

# Medicare Fee-for-Service 2011 Improper Payments Report

## EXECUTIVE SUMMARY

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

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments in those programs;
- Report the estimates to Congress and the public; and
- Describe the actions the Agency is taking to reduce improper payments in those programs.<sup>1</sup>

The Centers for Medicare & Medicaid Services (CMS) has identified the Medicare Fee-for-Service (FFS) program as being at risk for significant improper payments. The 2011 Medicare FFS program improper payment rate was 8.6 percent, representing \$28.8 billion in improper payments.

While CMS continued to review claims according to a significantly revised and improved methodology implemented in 2009, CMS further refined this methodology in 2011 to reflect the projected impact of late documentation and late appeals on the improper payment rate. Activity related to the receipt of additional documentation and the outcome of appeals decisions routinely occurs after the cutoff date for publication of the annual improper payment rate. To account for this late activity, CMS refined the improper payment rate methodology based on 2009 and 2010 historical data for actual appeal results and the submission of late documentation received after the cutoff date. CMS decided to use 2010 actual results to adjust the 2011 rate because this was more conservative than using a blended rate from 2009 and 2010 historical data. CMS calculated an adjusted rate for the overall Medicare FFS improper payment rate and high-level claim types (Parts A, B, and durable medical equipment). The service-specific improper payment rates provided in this report are unadjusted.

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<sup>1</sup> The Office of Management and Budget (OMB) issued guidance for IPIA implementation requirements through

The 2011 overall unadjusted improper payment rate (before factoring in late appeals and receipt of additional documentation) is 9.9 percent. The 2011 overall adjusted improper payment rate of 8.6 percent more accurately reflects the estimated improper payment rate in the Medicare FFS program. For purposes of comparison in this report, CMS also adjusted the 2009 and 2010 improper payment rates. In 2009, the improper payment rate was reported as 12.4 percent, while the adjusted rate was calculated as 10.8 percent.<sup>2</sup> In 2010, the improper payment rate was reported as 10.5 percent, while the adjusted rate was calculated as 9.1 percent.<sup>3</sup> When comparing the adjusted rates, the 8.6 percent improper payment rate for 2011 represents a 0.5 percentage point reduction in the improper payment rate from 2010.

The table below summarizes the improper payment rates by claim type: Part A (Acute Inpatient Hospital Services); Part A (Excluding Acute Inpatient Hospital Services); Part B (Outpatient Services); and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). DMEPOS claims have the highest improper payment rate of 61.0 percent, while Part A claims have the highest amount of improper payments (\$15.1 billion).

**Summary Table: Adjusted Improper Payment Rates and Projected Improper Payments by Claim Type in 2011 (Dollars in Billions)<sup>4</sup>**

Claim Type	Total Paid Amount	Overall Improper Payment		
		Improper Payment (In Billions)	Improper Payment Rate	95% Confidence Interval
<b>Part A (Total)</b>	\$242.2	\$15.1	6.2%	5.4% - 7.0%
Part A (Excluding Acute Inpatient Hospital)	\$116.7	\$5.1	4.4%	3.7% - 5.0%
Part A (Acute Inpatient Hospital)	\$125.5	\$10.0	7.9%	6.6% - 9.3%
<b>Part B</b>	\$84.4	\$7.8	9.2%	7.9% - 10.6%
<b>DMEPOS</b>	\$9.7	\$5.9	61.0%	57.5% - 64.6%
<b>Overall</b>	\$336.4	\$28.8	8.6%	7.9% - 9.2%

<sup>2</sup> The HHS 2009 Agency Financial Report (AFR) reported the Medicare FFS improper payment rate as 7.8 percent, representing \$24.1 billion in improper payments. However, this rate reflected a combination of two different review methodologies. Under the first methodology, in which most of the 2009 claims were reviewed, the previous review process was used. Under the second methodology, a new, more stringent review process was used. After publication of the 2009 AFR, HHS decided to continue using the newer, more stringent review process in calculating the improper payment rate.

