufficient Documentation	11

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Table 12: Top Root Causes for Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)

Root Cause Description	Error Category	Sample Claim Count
Inpatient admission not medically necessary and the invasive procedure should have been billed as an outpatient procedure[7]	Medical Necessity	119
Discharge status incorrectly coded*	Incorrect Coding	36
Radiographs to support medical necessity for the billed surgical procedure(s) - Missing	Insufficient Documentation	30
Documentation does not support medical necessity for the service or item billed	Medical Necessity	25
Preoperative surgeon's office notes - Missing	Insufficient Documentation	19
Documentation to support conservative treatment for the billed surgical procedure(s) - Missing	Insufficient Documentation	18
Preoperative surgeon's office notes - Inadequate	Insufficient Documentation	6

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

Table 13: Top Root Causes for Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)

Root Cause Description	Error Category	Sample Claim Count
Preoperative surgeon's office notes - Missing	Insufficient Documentation	30
Discharge status incorrectly coded*	Incorrect Coding	22
Documentation to support medical necessity for the procedure - Missing	Insufficient Documentation	11
Incorrect secondary diagnosis code - DRG change*	Incorrect Coding	6

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

[7] Root cause associated with Part A to B rebilling. See footnote 2 for more information.

SUPPLEMENTAL STATISTICAL REPORTING

Appendix A: Summary of Projected Improper Payments Adjusted for A/B Rebill[8]

Table A1: 2025 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions) (Adjusted for Impact of A/B Rebilling)

Claim Type	Claims Sampled	Claims Reviewed	Total Payments	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Part A (Total)	28,242	17,401	$316.4	$16.9	5.4%	4.6% - 6.1%	58.7%
Part A (Excluding Hospital IPPS)	10,201	8,651	$197.9	$13.2	6.7%	5.5% - 7.8%	45.8%
Part A (Hospital IPPS)	18,041	8,750	$118.5	$3.7	3.1%	2.8% - 3.5%	12.9%
Part B	11,920	11,600	$114.1	$9.6	8.4%	7.6% - 9.3%	33.4%
DMEPOS	8,899	8,650	$9.4	$2.3	24.1%	16.7% - 31.6%	7.9%
Total	**49,061**	**37,651**	**$439.9**	**$28.8**	**6.6%**	**5.9% - 7.2%**	**100.0%**

Table A2: Comparison of 2024 and 2025 Overall Improper Payment Rates by Error Category (Adjusted for Impact of A/B Rebilling)

Error Category	2024	2025				
	Overall	Overall	Part A Excluding Hospital IPPS	Part A Hospital IPPS	Part B	DMEPOS
No Documentation	0.6%	0.8%	0.1%	0.0%	0.3%	0.3%
Insufficient Documentation	4.6%	3.5%	1.7%	0.3%	1.3%	0.2%
Medical Necessity	1.2%	1.0%	0.6%	0.3%	0.0%	0.0%
Incorrect Coding	0.8%	0.7%	0.1%	0.2%	0.4%	0.0%
Other	0.5%	0.6%	0.4%	0.0%	0.1%	0.1%
Total	**7.7%**	**6.6%**	**3.0%**	**0.8%**	**2.2%**	**0.5%**

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

Table A3: Improper Payment Rate Categories by Percentage of 2025 Overall Improper Payments (Adjusted for Impact of A/B Rebilling)

Error Category	Percent of Overall Improper Payments
No Documentation	12.0%
Insufficient Documentation	53.0%
Medical Necessity	15.3%
Incorrect Coding	11.1%
Other	8.5%
Total	**100.0%**

Table A4: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions) (Adjusted for Impact of A/B Rebilling)

Claim Type	Overall Improper Payments			Overpayments		Underpayments	
	Total Amount Paid	Projected Improper Payments	Improper Payment Rate	Projected Improper Payments	Improper Payment Rate	Projected Improper Payments	Improper Payment Rate
Part A (Total)	$316.4	$16.9	5.4%	$16.3	5.1%	$0.6	0.2%
Part A (Excluding Hospital IPPS)	$197.9	$13.2	6.7%	$13.0	6.6%	$0.2	0.1%
Part A (Hospital IPPS)	$118.5	$3.7	3.1%	$3.3	2.8%	$0.5	0.4%
Part B	$114.1	$9.6	8.4%	$9.3	8.2%	$0.3	0.3%
DMEPOS	$9.4	$2.3	24.1%	$2.3	24.1%	$0.0	0.1%
Total	**$439.9**	**$28.8**	**6.6%**	**$27.9**	**6.3%**	**$1.0**	**0.2%**

Table A5: 2025 Projected Improper Payments by Type of Error and Clinical Setting (Dollars in Billions) (Adjusted for Impact of A/B Rebilling)

Error Category	DMEPOS	Home Health Agencies	Hospital Outpatient Departments	Acute Inpatient Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	$1.1	$0.1	$0.4	$0.2	$0.9	$0.1	$0.6	$3.5
Insufficient Documentation	$0.7	$0.5	$4.4	$1.4	$3.9	$2.5	$1.8	$15.3
Medical Necessity	$0.1	$0.3	$0.9	$2.9	$0.0	$0.0	$0.2	$4.4
Incorrect Coding	$0.0	$0.0	$0.3	$0.9	$1.5	$0.1	$0.4	$3.2
Other	$0.3	$0.1	$0.0	$0.0	$0.3	$1.6	$0.2	$2.5
Total	**$2.3**	**$1.1**	**$5.9**	**$5.4**	**$6.6**	**$4.3**	**$3.3**	**$28.8**

Table A6: Summary of National Improper Payment Rates by Year and by Error Category (Adjusted for Impact of A/B Rebilling)[9]

Fiscal Year and Rate Type (Net/Gross)		No Doc Errors	Insufficient Document Errors	Medical Necessity Errors	Incorrect Coding Errors	Other Errors	Improper Payment Rate	Correct Payment Rate
1996[10]	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%	92.0%
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[11]	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[12]	Gross	0.2%	4.3%	3.0%	1.0%	0.1%	8.6%	91.4%
2012[13]	Gross	0.2%	5.0%	1.9%	1.3%	0.1%	8.5%	91.5%
2013	Gross	0.2%	6.1%	2.2%	1.5%	0.2%	10.1%	89.9%
2014	Gross	0.1%	8.2%	2.7%	1.6%	0.2%	12.7%	87.3%
2015	Gross	0.2%	8.1%	2.1%	1.3%	0.4%	12.09%	87.91%
2016	Gross	0.1%	7.2%	2.2%	1.1%	0.4%	11.00%	89.00%
2017	Gross	0.2%	6.1%	1.7%	1.2%	0.3%	9.51%	90.49%
2018	Gross	0.2%	4.7%	1.7%	1.0%	0.5%	8.12%	91.88%
2019	Gross	0.1%	4.3%	1.4%	1.0%	0.4%	7.25%	92.75%
2020	Gross	0.3%	4.0%	1.0%	0.7%	0.3%	6.27%	93.73%
2021	Gross	0.3%	4.0%	0.8%	0.7%	0.4%	6.26%	93.74%
2022	Gross	0.3%	4.7%	1.0%	0.8%	0.6%	7.46%	92.54%
2023	Gross	0.3%	4.6%	1.1%	0.9%	0.5%	7.38%	92.62%
2024	Gross	0.6%	4.6%	1.2%	0.8%	0.5%	7.66%	92.34%
2025	Gross	0.8%	3.5%	1.0%	0.7%	0.6%	6.55%	93.45%

[9] For purposes of this report, correct payments are considered total Medicare FFS payments minus payments considered an improper payment as identified through CERT. Please note that instances of fraud or other problems not discerned during the CERT review could still be present.
[10] FY 1996-2003 improper payments were calculated as Overpayments – Underpayments.
[11] FY 2004-2025 improper payments were calculated as Overpayments + Underpayments.
[12] The FY 2011 improper payment rate reported in this table is adjusted for the prospective impact of late appeals and documentation.
[13] The FY 2012-2025 improper payment rates reported in this table are adjusted for the impact of denied Part A inpatient claims under Part B.

Table A7: 2025 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions) (Adjusted for Impact of A/B Rebilling)

Claim Type	Claims Reviewed	Total Payments	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
DMEPOS	8,650	$9.4	$2.3	24.1%	16.7% - 31.6%	7.9%
Home Health & Hospice	2,119	$44.5	$2.8	6.3%	5.0% - 7.6%	9.8%
Parts A & B (Excluding Home Health & Hospice)	26,882	$386.0	$23.7	6.1%	5.5% - 6.8%	82.3%
Total	**37,651**	**$439.9**	**$28.8**	**6.6%**	**5.9% - 7.2%**	**100.0%**

Appendix B: Summary of Projected Improper Payments Unadjusted for A/B Rebill

Table B1: 2025 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions) (Unadjusted for Impact of A/B Rebilling)

Claim Type	Claims Sampled	Claims Reviewed	Total Payments	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Part A (Total)	28,242	17,401	$316.4	$17.8	5.6%	4.9% - 6.4%	60.0%
Part A (Excluding Hospital IPPS)	10,201	8,651	$197.9	$13.2	6.7%	5.5% - 7.8%	44.4%
Part A (Hospital IPPS)	18,041	8,750	$118.5	$4.6	3.9%	3.5% - 4.3%	15.5%
Part B	11,920	11,600	$114.1	$9.6	8.4%	7.6% - 9.3%	32.4%
DMEPOS	8,899	8,650	$9.4	$2.3	24.1%	16.7% - 31.6%	7.6%
Total	**49,061**	**37,651**	**$439.9**	**$29.7**	**6.8%**	**6.1% - 7.4%**	**100.0%**

Table B2: Comparison of 2024 and 2025 Overall Improper Payment Rates by Error Category (Unadjusted for Impact of A/B Rebilling)

Error Category	2024	2025				
	Overall	Overall	Part A Excluding Hospital IPPS	Part A Hospital IPPS	Part B	DMEPOS
No Documentation	0.6%	0.8%	0.1%	0.0%	0.3%	0.3%
Insufficient Documentation	4.6%	3.5%	1.7%	0.3%	1.3%	0.2%
Medical Necessity	1.5%	1.2%	0.6%	0.5%	0.0%	0.0%
Incorrect Coding	0.8%	0.7%	0.1%	0.2%	0.4%	0.0%
Other	0.5%	0.6%	0.4%	0.0%	0.1%	0.1%
Total	**7.9%**	**6.8%**	**3.0%**	**1.0%**	**2.2%**	**0.5%**

Table B3: Improper Payment Rate Categories by Percentage of 2025 Overall Improper Payments (Unadjusted for Impact of A/B Rebilling)

Error Category	Percent of Overall Improper Payments
No Documentation	11.7%
Insufficient Documentation	51.5%
Medical Necessity	17.8%
Incorrect Coding	10.8%
Other	8.3%
Total	**100.0%**

Table B4: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions) (Unadjusted for Impact of A/B Rebilling)

Claim Type	Overall Improper Payments			Overpayments		Underpayments	
	Total Amount Paid	Projected Improper Payments	Improper Payment Rate	Projected Improper Payments	Improper Payment Rate	Projected Improper Payments	Improper Payment Rate
Part A (Total)	$316.4	$17.8	5.6%	$17.2	5.4%	$0.6	0.2%
Part A (Excluding Hospital IPPS)	$197.9	$13.2	6.7%	$13.0	6.6%	$0.2	0.1%
Part A (Hospital IPPS)	$118.5	$4.6	3.9%	$4.1	3.5%	$0.5	0.4%
Part B	$114.1	$9.6	8.4%	$9.3	8.2%	$0.3	0.3%
DMEPOS	$9.4	$2.3	24.1%	$2.3	24.1%	$0.0	0.1%
Total	**$439.9**	**$29.7**	**6.8%**	**$28.7**	**6.5%**	**$1.0**	**0.2%**

Table B5: 2025 Projected Improper Payments by Type of Error and Clinical Setting (Dollars in Billions) (Unadjusted for Impact of A/B Rebilling)

Error Category	DMEPOS	Home Health Agencies	Hospital Outpatient Departments	Acute Inpatient Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	$1.2	$0.1	$0.4	$0.2	$0.9	$0.1	$0.6	$3.5
Insufficient Documentation	$0.7	$0.5	$4.4	$1.4	$3.9	$2.5	$1.8	$15.3
Medical Necessity	$0.1	$0.3	$0.9	$3.7	$0.0	$0.0	$0.2	$5.3
Incorrect Coding	$0.0	$0.0	$0.3	$0.9	$1.5	$0.2	$0.4	$3.2
Other	$0.3	$0.1	$0.0	$0.0	$0.3	$1.6	$0.2	$2.5
Total	**$2.3**	**$1.1**	**$5.9**	**$6.3**	**$6.6**	**$4.3**	**$3.3**	**$29.7**

Table B6: Summary of National Improper Payment Rates by Year and by Error Category (Unadjusted for Impact of A/B Rebilling)[14]

Fiscal Year and Rate Type (Net/Gross)		No Doc Errors	Insufficient Document Errors	Medical Necessity Errors	Incorrect Coding Errors	Other Errors	Improper Payment Rate	Correct Payment Rate
1996[15]	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%	92.0%
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[16]	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	Gross	0.2%	5.0%	3.4%	1.2%	0.1%	9.9%	90.1%
2012	Gross	0.2%	5.0%	2.6%	1.3%	0.1%	9.3%	90.7%
2013	Gross	0.2%	6.1%	2.8%	1.5%	0.2%	10.7%	89.3%
2014	Gross	0.1%	8.2%	3.6%	1.6%	0.2%	13.6%	86.4%
2015	Gross	0.2%	8.2%	2.5%	1.3%	0.4%	12.47%	87.53%
2016	Gross	0.1%	7.2%	2.4%	1.1%	0.4%	11.19%	88.81%
2017	Gross	0.2%	6.1%	1.8%	1.2%	0.3%	9.64%	90.36%
2018	Gross	0.2%	4.7%	1.9%	1.0%	0.5%	8.27%	91.73%
2019	Gross	0.1%	4.3%	1.6%	1.0%	0.4%	7.45%	92.55%
2020	Gross	0.3%	4.0%	1.3%	0.7%	0.3%	6.56%	93.44%
2021	Gross	0.3%	4.0%	1.0%	0.7%	0.4%	6.44%	93.56%
2022	Gross	0.3%	4.7%	1.2%	0.8%	0.6%	7.63%	92.37%
2023	Gross	0.3%	4.6%	1.3%	0.9%	0.5%	7.61%	92.39%
2024	Gross	0.6%	4.6%	1.2%	0.8%	0.5%	7.66%	92.34%
2025	Gross	0.8%	3.5%	1.2%	0.7%	0.6%	6.75%	93.25%

[14] For purposes of this report, correct payments are considered total Medicare FFS payments minus payments considered an improper payment as identified through CERT. Please note that instances of fraud or other problems not discerned during the CERT review could still be present.
[15] FY 1996-2003 improper payments were calculated as Overpayments – Underpayments.
[16] FY 2004-2025 improper payments were calculated as Overpayments + absolute value of Underpayments.

Table B7: Projected Improper Payments by Length of Stay (Dollars in Billions) (Unadjusted for Impact of A/B Rebilling)

Part A (Hospital IPPS) Length of Stay	Claims Reviewed	Improper Payment Rate	Projected Improper Payments	Percent of Overall Improper Payments
Medicare FFS	**37,651**	**6.8%**	**$29.7**	**100.0%**
Overall Part A (Hospital IPPS)	**8,750**	**3.9%**	**$4.6**	**15.5%**
0 or 1 day	1,408	17.8%	$1.7	5.9%
2 days	1,436	7.3%	$1.0	3.3%
3 days	1,292	3.2%	$0.5	1.5%
4 days	1,066	3.3%	$0.4	1.4%
5 days	739	2.5%	$0.3	0.8%
More than 5 days	2,809	1.3%	$0.8	2.6%

All estimates in Tables B8-B11 are based on a minimum of 30 lines in the sample.

Table B8: Medicare FFS Projected Improper Payments by State (Dollars in Millions) (Unadjusted for Impact of A/B Rebilling)

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
CA	4,542	$4,135.0	7.8%	6.4% - 9.1%	13.9%
TX	2,824	$2,545.1	9.2%	7.4% - 10.8%	8.6%
FL	2,774	$2,172.1	6.6%	5.1% - 8.2%	7.3%
NY	2,089	$1,716.9	5.7%	4.4% - 7.0%	5.8%
MD	886	$1,439.3	12.0%	1.8% - 22.3%	4.9%
OH	1,264	$1,335.8	8.6%	2.2% - 14.9%	4.5%
NJ	1,081	$1,132.5	7.6%	4.4% - 10.8%	3.8%
VA	1,003	$1,076.2	9.5%	2.4% - 16.6%	3.6%
PA	1,685	$1,035.8	6.0%	4.6% - 7.3%	3.5%
IL	1,615	$1,032.3	5.5%	3.8% - 7.2%	3.5%
NC	1,051	$921.1	8.5%	1.3% - 15.7%	3.1%
SC	656	$914.7	13.7%	0.7% - 26.7%	3.1%
GA	955	$710.9	7.1%	4.8% - 9.3%	2.4%
MA	1,090	$630.5	4.4%	3.0% - 5.8%	2.1%
MO	749	$603.2	7.8%	4.2% - 11.4%	2.0%
AZ	846	$593.9	6.6%	4.6% - 8.6%	2.0%
MI	942	$561.1	4.9%	3.1% - 6.7%	1.9%
KY	544	$541.2	11.3%	5.8% - 16.8%	1.8%
LA	529	$491.4	8.5%	4.9% - 12.1%	1.7%
AL	518	$436.7	7.6%	4.4% - 10.8%	1.5%
TN	985	$420.8	3.6%	2.2% - 5.1%	1.4%
IN	767	$411.7	5.9%	3.4% - 8.3%	1.4%
IA	420	$398.9	7.5%	3.1% - 11.8%	1.3%
NV	304	$373.1	9.6%	4.4% - 14.7%	1.3%
OK	522	$369.5	7.2%	4.1% - 10.2%	1.2%
WA	669	$369.5	4.7%	2.3% - 7.1%	1.2%
CO	477	$315.6	4.1%	1.6% - 6.7%	1.1%
WI	596	$300.2	4.3%	2.1% - 6.6%	1.0%
AR	469	$265.3	5.0%	1.4% - 8.6%	0.9%
MN	558	$229.7	3.4%	0.8% - 6.1%	0.8%
WV	251	$209.7	8.5%	3.7% - 13.3%	0.7%
NM	200	$200.0	7.1%	1.3% - 12.8%	0.7%
KS	489	$199.4	3.9%	1.9% - 5.9%	0.7%

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
NH	192	$164.5	4.6%	1.0% - 8.3%	0.6%
SD	158	$155.7	6.3%	1.9% - 10.7%	0.5%
MS	467	$152.5	3.2%	1.0% - 5.4%	0.5%
NE	268	$148.4	5.5%	2.2% - 8.8%	0.5%
WY	76	$143.6	18.5%	(7.0%) - 44.1%	0.5%
CT	328	$138.2	3.4%	1.3% - 5.6%	0.5%
OR	337	$110.8	1.8%	0.6% - 3.1%	0.4%
MT	158	$103.3	5.5%	0.5% - 10.5%	0.4%
UT	298	$95.3	3.5%	1.6% - 5.3%	0.3%
ID	179	$56.0	2.8%	0.8% - 4.8%	0.2%
DE	168	$55.7	2.4%	0.1% - 4.7%	0.2%
HI	56	$52.8	6.9%	(3.6%) - 17.3%	0.2%
RI	88	$50.9	5.5%	1.0% - 10.0%	0.2%
PR	54	$44.1	10.9%	0.2% - 21.5%	0.2%
AK	86	$38.2	3.4%	0.5% - 6.3%	0.1%
ME	131	$35.8	2.1%	(1.0%) - 5.3%	0.1%
VT	86	$33.5	3.2%	(1.3%) - 7.8%	0.1%
ND	103	$20.3	1.6%	0.2% - 3.0%	0.1%
DC	48	$16.5	2.3%	(0.3%) - 5.0%	0.1%
All States	**37,651**	**$29,705.5**	**6.8%**	**6.1% - 7.4%**	**100.0%**

Table B9: Medicare FFS Projected Improper Payments by State – Parts A & B (Excluding Home Health and Hospice) (Dollars in Millions) (Unadjusted for Impact of A/B Rebilling)