<sup>3</sup> The HHS OIG report entitled “ Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010” (A-01-11-00504) reported on the impact of late appeals on the CERT improper payment rates in 2009 and 2010. HHS OIG calculated that CERT claim payment denials overturned after the cutoff date for determining the Medicare FFS improper payment rate would have reduced the reported rate from 10.5 percent to 9.9 percent in 2010. The difference between the HHS OIG rate of 9.5 percent and the CMS rate of 9.1 percent is due the calculations being made at different points in time; because the CMS rate was calculated at a later date, this allowed for the incorporation of more claim errors that were overturned on appeal. Whether there is a difference between the CMS and HHS OIG rates in 2009 is unknown because HHS OIG applied its calculation to the 2009 improper payment rate of 7.8 percent, while CMS applied its calculation to the rate of 12.4 percent (see Footnote 2).

<sup>4</sup> Some columns and/or rows may not sum correctly due to rounding.

A large proportion of the 2011 improper payments (over 20 percent) resulted because the inpatient claim was denied, yet would have been payable had the services been billed in the outpatient setting (e.g., observation services, procedures that should have been billed as outpatient claims). This trend has been seen and reported in past years as well. . CMS has implemented a demonstration program that allows a limited number of hospitals to rebill denied inpatient claims that would have been payable in an outpatient setting. Further information regarding incorrect hospital setting errors may be found on page 20 (*Incorrect Setting*) and page 34 (*Corrective Actions to Reduce Improper Payments*).

Reducing the incidence of improper payments is a high priority for CMS. Pursuant to the President's directive to reduce improper payments, CMS established the goal of reducing the 2009 improper payment rate by half by 2012. CMS is working on multiple fronts to meet its improper payment reduction goals, including increased prepayment medical review, enhanced analytics, augmented education and outreach to the provider and supplier communities, and expanded review of paid claims by the CMS Recovery Auditors. CMS will continue to assess improper payment rate measurement procedures and will make improvements and modifications as necessary to ensure the most accurate accounting of improper payments. In addition, CMS plans to implement the following three demonstration programs that will test whether improper payments can be further reduced from the current levels.

- **Recovery Auditor Prepay Review Demonstration**  
Expanding the use of Medicare Recovery Auditors in the Medicare FFS program. In fiscal year (FY) 2011, Recovery Auditors recovered \$939.4 million in improperly paid claims. This Medicare program demonstration will allow Recovery Auditors to review claims before they are paid, which will prevent improper payments from happening in the first place.
- **A/B Rebilling Demonstration**  
Allowing a limited number of hospitals to rebill denied inpatient claims that would have been payable in an outpatient setting. Permitting participating hospitals to rebill will allow them to obtain reimbursement for medically necessary services while also protecting beneficiaries, encouraging hospitals to make proper inpatient admission determinations, and reducing appeals. The demonstration will be limited to a representative sample of hospitals nationwide that volunteered to be part of the program.
- **Power Mobility Device Prior Authorization Demonstration**  
Establishing a limited demonstration program that tests whether a prior authorization requirement can reduce fraud and improper payments for certain power mobility devices.

Together, these efforts will result in more accurate claim payments and a reduction of waste and abuse in the Medicare FFS program. The overall goals of these efforts are to maintain the fiscal health of the Medicare FFS Trust Funds while protecting Medicare beneficiaries.

This report describes the background of the Medicare FFS and Comprehensive Error Rate Testing (CERT) programs, the incidence of improper payments in 2011, the common causes of these errors, and the various steps CMS is taking to reduce the occurrence of these improper payments.

# THE MEDICARE FEE-FOR-SERVICE PROGRAM

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## Features of the Medicare Fee-for-Service Program

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

Both the number of Medicare beneficiaries and the associated health expenditures have increased dramatically since 1965. Approximately 47 million beneficiaries were enrolled in the Medicare program in FY 2010, representing a 147 percent increase in enrollment since program inception. This increase occurred simultaneously with a rise in national health expenditures from \$211 per person in 1965 to \$8,086 in 2009. The total Medicare benefit payments were estimated at \$518.8 billion in FY 2010.<sup>5</sup>