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
CA	3,368	$3,112.9	6.9%	5.5% - 8.3%	10.5%
TX	1,996	$1,814.9	8.0%	6.3% - 9.7%	6.1%
FL	2,046	$1,804.1	6.5%	4.8% - 8.2%	6.1%
NY	1,541	$1,593.7	5.6%	4.2% - 6.9%	5.4%
MD	650	$1,289.7	11.8%	0.5% - 23.0%	4.3%
OH	900	$1,233.1	9.1%	1.9% - 16.4%	4.2%
NJ	798	$1,080.4	8.1%	4.5% - 11.5%	3.6%
PA	1,240	$972.9	6.3%	4.7% - 7.8%	3.3%
NC	740	$887.1	9.6%	1.3% - 18.0%	3.0%
SC	466	$879.2	14.8%	0.4% - 29.3%	3.0%
IL	1,083	$826.7	5.1%	3.4% - 6.8%	2.8%
GA	678	$649.6	7.6%	5.1% - 10.0%	2.2%
AZ	622	$544.6	7.3%	4.9% - 9.6%	1.8%
MA	829	$524.1	3.9%	2.6% - 5.3%	1.8%
VA	696	$494.7	5.1%	3.1% - 7.2%	1.7%
KY	342	$479.8	11.6%	5.5% - 17.7%	1.6%
MO	529	$456.8	6.5%	3.3% - 9.7%	1.5%
TN	730	$382.5	3.7%	2.1% - 5.2%	1.3%
MI	656	$379.8	3.8%	2.3% - 5.4%	1.3%
AL	359	$365.8	7.7%	4.2% - 11.1%	1.2%
NV	219	$354.1	10.1%	4.4% - 15.8%	1.2%
IN	504	$339.2	5.4%	2.9% - 7.9%	1.1%
LA	361	$335.4	7.4%	4.1% - 10.7%	1.1%
IA	316	$333.4	6.7%	2.5% - 11.0%	1.1%
WA	475	$318.5	4.4%	1.8% - 7.1%	1.1%
WI	410	$270.4	4.4%	1.9% - 6.9%	0.9%
AR	327	$259.2	5.5%	1.3% - 9.7%	0.9%
CO	329	$255.5	3.6%	1.1% - 6.0%	0.9%
OK	317	$230.8	5.7%	2.7% - 8.6%	0.8%
MN	387	$211.1	3.6%	0.6% - 6.5%	0.7%
WV	183	$193.0	9.1%	3.6% - 14.6%	0.7%
KS	347	$191.4	4.1%	1.9% - 6.3%	0.6%
NH	139	$162.0	5.0%	1.0% - 8.9%	0.6%
SD	127	$142.4	5.9%	1.5% - 10.2%	0.5%
MS	312	$135.5	3.3%	0.8% - 5.7%	0.5%

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
NM	130	$133.7	5.3%	0.4% - 10.2%	0.5%
WY	34	$131.3	18.4%	(9.2%) - 46.1%	0.4%
CT	239	$131.2	3.6%	1.2% - 5.9%	0.4%
NE	178	$106.9	4.3%	1.9% - 6.7%	0.4%
MT	100	$97.1	5.4%	0.2% - 10.5%	0.3%
UT	209	$84.6	3.7%	1.6% - 5.9%	0.3%
OR	235	$73.0	1.3%	0.3% - 2.4%	0.3%
HI	36	$51.9	9.6%	(4.9%) - 24.1%	0.2%
RI	67	$47.6	5.5%	0.7% - 10.3%	0.2%
ID	120	$43.6	2.4%	0.5% - 4.4%	0.2%
PR	37	$42.1	12.4%	(0.3%) - 25.0%	0.1%
AK	70	$37.6	3.4%	0.5% - 6.3%	0.1%
ME	89	$35.5	2.7%	(1.3%) - 6.7%	0.1%
VT	62	$32.7	3.2%	(1.4%) - 7.8%	0.1%
DE	120	$26.6	1.2%	0.1% - 2.3%	0.1%
ND	81	$19.6	1.7%	0.1% - 3.3%	0.1%
DC	36	$15.1	2.2%	(0.5%) - 4.8%	0.1%
All States	**26,882**	**$24,614.4**	**6.4%**	**5.7% - 7.0%**	**82.9%**

Table B10: Medicare FFS Projected Improper Payments by State – DMEPOS Only (Dollars in Millions) (Unadjusted for Impact of A/B Rebilling)

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
VA	261	$542.8	73.2%	37.0% - 109.3%	1.8%
FL	582	$236.6	31.6%	22.5% - 40.7%	0.8%
CA	808	$171.1	18.8%	13.5% - 24.0%	0.6%
TX	518	$155.4	30.5%	14.7% - 46.3%	0.5%
MD	210	$128.6	46.1%	38.6% - 53.7%	0.4%
IL	413	$121.8	29.0%	7.2% - 50.8%	0.4%
NY	490	$81.8	20.0%	11.2% - 28.8%	0.3%
KY	182	$61.4	31.3%	2.2% - 60.3%	0.2%
MI	237	$52.2	21.0%	3.0% - 38.9%	0.2%
NJ	246	$52.1	21.3%	0.1% - 42.5%	0.2%
OH	287	$48.0	20.6%	10.1% - 31.0%	0.2%
PA	388	$47.3	13.0%	7.7% - 18.2%	0.2%
MA	234	$36.8	14.4%	6.8% - 22.0%	0.1%
OK	141	$34.6	21.5%	8.8% - 34.3%	0.1%
NC	260	$33.9	16.3%	6.4% - 26.2%	0.1%
OR	84	$32.9	31.6%	3.5% - 59.7%	0.1%
WA	168	$31.1	16.5%	7.8% - 25.2%	0.1%
WI	161	$29.8	18.5%	(2.7%) - 39.7%	0.1%
DE	46	$29.2	31.2%	(7.9%) - 70.4%	0.1%
TN	215	$26.3	12.9%	6.5% - 19.4%	0.1%
SC	163	$23.7	15.3%	6.5% - 24.0%	0.1%
IN	234	$22.7	12.3%	5.6% - 18.9%	0.1%
MO	197	$21.3	10.0%	4.8% - 15.3%	0.1%
AL	110	$20.2	25.7%	12.3% - 39.1%	0.1%
GA	225	$19.4	7.3%	3.1% - 11.5%	0.1%
MN	142	$18.6	8.2%	(2.0%) - 18.5%	0.1%
AZ	177	$18.3	8.4%	3.1% - 13.6%	0.1%
WV	58	$16.8	28.2%	10.5% - 45.9%	0.1%
MS	127	$15.3	12.2%	4.0% - 20.4%	0.1%
NV	58	$14.3	17.2%	(5.1%) - 39.6%	0.1%
ID	55	$12.4	20.0%	(5.5%) - 45.5%	0.0%
WY	41	$12.3	29.1%	5.7% - 52.4%	0.0%
CO	131	$12.0	11.4%	0.8% - 21.9%	0.0%
UT	73	$10.7	12.1%	0.0% - 24.3%	0.0%
IA	89	$10.6	15.1%	3.3% - 26.8%	0.0%

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
NM	55	$8.9	28.0%	12.6% - 43.3%	0.0%
LA	107	$8.5	8.7%	3.4% - 14.0%	0.0%
KS	122	$7.9	7.1%	1.5% - 12.7%	0.0%
CT	77	$7.0	11.6%	(2.0%) - 25.3%	0.0%
NE	83	$6.6	7.2%	0.8% - 13.5%	0.0%
MT	56	$6.3	10.0%	(1.1%) - 21.1%	0.0%
AR	122	$4.9	4.6%	(2.0%) - 11.2%	0.0%
NH	44	$2.6	6.6%	(0.5%) - 13.6%	0.0%
ME	33	$0.4	1.9%	(1.9%) - 5.6%	0.0%
All States (Incl. States Not Listed)	**8,650**	**$2,271.9**	**24.1%**	**16.7% - 31.6%**	**7.7%**

Table B11: Medicare FFS Projected Improper Payments by State – Home Health and Hospice Only (Dollars in Millions) (Unadjusted for Impact of A/B Rebilling)

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
CA	366	$850.9	12.0%	7.5% - 16.5%	2.9%
TX	310	$574.8	12.3%	6.7% - 17.8%	1.9%
LA	61	$147.5	12.7%	0.8% - 24.6%	0.5%
FL	146	$131.4	3.2%	0.3% - 6.2%	0.4%
MI	49	$129.2	10.7%	1.2% - 20.3%	0.4%
OK	64	$104.2	11.6%	1.4% - 21.8%	0.4%
IL	119	$83.8	3.9%	0.2% - 7.6%	0.3%
OH	77	$54.7	2.9%	(1.4%) - 7.2%	0.2%
AL	49	$50.6	5.9%	(3.1%) - 14.8%	0.2%
GA	52	$41.9	3.6%	(2.6%) - 9.7%	0.1%
NY	58	$41.4	3.1%	(0.8%) - 7.0%	0.1%
VA	46	$38.7	4.0%	(1.9%) - 9.9%	0.1%
AZ	47	$31.0	2.4%	(0.4%) - 5.1%	0.1%
PA	57	$15.7	1.1%	(1.0%) - 3.1%	0.1%
TN	40	$11.9	1.3%	(1.2%) - 3.8%	0.0%
NC	51	$0.0	0.0%	0.0% - 0.0%	0.0%
NJ	37	$0.0	0.0%	0.0% - 0.0%	0.0%
All States (Incl. States Not Listed)	**2,119**	**$2,819.2**	**6.3%**	**5.0% - 7.6%**	**9.5%**

Appendix C: Medicare Access and CHIP Reauthorization Act of 2015 Section 517 Reporting

Table C1: Services Paid under the Physician Fee Schedule (PFS) in which the Fee Schedule Amount is in Excess of $250 and the Improper Payment Rate is in Excess of 20 Percent

Service Label	PFS Amount	Improper Payment Rate	95% Confidence Interval
ESRD srv 4 visits p mo 20+ (90960)	$342.9	22.8%	12.6% - 33.0%
Radiation tx delivery imrt (G6015)	$337.4	21.4%	9.8% - 33.0%

Appendix D: Projected Improper Payments and Type of Error by Type of Service for Each Claim Type

This series of tables is sorted in descending order by projected improper payments. All estimates in these tables are based on a minimum of 30 lines in the sample. For a full listing of all services with 30 or more claims, see Appendix G.

Table D1: Top 20 Service Types with Highest Improper Payments: Part B

Part B Services (BETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Lab tests - other (non-Medicare fee schedule)	$1,360,881,387	27.9%	20.1% - 35.7%	18.1%	79.9%	0.9%	0.4%	0.8%	4.6%
Minor procedures - other (Medicare fee schedule)	$991,373,197	17.6%	12.9% - 22.2%	14.2%	77.6%	0.7%	1.0%	6.4%	3.3%
Office visits - established	$853,651,814	5.3%	4.1% - 6.6%	18.4%	16.4%	0.0%	65.2%	0.0%	2.9%
Hospital visit - subsequent	$702,987,599	13.8%	11.2% - 16.5%	10.3%	19.6%	0.0%	51.4%	18.7%	2.4%
Specialist - other	$675,466,542	25.0%	18.1% - 31.9%	3.9%	84.0%	0.2%	3.9%	8.0%	2.3%
Ambulance	$452,598,022	10.4%	5.6% - 15.3%	11.5%	46.7%	24.9%	0.3%	16.6%	1.5%
Other drugs	$329,953,491	2.0%	0.5% - 3.4%	10.3%	69.7%	1.9%	13.9%	4.2%	1.1%
Other tests - other	$316,850,574	19.9%	7.0% - 32.7%	51.0%	46.3%	0.0%	2.3%	0.4%	1.1%
Ambulatory procedures - other	$313,317,980	24.2%	16.9% - 31.5%	10.4%	80.4%	0.0%	1.1%	8.1%	1.1%
Nursing home visit	$271,609,544	12.7%	9.0% - 16.5%	18.0%	26.9%	0.0%	49.6%	5.5%	0.9%
Hospital visit - initial	$246,367,398	12.0%	9.0% - 15.0%	8.8%	40.7%	0.0%	42.3%	8.2%	0.8%
Office visits - new	$229,732,141	7.6%	4.4% - 10.8%	1.9%	20.5%	0.0%	77.6%	0.0%	0.8%
Major procedure - Other	$195,275,659	6.6%	1.7% - 11.5%	6.3%	74.0%	0.0%	0.2%	19.5%	0.7%
Emergency room visit	$182,077,670	11.6%	7.4% - 15.8%	16.0%	0.0%	0.0%	84.0%	0.0%	0.6%
Oncology - radiation therapy	$164,702,573	12.2%	5.8% - 18.7%	10.1%	89.9%	0.0%	0.0%	0.0%	0.6%
Chiropractic	$144,031,007	30.4%	18.7% - 42.2%	6.0%	89.5%	3.0%	1.5%	0.0%	0.5%
Hospital visit - critical care	$143,753,020	15.0%	9.9% - 20.2%	17.3%	18.2%	0.0%	54.2%	10.3%	0.5%
Advanced imaging - MRI/MRA: other	$125,722,342	7.1%	(1.2%) - 15.4%	2.6%	97.3%	0.0%	0.1%	0.0%	0.4%
Eye procedure - cataract removal/lens insertion	$111,522,787	5.7%	2.2% - 9.1%	0.0%	100.0%	0.0%	0.0%	0.0%	0.4%
Anesthesia	$106,638,736	7.0%	2.6% - 11.5%	81.0%	17.6%	0.2%	0.9%	0.3%	0.4%
All Type of Services (Incl. Codes Not Listed)	**$9,624,572,895**	**8.4%**	**7.6% - 9.3%**	**15.7%**	**58.4%**	**1.6%**	**18.8%**	**5.5%**	**32.4%**

Table D2: Top 20 Service Types with Highest Improper Payments: DMEPOS

DMEPOS (Policy Group)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Urological Supplies	$885,848,191	74.1%	53.9% - 94.3%	93.7%	5.1%	0.0%	0.0%	1.1%	3.0%
Surgical Dressings	$203,604,968	47.1%	36.9% - 57.4%	61.2%	26.6%	0.9%	0.7%	10.5%	0.7%
Glucose Monitor	$203,362,829	17.3%	10.8% - 23.9%	36.2%	47.1%	1.4%	0.0%	15.3%	0.7%
CPAP	$122,534,610	10.6%	6.0% - 15.2%	4.0%	64.3%	18.3%	0.0%	13.4%	0.4%
Lower Limb Orthoses	$122,058,454	47.2%	35.2% - 59.2%	26.5%	46.4%	8.7%	0.1%	18.4%	0.4%
Oxygen Supplies/Equipment	$80,293,195	12.9%	8.5% - 17.3%	0.4%	74.2%	0.0%	0.0%	25.5%	0.3%
Ventilators	$78,225,403	16.2%	8.4% - 24.0%	33.1%	44.9%	0.0%	0.0%	22.0%	0.3%
LSO	$60,327,704	52.3%	38.3% - 66.3%	42.9%	46.1%	0.2%	0.0%	10.7%	0.2%
Infusion Pumps & Related Drugs	$59,806,541	7.3%	4.2% - 10.4%	3.7%	60.4%	14.3%	2.7%	18.9%	0.2%
All Policy Groups with Less than 30 Claims	$55,236,423	12.8%	3.7% - 21.9%	5.3%	68.9%	8.1%	0.1%	17.6%	0.2%
Parenteral Nutrition	$49,011,636	20.9%	13.2% - 28.5%	3.1%	45.0%	10.0%	0.1%	41.8%	0.2%
Upper Limb Orthoses	$48,994,518	48.1%	38.5% - 57.8%	32.9%	42.5%	2.2%	0.0%	22.4%	0.2%
Diabetic Shoes	$40,336,039	52.8%	36.8% - 68.7%	0.1%	94.6%	0.0%	0.0%	5.4%	0.1%
Immunosuppressive Drugs	$31,512,980	15.4%	9.1% - 21.8%	9.2%	39.9%	16.3%	1.5%	33.1%	0.1%
Nebulizers & Related Drugs	$27,054,535	9.4%	5.0% - 13.8%	0.2%	54.7%	22.0%	0.4%	22.6%	0.1%
Enteral Nutrition	$25,340,806	17.7%	10.2% - 25.1%	2.5%	49.7%	31.0%	2.3%	14.4%	0.1%
Ostomy Supplies	$21,052,453	11.0%	5.0% - 17.0%	0.0%	79.9%	0.0%	0.0%	20.0%	0.1%
Wheelchairs Manual	$20,969,838	22.1%	15.2% - 29.0%	0.4%	68.8%	0.0%	0.4%	30.4%	0.1%
Wheelchairs Options/Accessories	$20,600,080	9.3%	4.6% - 14.1%	2.5%	26.4%	56.6%	0.0%	14.4%	0.1%
Pneumatic Compression Device	$20,085,528	27.2%	18.7% - 35.8%	2.3%	62.9%	31.5%	0.0%	3.3%	0.1%
All Type of Services (Incl. Codes Not Listed)	**$2,271,938,624**	**24.1%**	**16.7% - 31.6%**	**50.5%**	**32.8%**	**4.6%**	**0.2%**	**11.9%**	**7.6%**

Table D3: Top Service Types with Highest Improper Payments: Part A Excluding Hospital IPPS

Part A Excluding Hospital IPPS Services (TOB)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
SNF Inpatient	$4,042,025,227	12.1%	10.0% - 14.1%	1.6%	57.2%	0.0%	2.8%	38.3%	13.6%
Hospital Outpatient	$3,612,536,964	4.5%	1.9% - 7.1%	1.6%	95.9%	0.5%	1.9%	0.2%	12.2%
Hospital Inpatient (Part A)	$1,794,701,945	15.1%	11.9% - 18.4%	3.0%	6.3%	90.8%	0.0%	0.0%	6.0%
Nonhospital based hospice	$1,613,176,463	5.9%	4.0% - 7.8%	18.7%	29.0%	50.3%	1.4%	0.6%	5.4%
Home Health	$1,070,619,633	6.9%	5.3% - 8.5%	11.8%	49.4%	30.4%	3.6%	4.8%	3.6%
CAH	$347,021,804	3.7%	0.9% - 6.5%	1.1%	52.0%	0.8%	45.8%	0.3%	1.2%
SNF Inpatient Part B	$246,063,428	8.5%	(1.5%) - 18.5%	0.0%	65.9%	15.0%	13.3%	5.8%	0.8%
Hospital based hospice	$135,392,734	9.3%	4.3% - 14.4%	2.8%	77.3%	16.6%	0.2%	3.0%	0.5%
FQHC	$118,547,892	10.3%	3.3% - 17.3%	9.9%	47.3%	0.0%	42.8%	0.0%	0.4%
Clinical Rural Health	$85,042,754	3.8%	1.6% - 6.1%	12.3%	82.0%	0.0%	0.0%	5.7%	0.3%
Hospital Other Part B	$44,616,087	10.1%	2.6% - 17.5%	0.0%	92.4%	2.8%	4.7%	0.0%	0.2%
Clinic ESRD	$26,897,943	0.3%	(0.1%) - 0.8%	0.0%	90.1%	0.0%	8.3%	1.6%	0.1%
SNF Outpatient	$26,051,593	9.0%	0.4% - 17.6%	0.0%	100.0%	0.0%	0.0%	0.0%	0.1%
Clinic OPT	$15,312,841	2.2%	(0.1%) - 4.5%	18.2%	81.8%	0.0%	0.0%	0.0%	0.1%
Hospital Inpatient Part B	$15,080,641	1.4%	(0.7%) - 3.4%	0.0%	92.8%	6.5%	0.0%	0.7%	0.1%
Clinic CORF	$5,181,451	20.7%	9.9% - 31.6%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
All Codes With Less Than 30 Claims	$0	0.0%	0.0% - 0.0%	N/A	N/A	N/A	N/A	N/A	0.0%
All Type of Services (Incl. Codes Not Listed)	**$13,198,269,399**	**6.7%**	**5.5% - 7.8%**	**4.8%**	**57.5%**	**21.6%**	**3.7%**	**12.4%**	**44.4%**

Table D4: Top 20 Service Types with Highest Improper Payments: Part A Hospital IPPS

Part A Hospital IPPS Services (MS-DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Percutaneous Intracardiac Procedures (273, 274)	$708,222,635	37.8%	29.8% - 45.8%	0.9%	95.1%	4.0%	0.0%	0.0%	2.4%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$474,175,197	34.5%	28.8% - 40.1%	1.0%	2.0%	96.4%	0.6%	0.0%	1.6%
Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)	$255,161,318	8.9%	6.0% - 11.8%	2.2%	91.3%	4.7%	1.9%	0.0%	0.9%
Combined Anterior/Posterior Spinal Fusion (453, 454, 455)	$200,703,971	9.8%	5.3% - 14.3%	6.7%	22.3%	69.2%	1.8%	0.0%	0.7%
Psychoses (885)	$155,540,712	10.0%	(2.3%) - 22.3%	0.0%	71.7%	28.3%	0.0%	0.0%	0.5%
Degenerative Nervous System Disorders (056, 057)	$112,609,401	15.1%	7.3% - 22.9%	1.5%	13.5%	70.7%	14.2%	0.0%	0.4%
Cervical Spinal Fusion (471, 472, 473)	$102,697,237	15.2%	4.7% - 25.8%	8.8%	55.9%	33.3%	1.9%	0.0%	0.3%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes (640, 641)	$91,723,421	7.4%	(0.6%) - 15.3%	0.0%	0.0%	36.3%	63.7%	0.0%	0.3%
Spinal Fusion Except Cervical (459, 460)	$84,016,687	8.1%	3.3% - 13.0%	0.0%	5.2%	81.5%	13.3%	0.0%	0.3%
Kidney & Urinary Tract Infections (689, 690)	$80,056,269	4.7%	1.3% - 8.1%	22.0%	0.0%	30.0%	34.5%	13.5%	0.3%
Major Joint/Limb Reattachment Procedure Of Upper Extremities (483)	$71,488,881	22.9%	11.2% - 34.6%	0.0%	0.0%	99.7%	0.3%	0.0%	0.2%
Other Disorders Of Nervous System (091, 092, 093)	$68,650,205	11.8%	3.7% - 20.0%	0.0%	0.0%	97.1%	2.9%	0.0%	0.2%
Other Vascular Procedures (252, 253, 254)	$65,237,584	5.5%	(0.4%) - 11.3%	0.0%	0.0%	56.4%	43.6%	0.0%	0.2%
Medical Back Problems (551, 552)	$61,206,475	8.1%	0.8% - 15.4%	0.0%	0.0%	64.9%	35.1%	0.0%	0.2%
Percutaneous Cardiovascular Procedures With Intraluminal Device (321, 322)	$50,996,851	4.2%	(1.7%) - 10.0%	0.0%	0.0%	64.7%	35.3%	0.0%	0.2%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$50,860,165	4.3%	0.7% - 8.0%	37.4%	0.0%	56.2%	6.4%	0.0%	0.2%
Renal Failure (682, 683, 684)	$50,430,490	3.3%	(0.7%) - 7.3%	0.0%	0.0%	59.3%	40.7%	0.0%	0.2%
Organic Disturbances & Intellectual Disability (884)	$50,061,366	12.0%	1.5% - 22.4%	15.3%	0.0%	84.7%	0.0%	0.0%	0.2%
Other Kidney & Urinary Tract Diagnoses (698, 699, 700)	$49,194,667	3.7%	(1.5%) - 8.9%	0.0%	0.0%	89.0%	11.0%	0.0%	0.2%
Other Musculoskelet Sys & Conn Tiss OR Proc (515, 516, 517)	$46,466,610	13.5%	2.9% - 24.0%	0.0%	37.3%	62.5%	0.2%	0.0%	0.2%
All Type of Services (Incl. Codes Not Listed)	**$4,610,744,131**	**3.9%**	**3.5% - 4.3%**	**3.6%**	**29.0%**	**47.6%**	**19.5%**	**0.2%**	**15.5%**

Appendix E: Improper Payment Rates and Type of Error by Type of Service for Each Claim Type

Appendix E tables are sorted in descending order by improper payment rate. All estimates in these tables are based on a minimum of 30 lines in the sample. For a full listing of all services with 30 or more claims, see Appendix G.

Table E1: Top 20 Service Type Improper Payment Rates: Part B

Part B Services (BETOS Codes)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Other - non-Medicare fee schedule	46.9%	18.7% - 75.1%	17.9%	26.4%	0.0%	9.6%	46.1%	0.1%
Chiropractic	30.4%	18.7% - 42.2%	6.0%	89.5%	3.0%	1.5%	0.0%	0.5%
Lab tests - other (non-Medicare fee schedule)	27.9%	20.1% - 35.7%	18.1%	79.9%	0.9%	0.4%	0.8%	4.6%
Specialist - other	25.0%	18.1% - 31.9%	3.9%	84.0%	0.2%	3.9%	8.0%	2.3%
Ambulatory procedures - other	24.2%	16.9% - 31.5%	10.4%	80.4%	0.0%	1.1%	8.1%	1.1%
Lab tests - urinalysis	22.1%	7.6% - 36.6%	9.4%	78.9%	0.0%	0.0%	11.7%	0.0%
Other tests - other	19.9%	7.0% - 32.7%	51.0%	46.3%	0.0%	2.3%	0.4%	1.1%
Standard imaging - chest	18.0%	10.5% - 25.5%	16.9%	78.2%	0.0%	0.0%	4.9%	0.1%
Minor procedures - other (Medicare fee schedule)	17.6%	12.9% - 22.2%	14.2%	77.6%	0.7%	1.0%	6.4%	3.3%
Standard imaging - other	17.1%	5.0% - 29.2%	7.0%	88.5%	0.0%	0.0%	4.5%	0.2%
Home visit	15.1%	8.1% - 22.1%	13.2%	27.7%	0.0%	56.2%	2.9%	0.3%
Hospital visit - critical care	15.0%	9.9% - 20.2%	17.3%	18.2%	0.0%	54.2%	10.3%	0.5%
Echography/ultrasonography - carotid arteries	14.2%	4.7% - 23.8%	0.0%	82.0%	0.0%	0.0%	18.0%	0.1%
Hospital visit - subsequent	13.8%	11.2% - 16.5%	10.3%	19.6%	0.0%	51.4%	18.7%	2.4%
Nursing home visit	12.7%	9.0% - 16.5%	18.0%	26.9%	0.0%	49.6%	5.5%	0.9%
Oncology - radiation therapy	12.2%	5.8% - 18.7%	10.1%	89.9%	0.0%	0.0%	0.0%	0.6%
Hospital visit - initial	12.0%	9.0% - 15.0%	8.8%	40.7%	0.0%	42.3%	8.2%	0.8%
Other - Medicare fee schedule	11.7%	6.2% - 17.1%	4.0%	90.9%	0.0%	2.4%	2.7%	0.1%
Emergency room visit	11.6%	7.4% - 15.8%	16.0%	0.0%	0.0%	84.0%	0.0%	0.6%
Ambulance	10.4%	5.6% - 15.3%	11.5%	46.7%	24.9%	0.3%	16.6%	1.5%
Overall (incl. Service Types Not Listed)	**8.4%**	**7.6% - 9.3%**	**15.7%**	**58.4%**	**1.6%**	**18.8%**	**5.5%**	**32.4%**

Table E2: Top 20 Service Type Improper Payment Rates: DMEPOS

DMEPOS (Policy Group)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Urological Supplies	74.1%	53.9% - 94.3%	93.7%	5.1%	0.0%	0.0%	1.1%	3.0%
Diabetic Shoes	52.8%	36.8% - 68.7%	0.1%	94.6%	0.0%	0.0%	5.4%	0.1%
LSO	52.3%	38.3% - 66.3%	42.9%	46.1%	0.2%	0.0%	10.7%	0.2%
Upper Limb Orthoses	48.1%	38.5% - 57.8%	32.9%	42.5%	2.2%	0.0%	22.4%	0.2%
Lower Limb Orthoses	47.2%	35.2% - 59.2%	26.5%	46.4%	8.7%	0.1%	18.4%	0.4%
Surgical Dressings	47.1%	36.9% - 57.4%	61.2%	26.6%	0.9%	0.7%	10.5%	0.7%
Lenses	47.1%	30.2% - 63.9%	0.0%	35.0%	35.0%	0.0%	30.1%	0.0%
Pneumatic Compression Device	27.2%	18.7% - 35.8%	2.3%	62.9%	31.5%	0.0%	3.3%	0.1%
Repairs/DMEPOS	24.3%	13.7% - 34.9%	14.7%	9.5%	67.9%	7.0%	0.8%	0.0%
Breast Prostheses	24.2%	12.0% - 36.4%	0.0%	75.4%	0.0%	0.6%	24.0%	0.0%
Suction Pump	22.6%	4.9% - 40.3%	1.5%	32.5%	6.3%	0.0%	59.8%	0.0%
Wheelchairs Manual	22.1%	15.2% - 29.0%	0.4%	68.8%	0.0%	0.4%	30.4%	0.1%
Parenteral Nutrition	20.9%	13.2% - 28.5%	3.1%	45.0%	10.0%	0.1%	41.8%	0.2%
Tracheostomy Supplies	18.4%	5.7% - 31.0%	0.0%	58.4%	0.0%	0.0%	41.6%	0.0%
Hospital Beds/Accessories	18.3%	5.7% - 30.8%	0.0%	67.0%	0.0%	0.0%	33.0%	0.0%
Walkers	18.0%	6.1% - 30.0%	2.1%	69.3%	18.9%	0.0%	9.7%	0.0%
Enteral Nutrition	17.7%	10.2% - 25.1%	2.5%	49.7%	31.0%	2.3%	14.4%	0.1%
Glucose Monitor	17.3%	10.8% - 23.9%	36.2%	47.1%	1.4%	0.0%	15.3%	0.7%
Ventilators	16.2%	8.4% - 24.0%	33.1%	44.9%	0.0%	0.0%	22.0%	0.3%
Immunosuppressive Drugs	15.4%	9.1% - 21.8%	9.2%	39.9%	16.3%	1.5%	33.1%	0.1%
Overall (incl. Service Types Not Listed)	**24.1%**	**16.7% - 31.6%**	**50.5%**	**32.8%**	**4.6%**	**0.2%**	**11.9%**	**7.6%**

Table E3: Top Service Type Improper Payment Rates: Part A Excluding Hospital IPPS

Part A Excluding Hospital IPPS Services (TOB)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Clinic CORF	20.7%	9.9% - 31.6%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Hospital Inpatient (Part A)	15.1%	11.9% - 18.4%	3.0%	6.3%	90.8%	0.0%	0.0%	6.0%
SNF Inpatient	12.1%	10.0% - 14.1%	1.6%	57.2%	0.0%	2.8%	38.3%	13.6%
FQHC	10.3%	3.3% - 17.3%	9.9%	47.3%	0.0%	42.8%	0.0%	0.4%
Hospital Other Part B	10.1%	2.6% - 17.5%	0.0%	92.4%	2.8%	4.7%	0.0%	0.2%
Hospital based hospice	9.3%	4.3% - 14.4%	2.8%	77.3%	16.6%	0.2%	3.0%	0.5%
SNF Outpatient	9.0%	0.4% - 17.6%	0.0%	100.0%	0.0%	0.0%	0.0%	0.1%
SNF Inpatient Part B	8.5%	(1.5%) - 18.5%	0.0%	65.9%	15.0%	13.3%	5.8%	0.8%
Home Health	6.9%	5.3% - 8.5%	11.8%	49.4%	30.4%	3.6%	4.8%	3.6%
Nonhospital based hospice	5.9%	4.0% - 7.8%	18.7%	29.0%	50.3%	1.4%	0.6%	5.4%
Hospital Outpatient	4.5%	1.9% - 7.1%	1.6%	95.9%	0.5%	1.9%	0.2%	12.2%
Clinical Rural Health	3.8%	1.6% - 6.1%	12.3%	82.0%	0.0%	0.0%	5.7%	0.3%
CAH	3.7%	0.9% - 6.5%	1.1%	52.0%	0.8%	45.8%	0.3%	1.2%
Clinic OPT	2.2%	(0.1%) - 4.5%	18.2%	81.8%	0.0%	0.0%	0.0%	0.1%
Hospital Inpatient Part B	1.4%	(0.7%) - 3.4%	0.0%	92.8%	6.5%	0.0%	0.7%	0.1%
Clinic ESRD	0.3%	(0.1%) - 0.8%	0.0%	90.1%	0.0%	8.3%	1.6%	0.1%
All Codes With Less Than 30 Claims	0.0%	0.0% - 0.0%	N/A	N/A	N/A	N/A	N/A	0.0%
Overall (incl. Service Types Not Listed)	**6.7%**	**5.5% - 7.8%**	**4.8%**	**57.5%**	**21.6%**	**3.7%**	**12.4%**	**44.4%**

Table E4: Top 20 Service Type Improper Payment Rates: Part A Hospital IPPS

Part A Hospital IPPS Services (MS-DRGs)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Percutaneous Intracardiac Procedures (273, 274)	37.8%	29.8% - 45.8%	0.9%	95.1%	4.0%	0.0%	0.0%	2.4%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	34.5%	28.8% - 40.1%	1.0%	2.0%	96.4%	0.6%	0.0%	1.6%
Bilateral Or Multiple Major Joint Procs Of Lower Extremity (461, 462)	28.1%	17.2% - 39.0%	0.0%	16.9%	83.1%	0.0%	0.0%	0.0%
Major Joint/Limb Reattachment Procedure Of Upper Extremities (483)	22.9%	11.2% - 34.6%	0.0%	0.0%	99.7%	0.3%	0.0%	0.2%
Aftercare, Musculoskeletal System & Connective Tissue (559, 560, 561)	18.0%	11.5% - 24.6%	0.3%	24.1%	65.3%	9.5%	0.7%	0.1%
Chest Pain (313)	15.7%	0.6% - 30.8%	0.0%	0.0%	100.0%	0.0%	0.0%	0.1%
Cardiac Defibrillator Implant (276, 277)	15.5%	7.6% - 23.4%	0.0%	78.9%	20.2%	0.9%	0.0%	0.1%
Signs & Symptoms (947, 948)	15.4%	8.8% - 22.0%	6.8%	0.0%	87.9%	5.4%	0.0%	0.1%
Cervical Spinal Fusion (471, 472, 473)	15.2%	4.7% - 25.8%	8.8%	55.9%	33.3%	1.9%	0.0%	0.3%
Degenerative Nervous System Disorders (056, 057)	15.1%	7.3% - 22.9%	1.5%	13.5%	70.7%	14.2%	0.0%	0.4%
Other Musculoskelet Sys & Conn Tiss OR Proc (515, 516, 517)	13.5%	2.9% - 24.0%	0.0%	37.3%	62.5%	0.2%	0.0%	0.2%
Transient Ischemia W/O Thrombolytic (069)	12.2%	0.8% - 23.6%	0.0%	0.0%	100.0%	0.0%	0.0%	0.1%
Organic Disturbances & Intellectual Disability (884)	12.0%	1.5% - 22.4%	15.3%	0.0%	84.7%	0.0%	0.0%	0.2%
Other Disorders Of Nervous System (091, 092, 093)	11.8%	3.7% - 20.0%	0.0%	0.0%	97.1%	2.9%	0.0%	0.2%
Psychoses (885)	10.0%	(2.3%) - 22.3%	0.0%	71.7%	28.3%	0.0%	0.0%	0.5%
Combined Anterior/Posterior Spinal Fusion (453, 454, 455)	9.8%	5.3% - 14.3%	6.7%	22.3%	69.2%	1.8%	0.0%	0.7%
AICD Generator Procedures (245)	9.1%	1.4% - 16.9%	14.9%	30.7%	52.2%	2.2%	0.0%	0.0%
Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)	8.9%	6.0% - 11.8%	2.2%	91.3%	4.7%	1.9%	0.0%	0.9%
Aftercare (949, 950)	8.6%	2.3% - 14.8%	5.0%	35.0%	45.6%	14.3%	0.0%	0.0%
Fx, Sprn, Strn & Disl Except Femur, Hip, Pelvis & Thigh (562, 563)	8.3%	(0.2%) - 16.8%	0.0%	0.0%	99.8%	0.2%	0.0%	0.1%
Overall (incl. Service Types Not Listed)	**3.9%**	**3.5% - 4.3%**	**3.6%**	**29.0%**	**47.6%**	**19.5%**	**0.2%**	**15.5%**

Appendix F: Projected Improper Payments by Type of Service for Each Type of Error

This series of tables are sorted in descending order by projected improper payments. All estimates in these tables are based on a minimum of 30 lines in the sample.

Table F1: Top 20 Types of Services with No Documentation Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Urological Supplies	$830,183,220	69.4%	46.1% - 92.8%	2.8%
Nonhospital based hospice	$302,062,765	1.1%	0.2% - 2.0%	1.0%
Lab tests - other (non-Medicare fee schedule)	$246,089,312	5.0%	2.2% - 7.9%	0.8%
Other tests - other	$161,478,180	10.1%	(3.1%) - 23.3%	0.5%
Office visits - established	$156,915,756	1.0%	0.3% - 1.6%	0.5%
Minor procedures - other (Medicare fee schedule)	$140,822,550	2.5%	(0.7%) - 5.7%	0.5%
Home Health	$126,372,461	0.8%	0.2% - 1.4%	0.4%
Surgical Dressings	$124,617,941	28.9%	18.9% - 38.8%	0.4%
Anesthesia	$86,391,789	5.7%	1.5% - 9.9%	0.3%
Glucose Monitor	$73,711,970	6.3%	0.4% - 12.2%	0.2%
Hospital visit - subsequent	$72,290,966	1.4%	0.6% - 2.2%	0.2%
SNF Inpatient	$65,321,602	0.2%	0.0% - 0.3%	0.2%
Hospital Outpatient	$57,736,016	0.1%	0.0% - 0.1%	0.2%
Hospital Inpatient (Part A)	$53,435,229	0.5%	(0.1%) - 1.0%	0.2%
Ambulance	$52,086,088	1.2%	(0.2%) - 2.6%	0.2%
Nursing home visit	$48,988,174	2.3%	0.7% - 3.9%	0.2%
Other drugs	$34,119,448	0.2%	0.0% - 0.4%	0.1%
Ambulatory procedures - other	$32,433,161	2.5%	0.8% - 4.2%	0.1%
Lower Limb Orthoses	$32,356,287	12.5%	6.1% - 18.9%	0.1%
Lab tests - other (Medicare fee schedule)	$31,838,032	2.5%	(0.6%) - 5.5%	0.1%
Overall (Incl. Codes Not Listed)	**$3,464,346,673**	**0.8%**	**0.6% - 1.0%**	**11.7%**

Table F2: Top 20 Types of Services with Insufficient Documentation Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Hospital Outpatient	$3,464,787,362	4.4%	1.8% - 6.9%	11.7%
SNF Inpatient	$2,313,469,722	6.9%	5.5% - 8.4%	7.8%
Lab tests - other (non-Medicare fee schedule)	$1,087,049,622	22.3%	14.5% - 30.0%	3.7%
Minor procedures - other (Medicare fee schedule)	$769,641,180	13.6%	10.1% - 17.1%	2.6%
Percutaneous Intracardiac Procedures (273, 274)	$673,175,001	35.9%	28.0% - 43.8%	2.3%
Specialist - other	$567,474,991	21.0%	14.3% - 27.7%	1.9%
Home Health	$529,404,689	3.4%	2.1% - 4.7%	1.8%
Nonhospital based hospice	$467,902,632	1.7%	0.7% - 2.7%	1.6%
Ambulatory procedures - other	$252,054,200	19.5%	13.3% - 25.7%	0.8%
Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)	$232,891,899	8.1%	5.3% - 11.0%	0.8%
Other drugs	$230,133,848	1.4%	0.0% - 2.7%	0.8%
Ambulance	$211,268,377	4.9%	2.2% - 7.6%	0.7%
CAH	$180,457,804	1.9%	0.2% - 3.6%	0.6%
SNF Inpatient Part B	$162,193,838	5.6%	(4.4%) - 15.5%	0.5%
Oncology - radiation therapy	$148,078,138	11.0%	4.8% - 17.2%	0.5%
Other tests - other	$146,745,288	9.2%	4.6% - 13.8%	0.5%
Major procedure - Other	$144,584,787	4.9%	1.0% - 8.8%	0.5%
Office visits - established	$140,235,348	0.9%	0.2% - 1.5%	0.5%
Hospital visit - subsequent	$138,106,603	2.7%	1.3% - 4.1%	0.5%
Chiropractic	$128,898,870	27.2%	15.6% - 38.8%	0.4%
Overall (Incl. Codes Not Listed)	**$15,285,281,270**	**3.5%**	**2.9% - 4.0%**	**51.5%**

Table F3: Top 20 Types of Services with Medical Necessity Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Hospital Inpatient (Part A)	$1,628,851,772	13.7%	10.6% - 16.9%	5.5%
Nonhospital based hospice	$810,774,959	3.0%	1.6% - 4.3%	2.7%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$457,016,506	33.2%	27.6% - 38.9%	1.5%
Home Health	$324,955,841	2.1%	1.3% - 2.8%	1.1%
Combined Anterior/Posterior Spinal Fusion (453, 454, 455)	$138,827,490	6.8%	3.1% - 10.5%	0.5%
Ambulance	$112,602,711	2.6%	0.3% - 4.9%	0.4%
Degenerative Nervous System Disorders (056, 057)	$79,656,040	10.7%	3.2% - 18.1%	0.3%
Major Joint/Limb Reattachment Procedure Of Upper Extremities (483)	$71,247,784	22.8%	11.1% - 34.5%	0.2%
Spinal Fusion Except Cervical (459, 460)	$68,508,856	6.6%	2.1% - 11.1%	0.2%
Other Disorders Of Nervous System (091, 092, 093)	$66,664,276	11.5%	3.3% - 19.7%	0.2%
Psychoses (885)	$44,055,446	2.8%	(2.7%) - 8.3%	0.1%
Other Kidney & Urinary Tract Diagnoses (698, 699, 700)	$43,772,479	3.3%	(1.9%) - 8.4%	0.1%
Organic Disturbances & Intellectual Disability (884)	$42,425,341	10.1%	0.3% - 20.0%	0.1%
Medical Back Problems (551, 552)	$39,751,244	5.3%	(0.7%) - 11.2%	0.1%
SNF Inpatient Part B	$36,894,934	1.3%	(1.2%) - 3.8%	0.1%
Other Vascular Procedures (252, 253, 254)	$36,774,326	3.1%	(0.6%) - 6.8%	0.1%
Cervical Spinal Fusion (471, 472, 473)	$34,208,148	5.1%	0.5% - 9.7%	0.1%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes (640, 641)	$33,303,778	2.7%	(1.2%) - 6.5%	0.1%
Percutaneous Cardiovascular Procedures With Intraluminal Device (321, 322)	$33,020,210	2.7%	(2.5%) - 7.9%	0.1%
Respiratory Infections & Inflammations (177, 178, 179)	$31,872,789	1.3%	(0.2%) - 2.8%	0.1%
Overall (Incl. Codes Not Listed)	**$5,297,661,004**	**1.2%**	**1.1% - 1.4%**	**17.8%**

Table F4: Top 20 Types of Services with Incorrect Coding Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Office visits - established	$556,500,710	3.5%	2.6% - 4.3%	1.9%
Hospital visit - subsequent	$361,156,694	7.1%	5.8% - 8.4%	1.2%
Office visits - new	$178,377,755	5.9%	3.9% - 7.9%	0.6%
CAH	$159,024,018	1.7%	(0.5%) - 3.9%	0.5%
Emergency room visit	$152,935,085	9.7%	6.3% - 13.2%	0.5%
Nursing home visit	$134,623,746	6.3%	4.5% - 8.1%	0.5%
SNF Inpatient	$112,996,484	0.3%	0.1% - 0.6%	0.4%
Hospital visit - initial	$104,136,393	5.1%	4.0% - 6.2%	0.4%
Hospital visit - critical care	$77,900,065	8.1%	4.3% - 12.0%	0.3%
Hospital Outpatient	$66,944,709	0.1%	0.0% - 0.1%	0.2%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes (640, 641)	$58,419,643	4.7%	(2.3%) - 11.7%	0.2%
Home visit	$58,052,799	8.5%	3.3% - 13.7%	0.2%
FQHC	$50,744,327	4.4%	(1.1%) - 9.9%	0.2%
Standard imaging - nuclear medicine	$47,450,295	4.0%	(0.2%) - 8.1%	0.2%
Other drugs	$45,779,878	0.3%	(0.0%) - 0.5%	0.2%
Simple Pneumonia & Pleurisy (193, 194, 195)	$44,829,382	2.1%	(0.4%) - 4.6%	0.2%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	$39,031,497	2.1%	(0.2%) - 4.4%	0.1%
Infectious & Parasitic Diseases W OR Procedure (853, 854, 855)	$38,496,058	0.9%	(0.3%) - 2.1%	0.1%
Home Health	$38,478,623	0.2%	0.1% - 0.4%	0.1%
GI Hemorrhage (377, 378, 379)	$37,725,102	2.6%	(0.6%) - 5.7%	0.1%
Overall (Incl. Codes Not Listed)	**$3,203,471,704**	**0.7%**	**0.6% - 0.8%**	**10.8%**

Table F5: Top 20 Types of Services with Downcoding[17] Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
CAH	$106,070,062	1.1%	(0.9%) - 3.2%	0.4%
Office visits - established	$66,796,275	0.4%	(0.1%) - 0.9%	0.2%
Standard imaging - nuclear medicine	$47,378,692	4.0%	(0.2%) - 8.1%	0.2%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes (640, 641)	$46,593,782	3.7%	(3.2%) - 10.6%	0.2%
Other drugs	$39,163,788	0.2%	(0.0%) - 0.5%	0.1%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	$34,244,603	1.8%	(0.4%) - 4.1%	0.1%
Hospital visit - subsequent	$33,532,561	0.7%	0.1% - 1.2%	0.1%
Simple Pneumonia & Pleurisy (193, 194, 195)	$28,512,823	1.3%	(0.7%) - 3.4%	0.1%
Other Vascular Procedures (252, 253, 254)	$28,463,258	2.4%	(2.2%) - 7.0%	0.1%
Hospital Outpatient	$25,382,413	0.0%	(0.0%) - 0.1%	0.1%
Office visits - new	$22,997,994	0.8%	(0.0%) - 1.5%	0.1%
Major Chest Procedures (163, 164, 165)	$21,463,494	2.3%	(0.4%) - 5.1%	0.1%
Nonhospital based hospice	$21,401,800	0.1%	(0.1%) - 0.2%	0.1%
Septicemia Or Severe Sepsis W/O MV >96 Hours (871, 872)	$19,257,913	0.2%	(0.1%) - 0.5%	0.1%
Kidney & Urinary Tract Infections (689, 690)	$18,922,005	1.1%	(0.4%) - 2.6%	0.1%
Percutaneous Cardiovascular Procedures With Intraluminal Device (321, 322)	$17,957,235	1.5%	(1.4%) - 4.3%	0.1%
Revision Of Hip Or Knee Replacement (466, 467, 468)	$17,884,819	1.6%	(1.3%) - 4.6%	0.1%
Nursing home visit	$16,865,899	0.8%	0.1% - 1.5%	0.1%
GI Hemorrhage (377, 378, 379)	$16,606,544	1.1%	(1.1%) - 3.3%	0.1%
Major Gastrointestinal Disorders & Peritoneal Infections (371, 372, 373)	$11,212,982	3.0%	(2.8%) - 8.7%	0.0%
Overall (Incl. Codes Not Listed)	**$891,887,256**	**0.2%**	**0.1% - 0.3%**	**3.0%**

[17] Downcoding refers to billing a lower level service or a service with a lower payment than is supported by the medical record documentation.

Table F6: Top 20 Types of Services with Other Errors

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
SNF Inpatient	$1,549,649,823	4.6%	3.1% - 6.1%	5.2%
Hospital visit - subsequent	$131,433,336	2.6%	0.7% - 4.5%	0.4%
Ambulance	$75,125,135	1.7%	(0.7%) - 4.2%	0.3%
Minor procedures - other (Medicare fee schedule)	$63,773,981	1.1%	0.4% - 1.9%	0.2%
Specialist - other	$54,088,143	2.0%	0.1% - 3.9%	0.2%
Home Health	$51,408,019	0.3%	(0.0%) - 0.7%	0.2%
Major procedure - Other	$38,010,211	1.3%	(1.2%) - 3.7%	0.1%
Glucose Monitor	$31,158,543	2.7%	0.9% - 4.4%	0.1%
Ambulatory procedures - other	$25,307,142	2.0%	(0.5%) - 4.4%	0.1%
Lower Limb Orthoses	$22,412,608	8.7%	4.0% - 13.3%	0.1%
Surgical Dressings	$21,451,705	5.0%	2.3% - 7.6%	0.1%
Parenteral Nutrition	$20,511,079	8.7%	2.9% - 14.5%	0.1%
Oxygen Supplies/Equipment	$20,436,478	3.3%	0.9% - 5.7%	0.1%
Hospital visit - initial	$20,105,224	1.0%	(0.2%) - 2.1%	0.1%
Ventilators	$17,229,229	3.6%	1.6% - 5.6%	0.1%
CPAP	$16,457,113	1.4%	0.4% - 2.5%	0.1%
Nursing home visit	$15,049,559	0.7%	(0.7%) - 2.1%	0.1%
Endoscopy - colonoscopy	$14,991,670	1.4%	(1.3%) - 4.1%	0.1%
Hospital visit - critical care	$14,741,427	1.5%	(0.7%) - 3.8%	0.0%
SNF Inpatient Part B	$14,213,235	0.5%	(0.5%) - 1.5%	0.0%
Overall (Incl. Codes Not Listed)	**$2,454,764,398**	**0.6%**	**0.4% - 0.7%**	**8.3%**

Appendix G: Projected Improper Payments by Type of Service for Each Claim Type

This series of tables is sorted in descending order by projected improper payments. All estimates in these tables are based on a minimum of 30 lines in the sample.

Table G1: Improper Payment Rates by Service Type: Part B

Part B Services (BETOS Codes)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Lab tests - other (non-Medicare fee schedule)	1,716	$1,360,881,387	27.9%	20.1% - 35.7%	4.6%
Minor procedures - other (Medicare fee schedule)	1,236	$991,373,197	17.6%	12.9% - 22.2%	3.3%
Office visits - established	1,026	$853,651,814	5.3%	4.1% - 6.6%	2.9%
Hospital visit - subsequent	694	$702,987,599	13.8%	11.2% - 16.5%	2.4%
Specialist - other	914	$675,466,542	25.0%	18.1% - 31.9%	2.3%
All Codes With Less Than 30 Claims	948	$522,873,160	4.4%	1.6% - 7.1%	1.8%
Ambulance	342	$452,598,022	10.4%	5.6% - 15.3%	1.5%
Other drugs	1,346	$329,953,491	2.0%	0.5% - 3.4%	1.1%
Other tests - other	514	$316,850,574	19.9%	7.0% - 32.7%	1.1%
Ambulatory procedures - other	510	$313,317,980	24.2%	16.9% - 31.5%	1.1%
Nursing home visit	322	$271,609,544	12.7%	9.0% - 16.5%	0.9%
Hospital visit - initial	374	$246,367,398	12.0%	9.0% - 15.0%	0.8%
Office visits - new	232	$229,732,141	7.6%	4.4% - 10.8%	0.8%
Major procedure - Other	403	$195,275,659	6.6%	1.7% - 11.5%	0.7%
Emergency room visit	105	$182,077,670	11.6%	7.4% - 15.8%	0.6%
Oncology - radiation therapy	106	$164,702,573	12.2%	5.8% - 18.7%	0.6%
Chiropractic	101	$144,031,007	30.4%	18.7% - 42.2%	0.5%
Hospital visit - critical care	156	$143,753,020	15.0%	9.9% - 20.2%	0.5%
Advanced imaging - MRI/MRA: other	135	$125,722,342	7.1%	(1.2%) - 15.4%	0.4%
Eye procedure - cataract removal/lens insertion	223	$111,522,787	5.7%	2.2% - 9.1%	0.4%
Anesthesia	239	$106,638,736	7.0%	2.6% - 11.5%	0.4%
Specialist - psychiatry	308	$106,022,485	8.7%	2.9% - 14.6%	0.4%
Advanced imaging - CAT/CT/CTA: other	300	$104,551,484	8.1%	3.4% - 12.8%	0.4%
Home visit	135	$103,223,904	15.1%	8.1% - 22.1%	0.3%
Lab tests - other (Medicare fee schedule)	202	$102,386,288	8.0%	2.6% - 13.3%	0.3%
Standard imaging - nuclear medicine	161	$74,373,325	6.2%	1.5% - 11.0%	0.3%
Ambulatory procedures - skin	367	$70,775,590	2.0%	0.1% - 3.8%	0.2%
Minor procedures - musculoskeletal	180	$61,769,657	6.0%	2.2% - 9.7%	0.2%
Echography/ultrasonography - heart	101	$55,024,447	7.8%	2.2% - 13.3%	0.2%
Endoscopy - colonoscopy	97	$53,628,236	5.0%	(0.6%) - 10.5%	0.2%
Standard imaging - other	95	$52,430,283	17.1%	5.0% - 29.2%	0.2%
Minor procedures - skin	147	$48,353,718	5.7%	1.3% - 10.1%	0.2%

Part B Services (BETOS Codes)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Standard imaging - musculoskeletal	121	$39,068,376	8.4%	0.6% - 16.1%	0.1%
Echography/ultrasonography - other	104	$36,657,012	5.7%	0.5% - 10.9%	0.1%
Other - Medicare fee schedule	172	$31,299,754	11.7%	6.2% - 17.1%	0.1%
Standard imaging - chest	143	$27,373,939	18.0%	10.5% - 25.5%	0.1%
Other - non-Medicare fee schedule	77	$25,962,998	46.9%	18.7% - 75.1%	0.1%
Specialist - ophthalmology	257	$25,386,767	1.4%	0.1% - 2.8%	0.1%
Lab tests - routine venipuncture (non-Medicare fee schedule	339	$22,430,978	8.8%	5.0% - 12.7%	0.1%
Oncology - other	430	$22,028,741	8.3%	(0.4%) - 17.1%	0.1%
Echography/ultrasonography - carotid arteries	70	$21,753,255	14.2%	4.7% - 23.8%	0.1%
Lab tests - automated general profiles	221	$20,343,311	7.8%	3.5% - 12.2%	0.1%
Lab tests - blood counts	265	$18,692,462	9.9%	5.5% - 14.4%	0.1%
Eye procedure - other	276	$15,511,809	1.9%	(0.3%) - 4.0%	0.1%
Advanced imaging - CAT/CT/CTA: brain/head/neck	48	$14,596,426	5.6%	(1.0%) - 12.2%	0.0%
Undefined codes	448	$10,067,692	7.8%	1.6% - 14.0%	0.0%
Lab tests - urinalysis	102	$8,952,992	22.1%	7.6% - 36.6%	0.0%
Immunizations/Vaccinations	198	$4,951,575	0.1%	(0.1%) - 0.4%	0.0%
Other tests - electrocardiograms	165	$3,694,591	2.1%	0.2% - 4.1%	0.0%
Other tests - cardiovascular stress tests	60	$1,874,158	3.0%	(0.5%) - 6.5%	0.0%
Major procedure, orthopedic - other	39	$0	0.0%	N/A	0.0%
Standard imaging - breast	35	$0	0.0%	N/A	0.0%
All Type of Services (Incl. Codes Not Listed)	**11,600**	**$9,624,572,895**	**8.4%**	**7.6% - 9.3%**	**32.4%**

Table G2: Improper Payment Rates by Service Type: DMEPOS

DMEPOS (Policy Group)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Urological Supplies	490	$885,848,191	74.1%	53.9% - 94.3%	3.0%
Surgical Dressings	598	$203,604,968	47.1%	36.9% - 57.4%	0.7%
Glucose Monitor	757	$203,362,829	17.3%	10.8% - 23.9%	0.7%
CPAP	681	$122,534,610	10.6%	6.0% - 15.2%	0.4%
Lower Limb Orthoses	415	$122,058,454	47.2%	35.2% - 59.2%	0.4%
Oxygen Supplies/Equipment	383	$80,293,195	12.9%	8.5% - 17.3%	0.3%
Ventilators	384	$78,225,403	16.2%	8.4% - 24.0%	0.3%
LSO	177	$60,327,704	52.3%	38.3% - 66.3%	0.2%
Infusion Pumps & Related Drugs	674	$59,806,541	7.3%	4.2% - 10.4%	0.2%
All Policy Groups with Less than 30 Claims	395	$55,236,423	12.8%	3.7% - 21.9%	0.2%
Parenteral Nutrition	371	$49,011,636	20.9%	13.2% - 28.5%	0.2%
Upper Limb Orthoses	224	$48,994,518	48.1%	38.5% - 57.8%	0.2%
Diabetic Shoes	123	$40,336,039	52.8%	36.8% - 68.7%	0.1%
Immunosuppressive Drugs	379	$31,512,980	15.4%	9.1% - 21.8%	0.1%
Nebulizers & Related Drugs	719	$27,054,535	9.4%	5.0% - 13.8%	0.1%
Enteral Nutrition	215	$25,340,806	17.7%	10.2% - 25.1%	0.1%
Ostomy Supplies	259	$21,052,453	11.0%	5.0% - 17.0%	0.1%
Wheelchairs Manual	243	$20,969,838	22.1%	15.2% - 29.0%	0.1%
Wheelchairs Options/Accessories	428	$20,600,080	9.3%	4.6% - 14.1%	0.1%
Pneumatic Compression Device	149	$20,085,528	27.2%	18.7% - 35.8%	0.1%
Lower Limb Prostheses	179	$14,610,004	4.5%	0.7% - 8.4%	0.0%
Automatic External Defibrillator	44	$9,380,742	8.9%	0.4% - 17.4%	0.0%
Hospital Beds/Accessories	89	$8,661,774	18.3%	5.7% - 30.8%	0.0%
Breast Prostheses	56	$8,151,442	24.2%	12.0% - 36.4%	0.0%
Lenses	56	$7,371,851	47.1%	30.2% - 63.9%	0.0%
Intravenous Immune Globulin	71	$6,936,268	5.9%	(5.2%) - 17.0%	0.0%
Tracheostomy Supplies	58	$6,905,801	18.4%	5.7% - 31.0%	0.0%
Negative Pressure Wound Therapy	45	$6,504,562	11.1%	1.3% - 20.8%	0.0%
Walkers	72	$5,683,961	18.0%	6.1% - 30.0%	0.0%
Respiratory Assist Device	124	$4,753,775	6.4%	2.3% - 10.5%	0.0%
Suction Pump	75	$3,989,901	22.6%	4.9% - 40.3%	0.0%
Wheelchairs Seating	187	$3,851,360	8.9%	1.4% - 16.4%	0.0%
Oral Anti-Cancer Drugs	30	$2,514,005	6.1%	(1.2%) - 13.4%	0.0%
Speech Generating Devices	47	$1,818,868	13.1%	2.5% - 23.8%	0.0%
Wheelchairs Motorized	59	$1,398,081	1.2%	(0.6%) - 3.0%	0.0%
Repairs/DMEPOS	211	$1,319,390	24.3%	13.7% - 34.9%	0.0%
Patient Lift	36	$1,168,032	11.3%	(0.9%) - 23.5%	0.0%
Commodes/Bed Pans/Urinals	60	$662,075	10.0%	0.7% - 19.3%	0.0%
Routinely Denied Items	107	N/A	N/A	N/A	N/A

DMEPOS (Policy Group)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
All Type of Services (Incl. Codes Not Listed)	**8,650**	**$2,271,938,624**	**24.1%**	**16.7% - 31.6%**	**7.6%**

Table G3: Improper Payment Rates by Service Type: Part A Excluding Hospital IPPS

Part A Excluding Hospital IPPS Services (TOB)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
SNF Inpatient	1,624	$4,042,025,227	12.1%	10.0% - 14.1%	13.6%
Hospital Outpatient	2,285	$3,612,536,964	4.5%	1.9% - 7.1%	12.2%
Hospital Inpatient (Part A)	950	$1,794,701,945	15.1%	11.9% - 18.4%	6.0%
Nonhospital based hospice	749	$1,613,176,463	5.9%	4.0% - 7.8%	5.4%
Home Health	1,224	$1,070,619,633	6.9%	5.3% - 8.5%	3.6%
CAH	276	$347,021,804	3.7%	0.9% - 6.5%	1.2%
SNF Inpatient Part B	94	$246,063,428	8.5%	(1.5%) - 18.5%	0.8%
Hospital based hospice	143	$135,392,734	9.3%	4.3% - 14.4%	0.5%
FQHC	69	$118,547,892	10.3%	3.3% - 17.3%	0.4%
Clinical Rural Health	250	$85,042,754	3.8%	1.6% - 6.1%	0.3%
Hospital Other Part B	101	$44,616,087	10.1%	2.6% - 17.5%	0.2%
Clinic ESRD	650	$26,897,943	0.3%	(0.1%) - 0.8%	0.1%
SNF Outpatient	47	$26,051,593	9.0%	0.4% - 17.6%	0.1%
Clinic OPT	58	$15,312,841	2.2%	(0.1%) - 4.5%	0.1%
Hospital Inpatient Part B	50	$15,080,641	1.4%	(0.7%) - 3.4%	0.1%
Clinic CORF	75	$5,181,451	20.7%	9.9% - 31.6%	0.0%
All Codes With Less Than 30 Claims	6	$0	0.0%	N/A	0.0%
All Type of Services (Incl. Codes Not Listed)	**8,651**	**$13,198,269,399**	**6.7%**	**5.5% - 7.8%**	**44.4%**

Table G4: Improper Payment Rates by Service Type: Part A Hospital IPPS

Part A Hospital IPPS Services (MS-DRGs)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
All Codes With Less Than 30 Claims	1,733	$924,937,957	3.0%	2.2% - 3.7%	3.1%
Percutaneous Intracardiac Procedures (273, 274)	309	$708,222,635	37.8%	29.8% - 45.8%	2.4%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	464	$474,175,197	34.5%	28.8% - 40.1%	1.6%
Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)	338	$255,161,318	8.9%	6.0% - 11.8%	0.9%
Combined Anterior/Posterior Spinal Fusion (453, 454, 455)	207	$200,703,971	9.8%	5.3% - 14.3%	0.7%
Psychoses (885)	35	$155,540,712	10.0%	(2.3%) - 22.3%	0.5%
Degenerative Nervous System Disorders (056, 057)	220	$112,609,401	15.1%	7.3% - 22.9%	0.4%
Cervical Spinal Fusion (471, 472, 473)	106	$102,697,237	15.2%	4.7% - 25.8%	0.3%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes (640, 641)	95	$91,723,421	7.4%	(0.6%) - 15.3%	0.3%
Spinal Fusion Except Cervical (459, 460)	106	$84,016,687	8.1%	3.3% - 13.0%	0.3%
Kidney & Urinary Tract Infections (689, 690)	130	$80,056,269	4.7%	1.3% - 8.1%	0.3%
Major Joint/Limb Reattachment Procedure Of Upper Extremities (483)	65	$71,488,881	22.9%	11.2% - 34.6%	0.2%
Other Disorders Of Nervous System (091, 092, 093)	100	$68,650,205	11.8%	3.7% - 20.0%	0.2%
Other Vascular Procedures (252, 253, 254)	71	$65,237,584	5.5%	(0.4%) - 11.3%	0.2%
Medical Back Problems (551, 552)	48	$61,206,475	8.1%	0.8% - 15.4%	0.2%
Percutaneous Cardiovascular Procedures With Intraluminal Device (321, 322)	90	$50,996,851	4.2%	(1.7%) - 10.0%	0.2%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	137	$50,860,165	4.3%	0.7% - 8.0%	0.2%
Renal Failure (682, 683, 684)	101	$50,430,490	3.3%	(0.7%) - 7.3%	0.2%
Organic Disturbances & Intellectual Disability (884)	41	$50,061,366	12.0%	1.5% - 22.4%	0.2%
Other Kidney & Urinary Tract Diagnoses (698, 699, 700)	62	$49,194,667	3.7%	(1.5%) - 8.9%	0.2%
Other Musculoskelet Sys & Conn Tiss OR Proc (515, 516, 517)	78	$46,466,610	13.5%	2.9% - 24.0%	0.2%
Simple Pneumonia & Pleurisy (193, 194, 195)	67	$44,829,382	2.1%	(0.4%) - 4.6%	0.2%
Cardiac Arrhythmia & Conduction Disorders (308, 309, 310)	98	$42,634,999	4.0%	(0.6%) - 8.5%	0.1%
Respiratory Infections & Inflammations (177, 178, 179)	127	$40,140,446	1.6%	0.1% - 3.2%	0.1%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	121	$39,031,497	2.1%	(0.2%) - 4.4%	0.1%
Infectious & Parasitic Diseases W OR Procedure (853, 854, 855)	85	$38,496,058	0.9%	(0.3%) - 2.1%	0.1%
GI Hemorrhage (377, 378, 379)	71	$37,725,102	2.6%	(0.6%) - 5.7%	0.1%
Cardiac Defibrillator Implant (276, 277)	95	$37,416,814	15.5%	7.6% - 23.4%	0.1%
Signs & Symptoms (947, 948)	122	$32,862,762	15.4%	8.8% - 22.0%	0.1%
Aftercare, Musculoskeletal System & Connective Tissue (559, 560, 561)	347	$27,486,987	18.0%	11.5% - 24.6%	0.1%
Chest Pain (313)	33	$26,574,461	15.7%	0.6% - 30.8%	0.1%
AMI, Discharged Alive (280, 281, 282)	133	$26,570,490	1.7%	(0.2%) - 3.7%	0.1%
Pulmonary Edema & Respiratory Failure (189)	101	$26,092,506	2.1%	(0.4%) - 4.7%	0.1%
Transient Ischemia W/O Thrombolytic (069)	32	$25,823,634	12.2%	0.8% - 23.6%	0.1%
Septicemia Or Severe Sepsis W/O MV >96 Hours (871, 872)	127	$24,512,964	0.2%	(0.1%) - 0.6%	0.1%

Part A Hospital IPPS Services (MS-DRGs)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Fx, Sprn, Strn & Disl Except Femur, Hip, Pelvis & Thigh (562, 563)	42	$24,306,039	8.3%	(0.2%) - 16.8%	0.1%
Craniotomy & Endovascular Intracranial Procedures (025, 026, 027)	46	$22,782,124	1.5%	(0.6%) - 3.6%	0.1%
Major Chest Procedures (163, 164, 165)	34	$21,463,494	2.3%	(0.4%) - 5.1%	0.1%
Respiratory System Diagnosis W Ventilator Support <=96 Hours (208)	34	$21,215,572	2.4%	(0.8%) - 5.7%	0.1%
Revision Of Hip Or Knee Replacement (466, 467, 468)	54	$19,871,871	1.8%	(1.1%) - 4.8%	0.1%
Cellulitis (602, 603)	95	$19,751,225	2.8%	0.1% - 5.5%	0.1%
Lower Extrem & Humer Proc Except Hip, Foot, Femur (492, 493, 494)	31	$19,223,943	2.8%	(1.2%) - 6.8%	0.1%
Other Major Cardiovascular Procedures (270, 271, 272)	77	$17,554,537	1.5%	(0.6%) - 3.6%	0.1%
Other Digestive System Diagnoses (393, 394, 395)	66	$16,518,904	2.6%	(0.8%) - 6.1%	0.1%
Extensive OR Procedure Unrelated To Principal Diagnosis (981, 982, 983)	90	$16,334,950	1.3%	(0.3%) - 3.0%	0.1%
Back & Neck Proc Exc Spinal Fusion (518, 519, 520)	133	$14,739,900	8.2%	3.5% - 12.9%	0.0%
Circulatory Disorders Except AMI, W Card Cath (286, 287)	74	$14,177,700	1.4%	(0.5%) - 3.3%	0.0%
Major Gastrointestinal Disorders & Peritoneal Infections (371, 372, 373)	32	$13,784,029	3.7%	(2.2%) - 9.5%	0.0%
Nonspecific Cerebrovascular Disorders (070, 071, 072)	67	$13,313,608	3.2%	0.8% - 5.6%	0.0%
Bilateral Or Multiple Major Joint Procs Of Lower Extremity (461, 462)	72	$12,377,949	28.1%	17.2% - 39.0%	0.0%
Kidney & Ureter Procedures For Non-Neoplasm (659, 660, 661)	40	$12,270,851	2.6%	(1.4%) - 6.5%	0.0%
Fractures Of Hip & Pelvis (535, 536)	37	$11,119,699	5.1%	(0.6%) - 10.8%	0.0%
Other Circulatory System Diagnoses (314, 315, 316)	45	$10,195,815	1.2%	(1.2%) - 3.7%	0.0%
Lymphoma & Non-Acute Leukemia (840, 841, 842)	41	$9,745,861	3.3%	(1.5%) - 8.1%	0.0%
Cardiac Valve & Oth Maj Cardiothoracic Proc W/O Card Cath (219, 220, 221)	39	$8,994,051	0.6%	(0.6%) - 1.8%	0.0%
Cirrhosis & Alcoholic Hepatitis (432, 433, 434)	44	$7,862,120	2.1%	(2.0%) - 6.3%	0.0%
Coronary Bypass W/O Cardiac Cath (235, 236)	102	$7,693,164	0.7%	(0.1%) - 1.5%	0.0%
Red Blood Cell Disorders (811, 812)	66	$7,265,659	1.2%	(1.1%) - 3.4%	0.0%
Major Small & Large Bowel Procedures (329, 330, 331)	115	$6,706,278	0.3%	(0.3%) - 0.8%	0.0%
Cranial & Peripheral Nerve Disorders (073, 074)	34	$6,116,519	2.5%	(1.1%) - 6.2%	0.0%
Laparoscopic Cholecystectomy W/O C.D.E. (417, 418, 419)	39	$5,103,696	0.9%	(0.8%) - 2.7%	0.0%
Heart Transplant Or Implant Of Heart Assist System (001, 002)	62	$4,423,883	0.7%	(0.7%) - 2.1%	0.0%
Heart Failure & Shock (291, 292, 293)	61	$3,535,909	0.1%	(0.0%) - 0.2%	0.0%
Aftercare (949, 950)	81	$3,336,162	8.6%	2.3% - 14.8%	0.0%
Diabetes (637, 638, 639)	66	$2,798,865	0.4%	(0.2%) - 1.1%	0.0%
AICD Generator Procedures (245)	61	$2,611,319	9.1%	1.4% - 16.9%	0.0%
Coronary Bypass W Cardiac Cath (233, 234)	62	$2,017,013	0.2%	(0.2%) - 0.6%	0.0%
Other Resp System OR Procedures (166, 167, 168)	39	$1,929,197	0.3%	(0.2%) - 0.8%	0.0%
GI Obstruction (388, 389, 390)	66	$1,220,790	0.2%	(0.1%) - 0.6%	0.0%
Chronic Obstructive Pulmonary Disease (190, 191, 192)	63	$1,135,644	0.2%	(0.1%) - 0.5%	0.0%

Part A Hospital IPPS Services (MS-DRGs)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Peripheral Vascular Disorders (299, 300, 301)	52	$1,072,449	0.2%	(0.1%) - 0.6%	0.0%
ECMO Or Trach W MV >96 Hrs Or PDX Exc Face, Mouth & Neck (003)	61	$906,371	0.1%	(0.0%) - 0.1%	0.0%
Hip Replacement With Principal Diagnosis Of Hip Fracture (521, 522)	52	$341,798	0.0%	(0.0%) - 0.1%	0.0%
Alcohol/Drug Abuse Or Dependence W/O Rehabilitation Therapy (896, 897)	31	$288,908	0.1%	(0.1%) - 0.3%	0.0%
Permanent Cardiac Pacemaker Implant (242, 243, 244)	68	$59	0.0%	(0.0%) - 0.0%	0.0%
Bronchitis & Asthma (202, 203)	30	$0	0.0%	N/A	0.0%
Chimeric Antigen Receptor (Car) T-Cell Immunotherapy (018)	31	$0	0.0%	N/A	0.0%
Hip & Femur Procedures Except Major Joint (480, 481, 482)	96	$0	0.0%	N/A	0.0%
Pulmonary Embolism (175, 176)	41	$0	0.0%	N/A	0.0%
Seizures (100, 101)	48	$0	0.0%	N/A	0.0%
Traumatic Stupor & Coma, Coma <1 Hr (085, 086, 087)	35	$0	0.0%	N/A	0.0%
All Type of Services (Incl. Codes Not Listed)	**8,750**	**$4,610,744,131**	**3.9%**	**3.5% - 4.3%**	**15.5%**

Appendix H: Projected Improper Payments by Referring Provider Type for Specific Types of Service

This series of tables is sorted in descending order by projected improper payments. All estimates in these tables are based on a minimum of 30 lines in the sample. Appendix H shows the referring providers or provider types for the top three service types for Part B and DMEPOS.

Table H1: Improper Payment Rates for Lab tests - other (non-Medicare fee schedule) by Referring Provider

Lab tests - other (non-Medicare fee schedule)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
Family Practice	167	$438,128,138	46.4%	24.0% - 68.7%	32.2%
Internal Medicine	738	$297,973,046	17.1%	11.1% - 23.2%	21.9%
Nurse Practitioner	204	$142,225,353	19.3%	6.1% - 32.4%	10.5%
No Referring Provider Type	53	$82,755,505	25.9%	1.0% - 50.9%	6.1%
Urology	81	$32,387,642	18.4%	2.6% - 34.1%	2.4%
Obstetrics/Gynecology	30	$22,858,362	48.5%	27.9% - 69.2%	1.7%
Physician Assistant	94	$22,101,269	10.5%	1.3% - 19.6%	1.6%
General Surgery	84	$18,502,459	16.2%	6.7% - 25.6%	1.4%
Pathology	57	$12,384,802	26.1%	7.8% - 44.4%	0.9%
All Referring Providers	**1,716**	**$1,360,881,387**	**27.9%**	**20.1% - 35.7%**	**100.0%**

Table H2: Improper Payment Rates for Minor procedures - other (Medicare fee schedule) by Provider Type

Minor procedures - other (Medicare fee schedule)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
General Surgery	182	$272,636,963	24.0%	15.5% - 32.5%	27.5%
Internal Medicine	402	$212,284,198	15.4%	7.2% - 23.6%	21.4%
Family Practice	155	$163,965,145	21.6%	1.6% - 41.6%	16.5%
Physician Assistant	63	$64,728,210	17.8%	3.7% - 31.8%	6.5%
Nurse Practitioner	95	$62,565,706	14.0%	3.7% - 24.2%	6.3%
No Referring Provider Type	114	$27,939,640	6.8%	(1.8%) - 15.4%	2.8%
Neurology	35	$20,330,922	15.8%	(8.3%) - 39.8%	2.1%
All Referring Providers	**1,236**	**$991,373,197**	**17.6%**	**12.9% - 22.2%**	**100.0%**

Table H3: Improper Payment Rates for Office visits - established by Provider Type

Office visits - established	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
Internal Medicine	173	$156,222,924	5.7%	2.1% - 9.3%	18.3%
Orthopedic Surgery	32	$93,441,992	14.1%	1.1% - 27.1%	10.9%
Nurse Practitioner	126	$66,790,734	4.1%	1.6% - 6.5%	7.8%
All Provider Types With Less Than 30 Claims	71	$63,344,140	8.2%	2.1% - 14.2%	7.4%
Dermatology	31	$55,129,353	6.3%	(0.2%) - 12.8%	6.5%
Family Practice	149	$47,813,645	2.0%	0.8% - 3.2%	5.6%
Cardiology	67	$47,779,629	4.8%	2.0% - 7.6%	5.6%
Physician Assistant	57	$47,555,081	6.0%	0.4% - 11.6%	5.6%
Hematology/Oncology	39	$42,886,977	7.1%	(0.8%) - 14.9%	5.0%
Ophthalmology	33	$27,677,103	4.1%	0.5% - 7.8%	3.2%
Neurology	31	$24,633,781	7.7%	(1.1%) - 16.4%	2.9%
All Provider Types	**1,026**	**$853,651,814**	**5.3%**	**4.1% - 6.6%**	**100.0%**

Table H4: Improper Payment Rates for Urological Supplies by Referring Provider

Urological Supplies	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
Family Practice	141	$832,363,352	96.3%	91.6% - 101.1%	94.0%
Nurse Practitioner	43	$38,106,658	44.1%	(12.7%) - 100.9%	4.3%
Urology	187	$7,906,901	4.5%	1.6% - 7.4%	0.9%
Internal Medicine	53	$795,310	2.9%	(0.6%) - 6.4%	0.1%
All Referring Providers	**490**	**$885,848,191**	**74.1%**	**53.9% - 94.3%**	**100.0%**

Table H5: Improper Payment Rates for Surgical Dressings by Referring Provider

Surgical Dressings	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
General Surgery	107	$102,256,547	75.9%	65.8% - 86.1%	50.2%
Family Practice	123	$32,300,909	27.5%	6.8% - 48.3%	15.9%
Internal Medicine	132	$21,992,368	34.4%	21.1% - 47.6%	10.8%
Nurse Practitioner	98	$9,718,617	26.1%	6.3% - 46.0%	4.8%
Podiatry	42	$4,472,017	27.9%	7.0% - 48.8%	2.2%
Physician Assistant	32	$4,122,317	29.1%	7.4% - 50.7%	2.0%
All Referring Providers	**598**	**$203,604,968**	**47.1%**	**36.9% - 57.4%**	**100.0%**

Table H6: Improper Payment Rates for Glucose Monitor by Referring Provider

Glucose Monitor	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
Family Practice	143	$88,074,096	37.1%	15.9% - 58.4%	43.3%
Internal Medicine	415	$59,513,239	8.5%	3.7% - 13.3%	29.3%
Nurse Practitioner	139	$34,230,596	18.2%	7.2% - 29.1%	16.8%
Physician Assistant	38	$16,207,229	43.0%	7.9% - 78.2%	8.0%
All Referring Providers	**757**	**$203,362,829**	**17.3%**	**10.8% - 23.9%**	**100.0%**

Appendix I: Projected Improper Payments by Provider Type for Each Claim Type

This series of tables is sorted in descending order by projected improper payments. All estimates in these tables are based on a minimum of 30 lines in the sample.

Table I1: Improper Payment Rates and Amounts by Provider Type: Part B

Providers Billing to Part B	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Clinical Laboratory (Billing Independently)	1,638	$1,421,143,632	26.7%	19.2% - 34.2%	4.8%
Internal Medicine	866	$773,434,434	9.8%	7.5% - 12.1%	2.6%
Physical Therapist in Private Practice	510	$731,760,479	19.9%	14.6% - 25.2%	2.5%
All Provider Types With Less Than 30 Claims	664	$695,663,017	10.8%	6.3% - 15.3%	2.3%
Nurse Practitioner	835	$476,720,264	7.2%	5.3% - 9.2%	1.6%
Ambulance Service Supplier (e.g., private ambulance companies)	342	$452,598,022	10.4%	5.6% - 15.3%	1.5%
Family Practice	509	$416,972,278	7.6%	4.3% - 11.0%	1.4%
Cardiology	379	$321,213,865	8.7%	5.8% - 11.5%	1.1%
Emergency Medicine	165	$278,578,295	14.8%	10.7% - 18.9%	0.9%
Diagnostic Radiology	564	$260,830,181	5.8%	3.3% - 8.3%	0.9%
Ophthalmology	507	$253,124,779	3.2%	0.2% - 6.3%	0.9%
Ambulatory Surgical Center	331	$241,912,063	3.7%	1.7% - 5.7%	0.8%
Radiation Oncology	173	$226,228,587	15.8%	9.0% - 22.6%	0.8%
Nephrology	140	$212,471,664	16.6%	10.0% - 23.2%	0.7%
IDTF	253	$200,118,305	21.5%	0.9% - 42.0%	0.7%
Orthopedic Surgery	147	$188,626,782	6.3%	0.9% - 11.8%	0.6%
Pulmonary Disease	107	$178,790,919	14.4%	8.2% - 20.6%	0.6%
Gastroenterology	133	$178,420,590	14.6%	0.9% - 28.3%	0.6%
Physician Assistant	304	$168,069,844	3.2%	0.8% - 5.5%	0.6%
Podiatry	170	$147,685,729	5.1%	0.6% - 9.7%	0.5%
Anesthesiology	202	$147,680,721	10.8%	2.0% - 19.6%	0.5%
Chiropractic	100	$144,031,007	30.4%	18.7% - 42.2%	0.5%
Hospitalist	166	$141,000,892	13.1%	5.5% - 20.8%	0.5%
Physical Medicine and Rehabilitation	136	$120,990,931	12.4%	6.3% - 18.6%	0.4%
Hematology/Oncology	292	$113,720,869	1.7%	0.2% - 3.2%	0.4%
Dermatology	202	$103,438,232	3.4%	0.9% - 5.8%	0.3%
Neurology	130	$99,438,247	7.8%	3.4% - 12.1%	0.3%
Psychiatry	60	$97,257,705	13.3%	5.2% - 21.5%	0.3%
Urology	85	$88,264,058	8.4%	2.3% - 14.6%	0.3%
Pathology	94	$79,860,881	8.9%	2.6% - 15.2%	0.3%
General Surgery	93	$74,238,495	3.6%	0.5% - 6.7%	0.2%
Unknown Provider Type	102	$68,179,750	13.4%	4.9% - 21.9%	0.2%

Providers Billing to Part B	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Cardiac Electrophysiology	46	$65,916,057	18.1%	3.8% - 32.5%	0.2%
Interventional Cardiology	92	$65,008,140	6.7%	1.9% - 11.5%	0.2%
CRNA	85	$58,766,845	8.3%	1.6% - 15.0%	0.2%
Occupational Therapist in Private Practice	45	$54,110,911	12.8%	2.5% - 23.2%	0.2%
Rheumatology	276	$46,043,608	1.6%	0.5% - 2.8%	0.2%
Clinical Psychologist	65	$45,406,287	8.2%	(0.1%) - 16.4%	0.2%
Portable X-Ray Supplier (Billing Independently)	75	$40,065,658	15.2%	4.8% - 25.6%	0.1%
Critical Care (Intensivists)	34	$35,838,802	16.1%	5.0% - 27.2%	0.1%
Infectious Disease	60	$30,210,351	4.0%	(0.0%) - 8.1%	0.1%
Optometry	116	$27,292,221	2.3%	0.2% - 4.4%	0.1%
Clinical Social Worker	68	$24,638,769	6.3%	0.7% - 12.0%	0.1%
Endocrinology	50	$23,153,862	5.5%	0.0% - 11.0%	0.1%
Medical Oncology	58	$5,655,870	0.6%	(0.1%) - 1.3%	0.0%
Centralized Flu	54	$0	0.0%	0.0% - 0.0%	0.0%
Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)	83	$0	0.0%	0.0% - 0.0%	0.0%
Overall (Incl. Codes Not Listed)	**11,600**	**$9,624,572,895**	**8.4%**	**7.6% - 9.3%**	**32.4%**

Table I2: Improper Payment Rates and Amounts by Provider Type[18]: DMEPOS

Providers Billing to DMEPOS	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Medical supply company not included in 51, 52, or 53	4,035	$1,427,676,968	29.9%	16.6% - 43.2%	4.8%
Pharmacy	2,654	$281,745,204	11.1%	8.7% - 13.5%	0.9%
Medical supply company with orthotic personnel certified by an accrediting organization	185	$207,672,506	72.5%	54.9% - 90.1%	0.7%
Medical Supply Company with Respiratory Therapist	791	$145,653,242	17.0%	11.0% - 23.0%	0.5%
All Provider Types With Less Than 30 Claims	217	$79,903,231	44.8%	32.1% - 57.6%	0.3%
Orthopedic Surgery	179	$44,066,621	48.2%	33.9% - 62.5%	0.1%
Individual orthotic personnel certified by an accrediting organization	133	$29,664,923	19.1%	6.1% - 32.1%	0.1%
Podiatry	75	$18,150,447	54.3%	32.7% - 75.9%	0.1%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	75	$9,835,500	5.1%	(1.3%) - 11.4%	0.0%
General Practice	79	$7,757,220	18.6%	7.2% - 29.9%	0.0%
Individual prosthetic personnel certified by an accrediting organization	101	$6,594,125	3.7%	0.5% - 6.8%	0.0%
Supplier of oxygen and/or oxygen related equipment	42	$6,283,557	11.7%	(0.0%) - 23.5%	0.0%
Optometry	35	$3,864,646	46.4%	24.9% - 68.0%	0.0%
Multispecialty Clinic or Group Practice	49	$3,070,435	17.7%	1.4% - 34.0%	0.0%
Overall (Incl. Codes Not Listed)	**8,650**	**$2,271,938,624**	**24.1%**	**16.7% - 31.6%**	**7.6%**

[18] Herein, "provider" will be used to refer to both providers and suppliers in DMEPOS provider type reporting.

Table I3: Improper Payment Rates and Amounts by Provider Type: Part A Excluding Hospital IPPS

Providers Billing to Part A Excluding Hospital IPPS	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
SNF	1,765	$4,314,140,247	11.8%	9.7% - 13.8%	14.5%
OPPS, Laboratory, Ambulatory	2,439	$3,672,233,692	4.4%	1.9% - 6.9%	12.4%
Hospice	892	$1,748,569,197	6.1%	4.2% - 7.9%	5.9%
Inpatient Rehabilitation Hospitals	362	$1,128,186,705	22.2%	16.9% - 27.5%	3.8%
HHA	1,227	$1,070,619,633	6.9%	5.2% - 8.5%	3.6%
Inpatient Rehab Unit	172	$508,996,369	20.0%	11.7% - 28.3%	1.7%
CAH Outpatient Services	276	$347,021,804	3.7%	0.9% - 6.5%	1.2%
FQHC	69	$118,547,892	10.3%	3.3% - 17.3%	0.4%
Other MAC Service Types	21	$90,171,046	29.1%	(0.8%) - 58.9%	0.3%
RHC	250	$85,042,754	3.8%	1.6% - 6.1%	0.3%
All Codes With Less Than 30 Claims	85	$42,082,429	3.1%	(1.0%) - 7.2%	0.1%
ESRD	650	$26,897,943	0.3%	(0.1%) - 0.8%	0.1%
Inpatient CAH	310	$25,265,396	1.0%	0.1% - 1.8%	0.1%
ORF	58	$15,312,841	2.2%	(0.1%) - 4.5%	0.1%
CORF	75	$5,181,451	20.7%	9.9% - 31.6%	0.0%
Overall (Incl. Codes Not Listed)	**8,651**	**$13,198,269,399**	**6.7%**	**5.5% - 7.8%**	**44.4%**

Table I4: Improper Payment Rates and Amounts by Provider Type: Part A Hospital IPPS

Providers Billing to Part A Hospital IPPS	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
DRG Short Term	8,541	$4,378,880,638	3.8%	3.4% - 4.2%	14.7%
Other MAC Service Type	96	$183,688,448	11.9%	(0.4%) - 24.2%	0.6%
DRG Long Term	113	$48,175,044	2.5%	(2.0%) - 6.9%	0.2%
Overall (Incl. Codes Not Listed)	**8,750**	**$4,610,744,131**	**3.9%**	**3.5% - 4.3%**	**15.5%**

Appendix J: Improper Payment Rates and Type of Error by Provider Type for Each Claim Type

Table J1: Improper Payment Rates by Provider Type and Type of Error: Part B

Provider Types Billing to Part B	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Chiropractic	30.4%	100	6.0%	89.5%	3.0%	1.5%	0.0%
Clinical Laboratory (Billing Independently)	26.7%	1,638	19.4%	77.0%	0.8%	0.6%	2.1%
IDTF	21.5%	253	71.0%	27.0%	0.0%	0.0%	1.9%
Physical Therapist in Private Practice	19.9%	510	2.9%	88.3%	0.0%	0.0%	8.8%
Cardiac Electrophysiology	18.1%	46	41.4%	42.7%	0.0%	15.9%	0.0%
Nephrology	16.6%	140	14.4%	51.8%	0.0%	23.2%	10.7%
Critical Care (Intensivists)	16.1%	34	0.0%	48.0%	0.0%	39.9%	12.1%
Radiation Oncology	15.8%	173	9.3%	87.9%	0.0%	2.3%	0.5%
Portable X-Ray Supplier (Billing Independently)	15.2%	75	6.0%	87.6%	0.0%	0.0%	6.4%
Emergency Medicine	14.8%	165	15.0%	15.2%	0.0%	69.8%	0.0%
Gastroenterology	14.6%	133	66.3%	24.9%	0.0%	8.6%	0.2%
Pulmonary Disease	14.4%	107	8.9%	27.7%	0.0%	47.3%	16.1%
Unknown Provider Type	13.4%	102	9.8%	87.0%	0.0%	0.1%	3.1%
Psychiatry	13.3%	60	6.6%	40.6%	0.0%	52.8%	0.0%
Hospitalist	13.1%	166	12.5%	4.4%	0.0%	49.3%	33.8%
Occupational Therapist in Private Practice	12.8%	45	32.6%	47.9%	0.0%	0.0%	19.6%
Physical Medicine and Rehabilitation	12.4%	136	8.1%	53.8%	0.0%	37.5%	0.6%
Anesthesiology	10.8%	202	27.4%	68.7%	0.0%	3.8%	0.1%
All Provider Types With Less Than 30 Claims	10.8%	664	10.4%	59.7%	0.6%	20.7%	8.7%
Ambulance Service Supplier (e.g., private ambulance companies)	10.4%	342	11.5%	46.7%	24.9%	0.3%	16.6%
Internal Medicine	9.8%	866	16.0%	46.1%	0.3%	32.9%	4.6%
Pathology	8.9%	94	13.5%	86.3%	0.0%	0.0%	0.3%
Cardiology	8.7%	379	8.1%	57.9%	0.0%	30.3%	3.8%
Urology	8.4%	85	23.9%	52.5%	0.0%	16.3%	7.3%
CRNA	8.3%	85	85.8%	14.2%	0.0%	0.0%	0.0%
Clinical Psychologist	8.2%	65	0.0%	86.2%	0.0%	13.8%	0.0%
Neurology	7.8%	130	23.2%	20.4%	1.1%	54.4%	0.9%
Family Practice	7.6%	509	10.7%	68.1%	0.3%	17.5%	3.4%
Nurse Practitioner	7.2%	835	12.0%	42.9%	2.2%	38.9%	4.0%
Interventional Cardiology	6.7%	92	0.0%	38.9%	0.0%	50.9%	10.2%
Clinical Social Worker	6.3%	68	42.6%	49.6%	0.0%	7.7%	0.0%

Provider Types Billing to Part B	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Orthopedic Surgery	6.3%	147	13.4%	62.3%	0.0%	24.2%	0.0%
Diagnostic Radiology	5.8%	564	23.3%	76.6%	0.1%	0.0%	0.0%
Endocrinology	5.5%	50	35.5%	18.4%	0.0%	46.1%	0.0%
Podiatry	5.1%	170	1.7%	65.2%	0.0%	21.3%	11.8%
Infectious Disease	4.0%	60	18.0%	0.0%	0.0%	82.0%	0.0%
Ambulatory Surgical Center	3.7%	331	4.3%	70.9%	0.0%	3.3%	21.4%
General Surgery	3.6%	93	21.1%	39.1%	0.0%	39.8%	0.0%
Dermatology	3.4%	202	26.2%	34.2%	0.0%	39.6%	0.0%
Ophthalmology	3.2%	507	0.0%	67.7%	0.0%	31.2%	1.1%
Physician Assistant	3.2%	304	13.2%	50.0%	0.7%	34.3%	1.7%
Optometry	2.3%	116	0.0%	60.1%	0.0%	39.9%	0.0%
Hematology/Oncology	1.7%	292	29.2%	37.6%	0.8%	31.2%	1.2%
Rheumatology	1.6%	276	19.7%	50.1%	0.0%	19.4%	10.9%
Medical Oncology	0.6%	58	0.0%	0.2%	0.0%	78.1%	21.7%
Centralized Flu	0.0%	54	N/A	N/A	N/A	N/A	N/A
Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)	0.0%	83	N/A	N/A	N/A	N/A	N/A
All Provider Types	**8.4%**	**11,600**	**15.7%**	**58.4%**	**1.6%**	**18.8%**	**5.5%**

Table J2: Improper Payment Rates by Provider Type and Type of Error: DMEPOS

Provider Types Billing to DMEPOS	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Medical supply company with orthotic personnel certified by an accrediting organization	72.5%	185	84.0%	11.5%	1.5%	0.0%	2.9%
Podiatry	54.3%	75	0.4%	81.9%	0.6%	0.0%	17.2%
Orthopedic Surgery	48.2%	179	0.0%	83.6%	1.4%	0.0%	15.0%
Optometry	46.4%	35	0.0%	42.4%	40.3%	0.0%	17.3%
All Provider Types With Less Than 30 Claims	44.8%	217	28.8%	49.3%	2.3%	0.0%	19.7%
Medical supply company not included in 51, 52, or 53	29.9%	4,035	63.1%	25.3%	2.5%	0.2%	9.0%
Individual orthotic personnel certified by an accrediting organization	19.1%	133	0.0%	58.5%	2.7%	0.0%	38.7%
General Practice	18.6%	79	2.1%	56.3%	13.7%	3.3%	24.6%
Multispecialty Clinic or Group Practice	17.7%	49	0.0%	90.3%	9.7%	0.0%	0.0%
Medical Supply Company with Respiratory Therapist	17.0%	791	12.0%	55.6%	18.4%	0.1%	13.9%
Supplier of oxygen and/or oxygen related equipment	11.7%	42	0.0%	25.9%	21.3%	0.0%	52.8%
Pharmacy	11.1%	2,654	10.4%	53.7%	11.1%	1.0%	23.8%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	5.1%	75	16.4%	37.4%	0.0%	0.0%	46.1%
Individual prosthetic personnel certified by an accrediting organization	3.7%	101	0.0%	82.7%	10.7%	1.3%	5.3%
All Provider Types	**24.1%**	**8,650**	**50.5%**	**32.8%**	**4.6%**	**0.2%**	**11.9%**

Table J3: Improper Payment Rates by Provider Type and Type of Error: Part A Excluding Hospital IPPS

Provider Types Billing to Part A Excluding Hospital IPPS	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Other MAC Service Types	29.1%	21	0.0%	7.7%	92.3%	0.0%	0.0%
Inpatient Rehabilitation Hospitals	22.2%	362	1.7%	2.5%	95.7%	0.0%	0.0%
CORF	20.7%	75	0.0%	100.0%	0.0%	0.0%	0.0%
Inpatient Rehab Unit	20.0%	172	6.7%	13.8%	79.5%	0.0%	0.0%
SNF	11.8%	1,765	1.5%	58.0%	0.9%	3.4%	36.2%
FQHC	10.3%	69	9.9%	47.3%	0.0%	42.8%	0.0%
HHA	6.9%	1,227	11.8%	49.4%	30.4%	3.6%	4.8%
Hospice	6.1%	892	17.5%	32.7%	47.7%	1.3%	0.8%
OPPS, Laboratory, Ambulatory	4.4%	2,439	1.6%	95.9%	0.5%	1.9%	0.2%
RHC	3.8%	250	12.3%	82.0%	0.0%	0.0%	5.7%
CAH Outpatient Services	3.7%	276	1.1%	52.0%	0.8%	45.8%	0.3%
All Codes With Less Than 30 Claims	3.1%	85	0.0%	11.5%	88.5%	0.0%	0.0%
ORF	2.2%	58	18.2%	81.8%	0.0%	0.0%	0.0%
Inpatient CAH	1.0%	310	0.0%	6.4%	93.6%	0.0%	0.0%
ESRD	0.3%	650	0.0%	90.1%	0.0%	8.3%	1.6%
All Provider Types	**6.7%**	**8,651**	**4.8%**	**57.5%**	**21.6%**	**3.7%**	**12.4%**

Table J4: Improper Payment Rates by Provider Type and Type of Error: Part A Hospital IPPS

Provider Types Billing to Part A Hospital IPPS	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Other MAC Service Types	11.9%	96	4.2%	67.4%	27.5%	1.0%	0.0%
DRG Short Term	3.8%	8,541	3.6%	27.7%	49.0%	19.4%	0.2%
DRG Long Term	2.5%	113	0.2%	0.0%	0.3%	99.2%	0.4%
All Provider Types	**3.9%**	**8,750**	**3.6%**	**29.0%**	**47.6%**	**19.5%**	**0.2%**

Appendix K: Coding Information

Table K1: E&M Service Types by Improper Payments

E & M Codes	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Sbsq hosp ip/obs high 50 (99233)	$502,418,067	22.7%	18.7% - 26.7%	9.4%	17.1%	0.0%	57.7%	15.9%	1.7%
All Codes With Less Than 30 Claims	$501,001,295	25.9%	17.6% - 34.2%	21.0%	68.0%	0.6%	5.4%	5.0%	1.7%
Office o/p est mod 30 min (99214)	$459,838,842	5.0%	3.3% - 6.6%	20.7%	16.7%	0.0%	62.5%	0.0%	1.5%
Office o/p est hi 40 min (99215)	$245,231,199	14.8%	11.6% - 18.1%	21.9%	5.6%	0.0%	72.5%	0.0%	0.8%
Chrnc care mgmt staff 1st 20 (99490)	$205,392,699	65.2%	53.4% - 77.0%	12.3%	87.7%	0.0%	0.0%	0.0%	0.7%
1st hosp ip/obs high 75 (99223)	$182,122,220	13.1%	9.9% - 16.4%	12.0%	31.8%	0.0%	53.1%	3.2%	0.6%
Emergency dept visit hi mdm (99285)	$164,273,212	14.3%	9.2% - 19.3%	12.5%	0.0%	0.0%	87.5%	0.0%	0.6%
Critical care first hour (99291)	$134,136,940	15.1%	9.6% - 20.6%	18.6%	19.5%	0.0%	54.0%	7.9%	0.5%
Office o/p est low 20 min (99213)	$101,291,185	2.1%	0.2% - 4.1%	4.5%	7.1%	0.0%	88.4%	0.0%	0.3%
Office o/p new mod 45 min (99204)	$86,479,262	5.4%	2.3% - 8.4%	5.1%	0.0%	0.0%	94.9%	0.0%	0.3%
Sbsq hosp ip/obs moderate 35 (99232)	$84,115,035	4.1%	1.9% - 6.3%	9.6%	33.9%	0.0%	49.3%	7.3%	0.3%
Sbsq nf care moderate mdm 30 (99309)	$73,996,964	7.2%	1.6% - 12.9%	0.0%	47.9%	0.0%	31.8%	20.3%	0.2%
Sbsq nf care low mdm 20 (99308)	$68,643,618	11.9%	4.5% - 19.3%	18.0%	32.7%	0.0%	49.3%	0.0%	0.2%
1st hosp ip/obs moderate 55 (99222)	$62,828,050	10.3%	3.5% - 17.1%	0.0%	67.6%	0.0%	9.6%	22.8%	0.2%
Sbsq nf care high mdm 45 (99310)	$54,878,146	24.6%	17.5% - 31.6%	32.3%	6.3%	0.0%	61.4%	0.0%	0.2%
Office o/p new hi 60 min (99205)	$53,926,227	11.1%	7.5% - 14.7%	0.0%	0.0%	0.0%	100.0%	0.0%	0.2%
Advncd care plan 30 min (99497)	$46,654,452	29.8%	15.6% - 44.1%	7.2%	90.1%	0.0%	0.0%	2.7%	0.2%
1st nf care high mdm 50 (99306)	$44,249,430	25.5%	18.4% - 32.7%	13.4%	23.7%	0.0%	63.0%	0.0%	0.1%
Office o/p new low 30 min (99203)	$42,344,006	6.3%	2.2% - 10.4%	0.0%	0.0%	0.0%	100.0%	0.0%	0.1%
Sbsq hosp ip/obs sf/low 25 (99231)	$35,749,762	15.4%	5.6% - 25.3%	38.1%	7.8%	0.0%	47.6%	6.4%	0.1%
Hosp ip/obs dschrg mgmt >30 (99239)	$32,538,080	7.5%	1.6% - 13.5%	0.0%	64.9%	0.0%	35.1%	0.0%	0.1%
Phone e/m phys/qhp 21-30 min (99443)	$25,767,845	29.0%	17.6% - 40.3%	6.4%	57.0%	0.0%	6.2%	30.4%	0.1%
Home/res vst est mod mdm 40 (99349)	$21,235,597	7.0%	2.3% - 11.7%	20.9%	0.0%	0.0%	65.1%	14.0%	0.1%
Phone e/m phys/qhp 11-20 min (99442)	$15,345,013	16.9%	8.1% - 25.6%	9.2%	51.9%	0.0%	15.2%	23.8%	0.1%
Chrnc care mgmt phys 1st 30 (99491)	$11,676,724	75.4%	68.7% - 82.2%	5.0%	92.5%	0.0%	0.7%	1.8%	0.0%
Off/op est may x req phy/qhp (99211)	$8,911,824	37.1%	21.5% - 52.7%	22.4%	65.1%	0.0%	12.5%	0.0%	0.0%
Overall (E&M Codes)	**$3,265,045,695**	**10.1%**	**9.0% - 11.1%**	**12.6%**	**31.1%**	**0.0%**	**50.0%**	**6.3%**	**11.0%**

Table K2: Impact of 1-Level E&M (Top 20)[19]

Final E & M Codes	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval
Sbsq hosp ip/obs high 50 (99233)	$258,923,334	11.7%	9.7% - 13.6%
Office o/p est mod 30 min (99214)	$238,758,920	2.6%	1.8% - 3.4%
Office o/p est hi 40 min (99215)	$144,385,324	8.7%	6.9% - 10.6%
Emergency dept visit hi mdm (99285)	$130,096,685	11.3%	7.6% - 15.0%
Office o/p est low 20 min (99213)	$89,522,153	1.9%	(0.1%) - 3.8%
1st hosp ip/obs high 75 (99223)	$89,216,569	6.4%	5.1% - 7.8%
Office o/p new mod 45 min (99204)	$82,107,521	5.1%	2.1% - 8.1%
Office o/p new hi 60 min (99205)	$45,525,154	9.4%	6.2% - 12.5%
Office o/p new low 30 min (99203)	$42,344,006	6.3%	2.2% - 10.4%
Sbsq hosp ip/obs moderate 35 (99232)	$41,443,658	2.0%	0.6% - 3.5%
Sbsq nf care low mdm 20 (99308)	$27,723,137	4.8%	1.6% - 8.0%
Sbsq nf care high mdm 45 (99310)	$26,789,622	12.0%	8.3% - 15.6%
Sbsq nf care moderate mdm 30 (99309)	$23,508,660	2.3%	0.5% - 4.1%
1st nf care high mdm 50 (99306)	$22,468,692	13.0%	9.5% - 16.4%
Hosp ip/obs dschrg mgmt >30 (99239)	$11,417,294	2.6%	0.6% - 4.6%
Home/res vst est mod mdm 40 (99349)	$10,277,534	3.4%	0.7% - 6.0%
Sbsq hosp ip/obs sf/low 25 (99231)	$10,155,131	4.4%	1.7% - 7.0%
1st hosp ip/obs moderate 55 (99222)	$6,040,923	1.0%	(0.1%) - 2.1%
Phone e/m phys/qhp 11-20 min (99442)	$2,327,891	2.6%	0.1% - 5.0%
Phone e/m phys/qhp 21-30 min (99443)	$1,602,383	1.8%	0.2% - 3.4%
All Other Codes	$64,162,102	0.1%	0.0% - 0.1%
Overall (1-Level E&M Codes)	**$1,368,796,694**	**1.2%**	**1.0% - 1.4%**

[19] Table K2 shows the improper payment rate estimate for claims that were found in error due to 1-Level E&M coding difference.

Table K3: Type of Services with Upcoding[20] Errors: Part B

Part B Services (BETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval
Office visits - established	$489,704,435	3.1%	2.4% - 3.8%
Hospital visit - subsequent	$327,624,133	6.4%	5.3% - 7.6%
Office visits - new	$155,379,761	5.1%	3.3% - 7.0%
Emergency room visit	$143,764,029	9.2%	5.8% - 12.5%
Nursing home visit	$117,757,847	5.5%	3.8% - 7.2%
Hospital visit - initial	$100,677,908	4.9%	3.8% - 6.0%
Hospital visit - critical care	$72,389,339	7.6%	3.7% - 11.5%
Home visit	$58,052,799	8.5%	3.3% - 13.7%
Specialist - other	$22,956,214	0.8%	(0.3%) - 2.0%
Specialist - ophthalmology	$9,803,532	0.6%	(0.5%) - 1.6%
Minor procedures - other (Medicare fee schedule)	$9,537,080	0.2%	(0.1%) - 0.5%
Ambulatory procedures - skin	$6,740,293	0.2%	(0.1%) - 0.5%
Other drugs	$6,616,090	0.0%	(0.0%) - 0.1%
Lab tests - other (non-Medicare fee schedule)	$4,976,870	0.1%	(0.1%) - 0.3%
Specialist - psychiatry	$3,500,190	0.3%	(0.3%) - 0.9%
Ambulatory procedures - other	$3,471,232	0.3%	(0.3%) - 0.8%
Oncology - other	$2,974,595	1.1%	(0.4%) - 2.6%
Other - non-Medicare fee schedule	$2,491,135	4.5%	(1.4%) - 10.4%
Standard imaging - musculoskeletal	$1,341,188	0.3%	(0.3%) - 0.8%
Chiropractic	$1,055,349	0.2%	(0.2%) - 0.7%
All Other Codes	$4,836,822	0.0%	0.0% - 0.0%
Overall (Part B)	**$1,545,650,842**	**1.4%**	**1.2% - 1.5%**

[20] Upcoding refers to billing a higher level service or a service with a higher payment than is supported by the medical record documentation

Table K4: Type of Services with Upcoding Errors: DMEPOS

DMEPOS (Policy Group)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval
Infusion Pumps & Related Drugs	$1,628,780	0.2%	0.0% - 0.4%
Surgical Dressings	$1,364,704	0.3%	0.1% - 0.6%
Enteral Nutrition	$568,855	0.4%	(0.1%) - 0.9%
Negative Pressure Wound Therapy	$501,364	0.9%	(0.8%) - 2.5%
Urological Supplies	$221,797	0.0%	(0.0%) - 0.1%
Repairs/DMEPOS	$93,008	1.7%	(0.1%) - 3.5%
Wheelchairs Manual	$77,715	0.1%	(0.1%) - 0.2%
Oral Anti-Cancer Drugs	$77,628	0.2%	(0.2%) - 0.6%
Parenteral Nutrition	$68,392	0.0%	(0.0%) - 0.1%
Lower Limb Orthoses	$66,644	0.0%	(0.0%) - 0.1%
Breast Prostheses	$45,687	0.1%	(0.1%) - 0.4%
All Policy Groups with Less than 30 Claims	$42,698	0.0%	(0.0%) - 0.0%
CPAP	$33,160	0.0%	(0.0%) - 0.0%
Wheelchairs Options/Accessories	$5,807	0.0%	(0.0%) - 0.0%
Nebulizers & Related Drugs	$2,241	0.0%	(0.0%) - 0.0%
Overall (DMEPOS)	**$4,798,480**	**0.1%**	**0.0% - 0.1%**

Table K5: Type of Services with Upcoding Errors: Part A Excluding Hospital IPPS

Part A Excluding Hospital IPPS Services (TOB)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval
SNF Inpatient	$110,358,266	0.3%	0.1% - 0.6%
CAH	$52,953,956	0.6%	(0.3%) - 1.4%
FQHC	$50,744,327	4.4%	(1.1%) - 9.9%
Hospital Outpatient	$41,562,296	0.1%	0.0% - 0.1%
SNF Inpatient Part B	$32,655,930	1.1%	(1.1%) - 3.3%
Home Health	$32,484,943	0.2%	0.0% - 0.4%
Hospital Other Part B	$2,001,540	0.5%	(0.4%) - 1.3%
Nonhospital based hospice	$1,353,038	0.0%	(0.0%) - 0.0%
Clinic ESRD	$506,826	0.0%	(0.0%) - 0.0%
Hospital based hospice	$289,784	0.0%	(0.0%) - 0.0%
Overall (Part A Excluding Hospital IPPS)	**$324,910,906**	**0.2%**	**0.1% - 0.2%**

Table K6: Type of Services with Upcoding Errors: Part A Hospital IPPS

Part A Hospital IPPS Services (MS-DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval
Infectious & Parasitic Diseases W OR Procedure (853, 854, 855)	$38,496,058	0.9%	(0.3%) - 2.1%
Craniotomy & Endovascular Intracranial Procedures (025, 026, 027)	$22,637,459	1.5%	(0.6%) - 3.6%
Respiratory System Diagnosis W Ventilator Support <=96 Hours (208)	$21,215,572	2.4%	(0.8%) - 5.7%
GI Hemorrhage (377, 378, 379)	$21,118,558	1.4%	(0.9%) - 3.8%
Renal Failure (682, 683, 684)	$20,529,959	1.3%	(0.1%) - 2.8%
Medical Back Problems (551, 552)	$16,619,649	2.2%	(2.1%) - 6.5%
Simple Pneumonia & Pleurisy (193, 194, 195)	$16,316,560	0.8%	(0.7%) - 2.3%
Extensive OR Procedure Unrelated To Principal Diagnosis (981, 982, 983)	$13,930,575	1.1%	(0.5%) - 2.7%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes (640, 641)	$11,825,860	0.9%	(0.4%) - 2.3%
Cellulitis (602, 603)	$8,700,292	1.2%	(0.5%) - 2.9%
Kidney & Urinary Tract Infections (689, 690)	$8,678,722	0.5%	(0.0%) - 1.1%
Degenerative Nervous System Disorders (056, 057)	$7,544,264	1.0%	0.2% - 1.9%
Lower Extrem & Humer Proc Except Hip, Foot, Femur (492, 493, 494)	$7,208,097	1.1%	(1.0%) - 3.1%
Lymphoma & Non-Acute Leukemia (840, 841, 842)	$7,050,100	2.4%	(2.1%) - 6.9%
Other Major Cardiovascular Procedures (270, 271, 272)	$6,260,163	0.5%	(0.3%) - 1.4%
AMI, Discharged Alive (280, 281, 282)	$5,934,434	0.4%	(0.1%) - 0.8%
Septicemia Or Severe Sepsis W/O MV >96 Hours (871, 872)	$5,255,051	0.1%	(0.0%) - 0.1%
Laparoscopic Cholecystectomy W/O C.D.E. (417, 418, 419)	$5,103,696	0.9%	(0.8%) - 2.7%
Respiratory Infections & Inflammations (177, 178, 179)	$4,959,598	0.2%	(0.1%) - 0.5%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	$4,786,894	0.3%	(0.2%) - 0.8%
All Other Codes	$182,052,660	0.2%	0.1% - 0.3%
Overall (Part A Hospital IPPS)	**$436,224,220**	**0.4%**	**0.3% - 0.5%**

Appendix L: Overpayments

Tables L1 through L4 provide the service-specific overpayment rates for each claim type. The tables are sorted in descending order by projected improper payments.

Table L1: Top 20 Service-Specific Overpayment Rates: Part B

Part B Services (HCPCS Codes)	Claims Reviewed	Lines Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	5,242	11,421	$361,023	$3,231,392	$3,683,116,444	6.6%	5.1% - 8.0%
Sbsq hosp ip/obs high 50 (99233)	334	463	$11,077	$50,585	$490,503,977	22.1%	18.2% - 26.1%
Office o/p est mod 30 min (99214)	450	451	$2,612	$50,515	$459,838,842	5.0%	3.3% - 6.6%
Therapeutic exercises (97110)	214	220	$1,947	$7,554	$286,653,227	25.2%	17.9% - 32.5%
Office o/p est hi 40 min (99215)	226	226	$5,536	$36,587	$245,231,199	14.8%	11.6% - 18.1%
Chrnc care mgmt staff 1st 20 (99490)	68	68	$2,662	$3,965	$205,392,699	65.2%	53.4% - 77.0%
1st hosp ip/obs high 75 (99223)	282	284	$5,782	$44,678	$182,122,220	13.1%	9.9% - 16.4%
Therapeutic activities (97530)	245	250	$2,699	$12,057	$179,101,995	18.1%	12.5% - 23.8%
Emergency dept visit hi mdm (99285)	70	70	$1,534	$11,040	$164,273,212	14.3%	9.2% - 19.3%
ALS1-emergency (A0427)	68	68	$3,307	$32,905	$156,804,531	10.4%	2.5% - 18.2%
Ppps, subseq visit (G0439)	194	194	$3,833	$22,330	$152,839,912	13.6%	7.8% - 19.3%
Manual therapy 1/> regions (97140)	223	230	$1,959	$5,980	$145,990,543	30.5%	22.7% - 38.2%
Critical care first hour (99291)	156	171	$4,674	$32,520	$134,136,940	15.1%	9.6% - 20.6%
Neuromuscular reeducation (97112)	280	285	$2,557	$11,741	$122,509,052	17.3%	11.5% - 23.2%
Unlisted molecular pathology (81479)	367	377	$169,537	$640,836	$114,983,372	26.0%	20.0% - 32.0%
BLS-emergency (A0429)	68	68	$3,234	$26,993	$107,645,005	12.2%	3.7% - 20.8%
Xcapsl ctrc rmvl w/o ecp (66984)	211	213	$8,419	$144,073	$92,578,007	5.6%	2.1% - 9.1%
Ground mileage (A0425)	204	207	$2,202	$17,971	$90,703,075	12.4%	0.4% - 24.4%
BLS (A0428)	131	138	$4,578	$26,844	$89,122,101	12.8%	4.4% - 21.2%
Office o/p new mod 45 min (99204)	69	69	$805	$10,383	$86,479,262	5.4%	2.3% - 8.4%
All Other Codes	6,777	9,510	$1,215,623	$14,626,168	$2,132,202,537	7.3%	6.5% - 8.1%
Total (Part B)	**11,600**	**24,983**	**$1,815,598**	**$19,047,116**	**$9,322,228,153**	**8.2%**	**7.3% - 9.0%**

Table L2: Top 20 Service-Specific Overpayment Rates: DMEPOS

DMEPOS (HCPCS)	Claims Reviewed	Lines Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
Intermittent urinary cath (A4353)	44	140	$54,634	$58,352	$851,491,178	96.0%	89.3% - 102.7%
All Codes With Less Than 30 Claims	2,852	5,756	$299,811	$3,333,059	$338,136,474	15.7%	12.1% - 19.2%
Non-adju cgm supply allow (A4239)	260	277	$15,565	$91,128	$178,457,559	16.6%	9.6% - 23.6%
Collagen dressing >48 sq in (A6023)	68	88	$291,211	$414,165	$87,163,818	65.0%	40.9% - 89.0%
Oxygen concentrator (E1390)	247	247	$3,441	$26,985	$61,647,459	12.3%	7.7% - 17.0%
Ko double upright prefab ots (L1852)	79	112	$47,781	$61,870	$53,988,737	84.1%	74.1% - 94.2%
Home vent non-invasive inter (E0466)	337	349	$45,514	$382,921	$49,296,838	11.6%	8.0% - 15.1%
Collagen based wound filler (A6010)	58	64	$86,702	$136,056	$35,790,653	44.8%	30.3% - 59.3%
Collagen dressing <=16 sq in (A6021)	215	242	$97,993	$206,732	$31,987,264	47.8%	37.6% - 58.0%
Replacement nasal cushion (A7032)	75	75	$1,771	$9,084	$23,909,777	20.3%	6.6% - 33.9%
Who nontorsion jnts pre ots (L3916)	48	82	$23,906	$37,121	$23,378,915	62.9%	47.5% - 78.3%
Straight tip urine catheter (A4351)	41	58	$3,049	$13,267	$19,505,543	18.9%	(1.2%) - 39.1%
Replacement facemask interfa (A7031)	184	187	$2,845	$19,317	$19,289,084	11.5%	6.1% - 16.9%
CPAP full face mask (A7030)	114	114	$1,443	$13,150	$18,025,008	10.5%	4.6% - 16.4%
Nasal application device (A7034)	83	83	$750	$5,954	$17,433,071	13.6%	4.8% - 22.4%
LSO sc r ant/pos pnl pre cst (L0637)	47	47	$31,573	$58,197	$16,257,131	56.0%	40.9% - 71.1%
Diab shoe for density insert (A5500)	42	83	$3,218	$6,598	$15,798,850	51.9%	35.8% - 68.1%
Parenteral sol 74-100 gm pro (B4197)	145	184	$33,578	$250,056	$15,244,664	16.8%	4.7% - 28.9%
Blood glucose/reagent strips (A4253)	45	45	$269	$843	$13,912,392	30.4%	15.6% - 45.2%
Parenteral sol 52-73 gm prot (B4193)	46	63	$21,626	$70,221	$13,377,519	30.6%	14.5% - 46.7%
All Other Codes	6,339	11,051	$871,919	$5,356,112	$382,655,443	12.5%	11.2% - 13.8%
Total (DMEPOS)	**8,650**	**19,347**	**$1,938,599**	**$10,551,188**	**$2,266,747,377**	**24.1%**	**16.6% - 31.5%**

Table L3: Service-Specific Overpayment Rates: Part A Excluding Hospital IPPS

Part A Excluding Hospital IPPS Services (TOB)	Claims Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
SNF Inpatient	1,624	$2,477,218	$14,610,966	$4,020,917,394	12.0%	10.0% - 14.0%
Hospital Outpatient	2,285	$155,473	$3,260,431	$3,587,154,551	4.5%	1.9% - 7.1%
Hospital Inpatient (Part A)	950	$3,295,866	$19,073,654	$1,794,701,945	15.1%	11.9% - 18.4%
Nonhospital based hospice	749	$200,075	$3,184,088	$1,591,774,663	5.8%	3.9% - 7.7%
Home Health	1,224	$215,326	$2,240,669	$1,064,625,953	6.8%	5.2% - 8.5%
SNF Inpatient Part B	94	$7,475	$78,654	$245,957,937	8.5%	(1.5%) - 18.5%
CAH	276	$5,627	$213,691	$240,951,742	2.6%	0.7% - 4.5%
Hospital based hospice	143	$48,660	$513,053	$135,392,734	9.3%	4.3% - 14.4%
FQHC	69	$1,093	$10,177	$118,547,892	10.3%	3.3% - 17.3%
Clinical Rural Health	250	$2,056	$50,821	$85,042,754	3.8%	1.6% - 6.1%
Hospital Other Part B	101	$364	$4,072	$44,407,467	10.0%	2.5% - 17.5%
SNF Outpatient	47	$2,933	$30,007	$26,051,593	9.0%	0.4% - 17.6%
Clinic ESRD	650	$5,879	$2,063,638	$25,168,013	0.3%	(0.2%) - 0.7%
Clinic OPT	58	$382	$14,684	$15,312,841	2.2%	(0.1%) - 4.5%
Hospital Inpatient Part B	50	$1,106	$113,310	$15,080,641	1.4%	(0.7%) - 3.4%
Clinic CORF	75	$3,286	$13,779	$5,181,451	20.7%	9.9% - 31.6%
All Other Codes	6	$0	$41,878	$0	0.0%	0.0% - 0.0%
Total (Part A Excluding Hospital IPPS)	**8,651**	**$6,422,821**	**$45,517,571**	**$13,016,269,570**	**6.6%**	**5.4% - 7.7%**

Table L4: Top 20 Service-Specific Overpayment Rates: Part A Hospital IPPS

Part A Inpatient Hospital PPS Services (DRG)	Claims Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	2,593	$1,128,563	$46,560,507	$1,208,309,714	2.0%	1.5% - 2.5%
Percutaneous Intracardiac Procedures W/O MCC (274)	299	$3,065,908	$7,225,447	$620,934,668	41.8%	35.6% - 47.9%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity W/O MCC (470)	397	$2,249,857	$5,565,690	$455,646,291	37.6%	31.3% - 43.8%
Endovascular Cardiac Valve Replacement & Supplement Procedures W/O MCC (267)	222	$918,355	$8,629,159	$162,992,913	10.0%	6.2% - 13.9%
Psychoses (885)	35	$41,377	$329,541	$155,540,712	10.0%	(2.3%) - 22.3%
Combined Anterior/Posterior Spinal Fusion W CC (454)	56	$310,919	$2,645,380	$105,526,283	10.8%	3.0% - 18.6%
Endovascular Cardiac Valve Replacement & Supplement Procedures W MCC (266)	116	$381,921	$5,626,544	$87,423,478	7.0%	2.6% - 11.5%
Combined Anterior/Posterior Spinal Fusion W/O CC/MCC (455)	83	$359,028	$2,714,035	$83,919,761	12.0%	5.0% - 19.0%
Cervical Spinal Fusion W CC (472)	35	$119,481	$805,928	$77,531,770	17.2%	2.4% - 31.9%
Spinal Fusion Except Cervical W/O MCC (460)	104	$267,167	$2,877,380	$73,276,689	9.0%	3.8% - 14.3%
Major Joint/Limb Reattachment Procedure Of Upper Extremities (483)	65	$245,441	$1,045,577	$71,247,784	22.8%	11.1% - 34.5%
Medical Back Problems W/O MCC (552)	36	$35,896	$321,267	$56,370,893	10.5%	0.5% - 20.4%
Degenerative Nervous System Disorders W/O MCC (057)	188	$276,379	$2,193,255	$54,511,758	12.0%	7.1% - 16.9%
Organic Disturbances & Intellectual Disability (884)	41	$52,153	$423,837	$50,061,366	12.0%	1.5% - 22.4%
Degenerative Nervous System Disorders W MCC (056)	32	$99,159	$532,188	$49,640,930	17.0%	(0.8%) - 34.8%
Renal Failure W MCC (682)	57	$27,140	$628,122	$42,371,591	4.5%	(1.7%) - 10.7%
Other Vascular Procedures W CC (253)	32	$67,260	$643,964	$36,774,326	11.5%	(1.4%) - 24.4%
Esophagitis, Gastroent & Misc Digest Disorders W/O MCC (392)	102	$30,889	$634,451	$34,982,203	5.0%	0.1% - 9.8%
Percutaneous Cardiovascular Procedures With Intraluminal Device W/O MCC (322)	43	$22,445	$578,389	$33,020,210	5.5%	(4.8%) - 15.8%
Kidney & Urinary Tract Infections W/O MCC (690)	33	$9,553	$199,539	$31,437,487	4.7%	(1.8%) - 11.2%
All Other Codes	4,181	$4,467,484	$116,440,622	$651,876,573	1.5%	1.2% - 1.8%
Total (Part A Hospital IPPS)	**8,750**	**$14,176,377**	**$206,620,821**	**$4,143,397,401**	**3.5%**	**3.1% - 3.9%**

Table L5: Overpayment Rate: All Claim Types

All Services	Claims Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
All	**37,651**	**$24,353,395**	**$281,736,696**	**$28,748,642,501**	**6.5%**	**5.9% - 7.1%**

Appendix M: Underpayments

The following tables provide the service-specific underpayment rates for each claim type. The tables are sorted in descending order by projected dollars underpaid. All estimates in these tables are based on a minimum of 30 claims in the sample with at least one claim underpaid.

Table M1: Service-Specific Underpayment Rates: Part B

Part B Services (HCPCS Codes)	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	5,242	11,421	$6,656	$3,231,392	$130,475,218	0.2%	0.1% - 0.4%
Office o/p est low 20 min (99213)	188	188	$150	$15,697	$65,124,855	1.4%	(0.4%) - 3.1%
Office o/p new low 30 min (99203)	73	73	$187	$6,633	$22,997,994	3.4%	0.1% - 6.8%
Sbsq hosp ip/obs sf/low 25 (99231)	80	139	$349	$6,140	$17,018,772	7.3%	1.3% - 13.3%
Sbsq nf care low mdm 20 (99308)	72	72	$136	$4,480	$16,865,899	2.9%	0.4% - 5.4%
Inj, faricimab-svoa, 0.1mg (J2777)	69	74	$2,158	$167,932	$13,073,694	1.3%	(1.3%) - 3.8%
Sbsq hosp ip/obs high 50 (99233)	334	463	$246	$50,585	$11,914,090	0.5%	(0.5%) - 1.6%
Psytx w pt 45 minutes (90834)	66	77	$161	$6,638	$4,653,103	2.1%	0.0% - 4.2%
Sbsq hosp ip/obs moderate 35 (99232)	227	363	$40	$25,100	$4,599,698	0.2%	(0.2%) - 0.7%
Inj. teprotumumab-trbw 10 mg (J3241)	63	114	$78,720	$2,839,347	$3,235,783	2.1%	(0.7%) - 4.9%
Zenith amniotic membrane psc (Q4253)	60	63	$20,878	$948,670	$2,407,706	3.5%	(3.2%) - 10.1%
1st hosp ip/obs moderate 55 (99222)	85	85	$42	$9,906	$2,041,357	0.3%	(0.3%) - 1.0%
Unlisted molecular pathology (81479)	367	377	$3,101	$640,836	$1,846,479	0.4%	(0.4%) - 1.2%
Phone e/m phys/qhp 11-20 min (99442)	70	70	$111	$5,504	$1,797,739	2.0%	(0.2%) - 4.2%
Implant neuroelectrodes (63650)	165	251	$5,276	$541,026	$1,232,928	0.6%	(0.4%) - 1.6%
Off/op est may x req phy/qhp (99211)	74	76	$56	$1,356	$1,115,444	4.6%	(4.4%) - 13.7%
Chiropract manj 3-4 regions (98941)	78	89	$11	$3,030	$1,104,396	0.3%	(0.3%) - 0.9%
Ground mileage (A0425)	204	207	$17	$17,971	$749,468	0.1%	(0.0%) - 0.2%
Rem ther mntr ea addl 20 min (98981)	66	68	$73	$3,437	$52,245	2.7%	(1.2%) - 6.6%
Kerecis omega3, per sq cm (Q4158)	64	75	$430	$356,572	$37,874	0.1%	(0.1%) - 0.4%
All Other Codes	7,716	10,638	$0	$10,164,864	$0	0.0%	0.0% - 0.0%
Total (Part B)	**11,600**	**24,983**	**$118,797**	**$19,047,116**	**$302,344,742**	**0.3%**	**0.1% - 0.4%**

Table M2: Service-Specific Underpayment Rates: DMEPOS

DMEPOS (HCPCS)	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
Non-adju cgm supply allow (A4239)	260	277	$262	$91,128	$2,992,413	0.3%	(0.3%) - 0.8%
Ko single upright pre cst (L1843)	81	102	$2,123	$86,589	$454,742	2.5%	(2.5%) - 7.5%
Mycophenolic acid (J7518)	50	51	$100	$4,601	$431,992	2.5%	(1.1%) - 6.2%
Sgd w multi methods msg/accs (E2510)	47	47	$9,235	$175,096	$426,756	4.1%	(4.2%) - 12.4%
Alginate dressing <=16 sq in (A6196)	124	131	$180	$37,723	$306,676	0.8%	(0.7%) - 2.3%
All Codes With Less Than 30 Claims	2,852	5,756	$177	$3,333,059	$191,045	0.0%	(0.0%) - 0.0%
Foam drg <=16 sq in w/border (A6212)	100	104	$95	$15,267	$161,745	1.1%	(1.1%) - 3.3%
Budesonide non-comp unit (J7626)	110	113	$36	$6,328	$96,911	0.4%	(0.4%) - 1.3%
Suspension sleeve lower ext (L2397)	106	156	$258	$18,309	$55,244	0.4%	(0.4%) - 1.1%
Mycophenolate mofetil oral (J7517)	52	53	$12	$1,372	$49,840	0.8%	(0.8%) - 2.5%
Adhesive remover, wipes (A4456)	50	52	$17	$1,046	$21,961	0.8%	(0.7%) - 2.3%
Waterproof tape (A4452)	69	69	$1	$2,458	$1,784	0.0%	(0.0%) - 0.1%
Albuterol non-comp unit (J7613)	71	71	$0	$487	$139	0.0%	(0.0%) - 0.0%
All Other Codes	6,987	12,365	$0	$6,777,725	$0	0.0%	0.0% - 0.0%
Total (DMEPOS)	**8,650**	**19,347**	**$12,495**	**$10,551,188**	**$5,191,248**	**0.1%**	**(0.0%) - 0.1%**

Table M3: Service-Specific Underpayment Rates: Part A Excluding Hospital IPPS

Part A Excluding Hospital IPPS Services (TOB)	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
CAH	276	276	$2,257	$213,691	$106,070,062	1.1%	(0.9%) - 3.2%
Hospital Outpatient	2,285	2,285	$927	$3,260,431	$25,382,413	0.0%	(0.0%) - 0.1%
Nonhospital based hospice	749	749	$2,574	$3,184,088	$21,401,800	0.1%	(0.1%) - 0.2%
SNF Inpatient	1,624	1,624	$9,220	$14,610,966	$21,107,833	0.1%	(0.0%) - 0.2%
Home Health	1,224	1,224	$2,150	$2,240,669	$5,993,679	0.0%	0.0% - 0.1%
Clinic ESRD	650	650	$426	$2,063,638	$1,729,931	0.0%	(0.0%) - 0.1%
Hospital Other Part B	101	101	$2	$4,072	$208,621	0.0%	(0.0%) - 0.1%
SNF Inpatient Part B	94	94	$3	$78,654	$105,490	0.0%	(0.0%) - 0.0%
All Other Codes	1,648	1,648	$0	$19,861,363	$0	0.0%	0.0% - 0.0%
Total (Part A Excluding Hospital IPPS)	**8,651**	**8,651**	**$17,558**	**$45,517,571**	**$181,999,829**	**0.1%**	**(0.0%) - 0.2%**

Table M4: Service-Specific Underpayment Rates: Part A Hospital IPPS

Part A Hospital IPPS Services (DRG)	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	2,593	2,593	$174,592	$46,560,507	$183,969,433	0.3%	0.1% - 0.5%
Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes W MCC (640)	69	69	$33,570	$798,014	$46,593,782	5.3%	(4.4%) - 15.0%
Intracranial Hemorrhage Or Cerebral Infarction W CC Or TPA In 24 Hrs (065)	35	35	$14,319	$257,468	$34,244,603	5.4%	(1.0%) - 11.8%
Simple Pneumonia & Pleurisy W MCC (193)	31	31	$4,893	$336,357	$21,510,992	1.3%	(1.2%) - 3.7%
Septicemia Or Severe Sepsis W/O MV >96 Hours W/O MCC (872)	98	98	$13,258	$909,036	$19,257,913	1.8%	(0.9%) - 4.5%
Percutaneous Cardiovascular Procedures With Intraluminal Device W/O MCC (322)	43	43	$22,074	$578,389	$17,957,235	3.0%	(2.8%) - 8.8%
GI Hemorrhage W CC (378)	35	35	$6,983	$276,016	$16,606,544	2.7%	(2.5%) - 7.9%
Cardiac Arrhythmia & Conduction Disorders W CC (309)	33	33	$2,856	$192,257	$11,167,349	2.3%	(2.1%) - 6.6%
Kidney & Urinary Tract Infections W/O MCC (690)	33	33	$3,557	$199,539	$11,098,725	1.7%	(1.5%) - 4.9%
Spinal Fusion Except Cervical W/O MCC (460)	104	104	$36,637	$2,877,380	$10,739,998	1.3%	(0.0%) - 2.7%
Kidney & Urinary Tract Infections W MCC (689)	97	97	$5,634	$917,927	$7,823,280	0.7%	(0.7%) - 2.2%
AMI, Discharged Alive W CC (281)	37	37	$6,225	$280,308	$7,252,770	2.3%	(2.2%) - 6.9%
Simple Pneumonia & Pleurisy W CC (194)	32	32	$3,739	$197,947	$7,001,831	1.8%	(1.6%) - 5.2%
Degenerative Nervous System Disorders W MCC (056)	32	32	$15,002	$532,188	$6,953,113	2.4%	(1.6%) - 6.4%
Circulatory Disorders Except AMI, W Card Cath W/O MCC (287)	33	33	$8,172	$246,925	$6,887,509	2.7%	(2.5%) - 7.9%
Major Small & Large Bowel Procedures W CC (330)	39	39	$4,473	$717,408	$6,476,360	0.8%	(0.7%) - 2.3%
Other Kidney & Urinary Tract Diagnoses W CC (699)	31	31	$4,136	$269,850	$5,340,058	1.6%	(1.5%) - 4.8%
Medical Back Problems W/O MCC (552)	36	36	$2,990	$321,267	$4,835,582	0.9%	(0.8%) - 2.6%
Endovascular Cardiac Valve Replacement & Supplement Procedures W/O MCC (267)	222	222	$23,850	$8,629,159	$4,447,071	0.3%	(0.1%) - 0.6%
Combined Anterior/Posterior Spinal Fusion W/O CC/MCC (455)	83	83	$16,529	$2,714,035	$3,610,005	0.5%	(0.5%) - 1.5%
All Other Codes	5,034	5,034	$190,120	$138,808,845	$33,572,578	0.1%	0.0% - 0.1%
Total (Part A Hospital IPPS)	**8,750**	**8,750**	**$593,608**	**$206,620,821**	**$467,346,730**	**0.4%**	**0.3% - 0.5%**

Table M5: Underpayment Rate: All Claim Types

All Services	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
All	**37,651**	**61,731**	**$742,459**	**$281,736,696**	**$956,882,548**	**0.2%**	**0.2% - 0.3%**

Appendix N: Statistics and Other Information for the CERT Sample

Summary of Sampling and Estimation Methodology for the CERT Program

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

The sampling process for CERT follows a service level stratification plan. This system allots approximately 100 service level strata per claim type, except for Part A Excluding Hospital IPPS, for which service level stratification is not possible. For this case, strata were designated by a two-digit type of bill, which results in fewer than 20 strata. This stratification system, by design, leads to greater sample sizes for the larger Medicare Administrative Contractors (MACs). Thus, the precision is greater for larger MAC jurisdictions.

Enhanced Stratification

In addition, CERT uses sub-strata for strata that represent high total payments as well as exhibit heterogeneity in improper payment rate by provider. These strata include Home Health, Inpatient Rehab Facility, Skilled Nursing Facility, DRGs 469 and 470, and Hospice. Sub-strata consist of two or more strata contained within a service level stratum and are defined by provider profile scores. Additionally, the CERT Hospital Outpatient and Part B Other strata have been divided into high and low payment strata to sample the larger payment claims more effectively, while ensuring a specific level of lower payment claims. These sub-strata have been developed with CMS collaboration to increase CERT's ability to adequately sample not just services, but also providers who are more likely to have improper billing.

For RY2025, the following strata contain sub-strata:

- Home Health
- Hospital Outpatient
- Inpatient Rehab Facility
- Skilled Nursing Facility
- DRGs 469 and 470
- Hospice
- Part B Other

Improper Payment Rate Formula

Sampled claims are subject to reviews, and an improper payment rate is calculated based on those reviews. The improper payment rate is an estimate of the proportion of improper payments made in the Medicare program to the total payments made.

After the claims have been reviewed for improper payments, the sample is projected to the universe statistically using a combination of sampling weights and universe expenditure amounts. CERT utilizes a generalized estimator to handle national, contractor cluster, and service level estimation. National level estimation reduces to a better-known estimator known as the separate ratio estimator. Using the separate ratio estimator, improper payment rates for contractor clusters are combined using their relative share of universe expenditures as weights.

Generalized ("Hybrid") Ratio Estimator

For CERT estimation, the Medicare universe can be partitioned by different groups. The groups relevant for developing the CERT estimator are defined as follows:

partition = group by which payment information is available (denoted by subscript 'i')
strata = sampling group (denoted by subscript 'k')
domain = area of interest within the universe (denoted by superscript 'd')

A partition is defined by the contractor cluster level payment amounts.[21] Strata are defined by service categorization and sampling month. Domains are areas that CERT focuses analysis on (e.g., motorized wheelchairs). Note for national level estimation, the domain, d, is the entire universe.

The estimator for a domain, d, is expressed as

$$\hat{R}^{d}_{HybridEstimator} = \frac{\hat{t}_e^{*d}}{\hat{t}_p^{*d}} = \frac{\sum_i \hat{t}_e^{*di}}{\sum_i \hat{t}_p^{*di}} = \frac{\sum_i \frac{\hat{t}_e^{di}}{\hat{t}_p^{i}} t_p^{*i}}{\sum_i \frac{\hat{t}_p^{di}}{\hat{t}_p^{i}} t_p^{*i}}$$

where,

$\hat{t}_e^{*d}$ = projected improper payment for the domain, d.

$\hat{t}_p^{*d}$ = projected payment for the domain, d.

t_p^{*i} = known payment for partition 'i'

$\hat{t}_p^{i}$ = projected payment for partition 'i'.

$\hat{t}_e^{di}$ = projected error for domain 'd' in partition 'i'.

$\hat{t}_p^{di}$ = projected payment for domain 'd' in partition 'i'.

Now, the projected error and payment for domain 'd' within partition 'i' can be computed using the following formulas:

$$\hat{t}_e^{di} = \sum_{k=1}^{a} \frac{N_k}{n_k} \sum_{j=1}^{n_k^{di}} e_{kj} = \sum_{k=1}^{a} W_k \sum_{j=1}^{n_k^{di}} e_{kj}$$

$$\hat{t}_p^{di} = \sum_{k=1}^{a} \frac{N_k}{n_k} \sum_{j=1}^{n_k^{di}} p_{kj} = \sum_{k=1}^{a} W_k \sum_{j=1}^{n_k^{di}} p_{kj}$$

where,

N_k = total number of claims in the universe for strata 'k'

n_k = total number of sampled claims for strata 'k'

[21] An A/B MAC consists of two contractor clusters. Each cluster represents their respective Part A and Part B claims. Expenditures (payments) are reported to CERT by contractor cluster. DMEPOS MACs are composed of a single cluster.

The following tables provide information on the sample size for each category for which this report makes national estimates. These tables also show the number of claims containing errors and the percent of claims with payment errors. Data in these tables for Part B and DMEPOS data is expressed in terms of line items, and data in these tables for Part A data is expressed in terms of claims. Totals cannot be calculated for these categories since CMS uses different units for each type of service.

Table N1: Lines in Error: Part B

Variable	Lines Reviewed	Lines Containing Errors	Percent of Lines Containing Errors
HCPCS			
1st hosp ip/obs high 75 (99223)	284	86	30.3%
All Codes With Less Than 30 Claims	11,421	1,804	15.8%
Implant neuroelectrodes (63650)	251	37	14.7%
Neuromuscular reeducation (97112)	285	62	21.8%
Office o/p est mod 30 min (99214)	451	51	11.3%
Routine venipuncture (36415)	330	29	8.8%
Sbsq hosp ip/obs high 50 (99233)	461	200	43.4%
Sbsq hosp ip/obs moderate 35 (99232)	357	34	9.5%
Therapeutic activities (97530)	250	53	21.2%
Unlisted molecular pathology (81479)	377	70	18.6%
Other	10,507	1,797	17.1%
TOS Code			
All Codes With Less Than 30 Claims	1,262	119	9.4%
Ambulatory procedures - other	714	268	37.5%
Hospital visit - subsequent	1,066	270	25.3%
Lab tests - other (non-Medicare fee schedule)	4,394	1,214	27.6%
Major procedure - Other	669	74	11.1%
Minor procedures - other (Medicare fee schedule)	2,082	345	16.6%
Office visits - established	1,040	182	17.5%
Other drugs	1,894	226	11.9%
Specialist - other	1,112	312	28.1%
Undefined codes	772	21	2.7%
Other	9,969	1,192	12.0%
Resolution Type[22]			
Automated	6,044	438	7.2%
Complex	8	0	0.0%
None	18,900	3,779	20.0%
Routine	22	6	27.3%
Diagnosis Code			
All Codes With Less Than 30 Claims	1,854	241	13.0%
Diabetes mellitus	653	102	15.6%
Disorders of choroid and retina	706	17	2.4%

[22] Created using the type of review a line received based upon the resolution code that the contractor used to resolve the line.

Variable	Lines Reviewed	Lines Containing Errors	Percent of Lines Containing Errors
Hypertensive diseases	720	239	33.2%
Inflammatory polyarthropathies	642	126	19.6%
Other dorsopathies	783	156	19.9%
Other forms of heart disease	668	104	15.6%
Persons encountering health services for examinations	828	93	11.2%
Persons with potential health hazards related to family and personal history and certain conditions	992	216	21.8%
Symptoms and signs involving the circulatory and respiratory systems	623	97	15.6%
Other	16,505	2,832	17.2%

Table N2: Lines in Error: DMEPOS

Variable	Lines Reviewed	Lines Containing Errors	Percent of Lines Containing Errors
Service			
All Codes With Less Than 30 Claims	5,756	1,017	17.7%
Coude tip urinary catheter (A4352)	471	194	41.2%
Disp fee inhal drugs/30 days (Q0513)	248	20	8.1%
Home vent non-invasive inter (E0466)	349	37	10.6%
Nebulizer with compression (E0570)	297	17	5.7%
Non-adju cgm supply allow (A4239)	277	45	16.2%
Parenteral administration ki (B4224)	392	45	11.5%
Parenteral supply kit premix (B4220)	355	46	13.0%
Pos airway pressure filter (A7038)	276	42	15.2%
Supp non-insulin inf cath/wk (A4221)	259	21	8.1%
Other	10,667	2,064	19.3%
TOS Code			
CPAP	1,624	196	12.1%
Glucose Monitor	796	136	17.1%
Immunosuppressive Drugs	814	132	16.2%
Infusion Pumps & Related Drugs	1,404	182	13.0%
Lower Limb Prostheses	1,222	66	5.4%
Nebulizers & Related Drugs	1,236	116	9.4%
Parenteral Nutrition	1,501	192	12.8%
Surgical Dressings	1,580	485	30.7%
Urological Supplies	940	371	39.5%
Wheelchairs Options/Accessories	1,492	229	15.3%
Other	6,738	1,443	21.4%
Resolution Type[23]			
Automated	3,708	94	2.5%
Complex	57	11	19.3%
None	15,503	3,411	22.0%
Routine	79	32	40.5%
Diagnosis Code			
All Codes With Less Than 30 Claims	1,644	296	18.0%
Cerebral palsy and other paralytic syndromes	645	33	5.1%
Chronic lower respiratory diseases	1,566	158	10.1%
Diabetes mellitus	1,553	377	24.3%
Episodic and paroxysmal disorders	1,770	208	11.8%
In situ neoplasms	712	82	11.5%
Osteoarthritis	609	269	44.2%
Other disorders of the skin and subcutaneous tissue	908	225	24.8%

[23] Created using the type of review a line received based upon the resolution code that the contractor used to resolve the line.

Variable	Lines Reviewed	Lines Containing Errors	Percent of Lines Containing Errors
Persons with potential health hazards related to family and personal history and certain conditions	3,015	411	13.6%
Symptoms and signs involving the genitourinary system	893	348	39.0%
Other	6,032	1,141	18.9%

Table N3: Claims in Error: Part A Excluding Hospital IPPS

Variable	Claims Reviewed	Claims Containing Errors	Percent of Claims Containing Errors
Type of Bill			
Clinic ESRD	650	22	3.4%
Clinical Rural Health	250	15	6.0%
CAH	276	36	13.0%
Home Health	1,224	163	13.3%
Hospital Inpatient (Part A)	950	145	15.3%
Hospital Other Part B	101	18	17.8%
Hospital Outpatient	2,285	164	7.2%
Hospital based hospice	143	24	16.8%
Nonhospital based hospice	749	71	9.5%
SNF Inpatient	1,624	584	36.0%
Other	399	56	14.0%
TOS Code			
Clinic ESRD	650	22	3.4%
Clinical Rural Health	250	15	6.0%
CAH	276	36	13.0%
Home Health	1,224	163	13.3%
Hospital Inpatient (Part A)	950	145	15.3%
Hospital Other Part B	101	18	17.8%
Hospital Outpatient	2,285	164	7.2%
Hospital based hospice	143	24	16.8%
Nonhospital based hospice	749	71	9.5%
SNF Inpatient	1,624	584	36.0%
Other	399	56	14.0%
Diagnosis Code			
Acute kidney failure and chronic kidney disease	748	39	5.2%
All Codes With Less Than 30 Claims	554	57	10.3%
Cerebrovascular diseases	426	88	20.7%
Chronic lower respiratory diseases	208	28	13.5%
Diabetes mellitus	263	48	18.3%
Encounters for other specific health care	444	72	16.2%
Hypertensive diseases	361	50	13.9%
Injuries to the hip and thigh	188	50	26.6%
Other degenerative diseases of the nervous system	273	25	9.2%
Other forms of heart disease	363	66	18.2%
Other	4,823	775	16.1%

Table N4: Claims in Error: Part A Hospital IPPS

Variable	Claims Reviewed	Claims Containing Errors	Percent of Claims Containing Errors
DRG Label			
Aftercare, Musculoskeletal System & Connective Tissue W CC (560)	199	56	28.1%
Aftercare, Musculoskeletal System & Connective Tissue W/O CC/MCC (561)	116	45	38.8%
All Codes With Less Than 30 Claims	2,593	344	13.3%
Degenerative Nervous System Disorders W/O MCC (057)	188	46	24.5%
Endovascular Cardiac Valve Replacement & Supplement Procedures W MCC (266)	116	18	15.5%
Endovascular Cardiac Valve Replacement & Supplement Procedures W/O MCC (267)	222	41	18.5%
Esophagitis, Gastroent & Misc Digest Disorders W/O MCC (392)	102	14	13.7%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity W/O MCC (470)	397	164	41.3%
Percutaneous Intracardiac Procedures W/O MCC (274)	299	122	40.8%
Spinal Fusion Except Cervical W/O MCC (460)	104	24	23.1%
Other	4,414	640	14.5%
TOS Code			
AMI, Discharged Alive (280, 281, 282)	133	11	8.3%
Aftercare, Musculoskeletal System & Connective Tissue (559, 560, 561)	347	107	30.8%
All Codes With Less Than 30 Claims	1,733	254	14.7%
Back & Neck Proc Exc Spinal Fusion (518, 519, 520)	133	23	17.3%
Combined Anterior/Posterior Spinal Fusion (453, 454, 455)	207	27	13.0%
Degenerative Nervous System Disorders (056, 057)	220	55	25.0%
Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)	338	59	17.5%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	137	18	13.1%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	464	178	38.4%
Percutaneous Intracardiac Procedures (273, 274)	309	127	41.1%
Other	4,729	655	13.9%
Diagnosis Code			
All Codes With Less Than 30 Claims	418	62	14.8%
Cerebrovascular diseases	250	28	11.2%
Complications of surgical and medical care, not elsewhere classified	676	110	16.3%
Hypertensive diseases	237	38	16.0%
Ischemic heart diseases	414	38	9.2%
Osteoarthritis	529	202	38.2%
Other bacterial diseases	250	30	12.0%
Other diseases of intestines	243	19	7.8%
Other forms of heart disease	991	233	23.5%

Variable	Claims Reviewed	Claims Containing Errors	Percent of Claims Containing Errors
Spondylopathies	460	93	20.2%
Other	4,282	661	15.4%

Table N5: Frequency of Claims "Included In" and "Excluded From" Paid Claims[24] Improper Payment Rate by Claim Type

Claim Type	Included	Excluded	Total	Percent Included
Part B	11,600	320	11,920	97.3%
DMEPOS	8,650	249	8,899	97.2%
Part A Including Hospital IPPS[25]	17,401	10,841	28,242	61.6%

[24] The paid claim improper payment rate includes paid line items, unpaid line items, line items denied for non-medical reasons, as well as automated medical review denials. The paid claim improper payment rate excludes no resolution, RTP, late resolution as well as inpatient, RAPS, or technical error line items.
[25] Part A Including Hospital IPPS includes Part A (Hospital IPPS) and Part A (Excluding Hospital IPPS).

Appendix O: List of Acronyms

Acronym	Definition
AFR	Agency Financial Report
AICD	Automatic Implantable Cardioverter Defibrillator
AMI	Acute Myocardial Infarction
ANSI	American National Standards Institute
ASC	Accredited Standards Committee
BETOS	Berenson-Eggers Type of Service
BLS	Basic Life Support
CAH	Critical Access Hospital
CAT/CT/CTA	Computed Axial Tomography/Computed Tomography/Computed Tomography Angiography
CC	Comorbidity or Complication
CERT	Comprehensive Error Rate Testing
CGM	Continuous Glucose Monitor
CMG	Case Mix Group
CMS	Centers for Medicare & Medicaid Services
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAP	Continuous Positive Airway Pressure
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics & Supplies
DRG	Diagnosis Related Group
ECMO	Extracorporeal Membrane Oxygenation
E&M	Evaluation and Management
ESRD	End-Stage Renal Disease
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GI	Gastrointestinal
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Human and Health Services
HIPPS	Health Insurance Prospective Payment System
IDTF	Independent Diagnostic Testing Facility
IPPS	Inpatient Prospective Payment System
LSO	Lumbar-Sacral Orthosis
MAC	Medicare Administrative Contractor
MCC	Major Complication or Comorbidity
MS-DRG	Medicare Severity Diagnosis Related Group
MV	Mechanical Ventilation
NCD	National Coverage Determination
OMB	Office of Management and Budget
OPT	Outpatient Physical Therapy
OPPS	Outpatient Prospective Payment System
OR	Operating Room

Acronym	Definition
ORF	Outpatient Rehabilitation Facility
PDX	Principal Diagnosis
PIIA	Payment Integrity Information Act of 2019
PPS	Prospective Payment System
RAP	Request for Advanced Payment
RHC	Rural Health Clinic
RTP	Return to Provider
SIA	Service Intensity Add-On
SNF	Skilled Nursing Facility
TOB	Type of Bill
TOS	Type of Service
UB	Uniform Billing
UOS	Units of Service
W	With
W/O	Without