## The Claims Processing Function in the Medicare Fee-for-Service Program

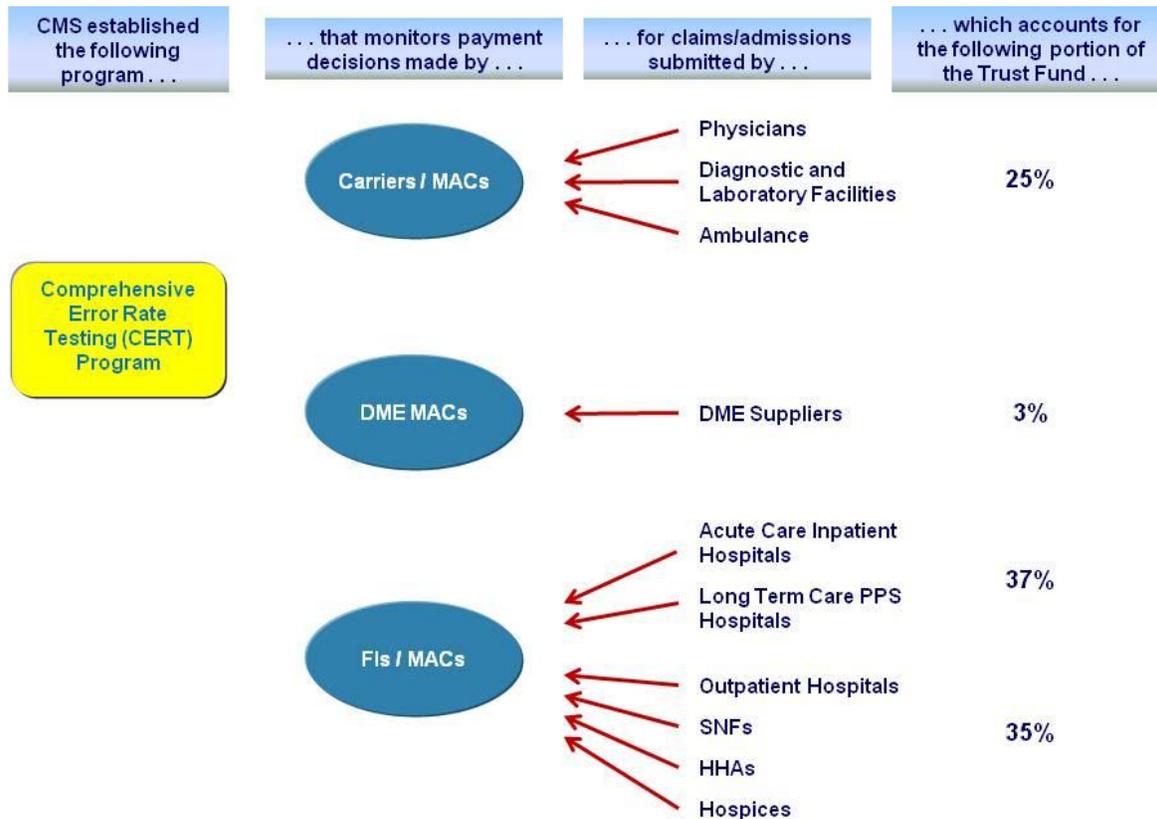
The CMS uses several types of contractors to process claims in the Medicare FFS program: Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries (FIs). These contractors are responsible for preventing improper payments in the Medicare FFS program through their claims payment decisions and processes.

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

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<sup>5</sup> 2011 CMS Statistics: U.S. Department of Health and Human Services, CMS Pub. No. 03504, June 2011.

**Figure 1: Flow of Claims by Provider and Supplier Types through the Medicare Contractor Claims Processing Entities**



The primary goal of each Medicare claims processing contractor is to "pay it right," i.e., to pay the proper amount for covered, medically necessary, and correctly coded services. In FY 2011, these contractors processed and paid more than one billion claims. As a result of the large number of claims that these contractors must process, they cannot manually review every claim that is submitted either before or after payment is rendered. Rather, automated methods are largely utilized to detect billing errors. In addition, these contractors conduct manual reviews on some claims. During such reviews, professional medical reviewers and coders examine the submitted claims and supporting medical documentation to make more complex claim decisions that are not possible through automated methods (e.g., medical necessity and correct coding determinations). The claims processing contractors decide what claim types should undergo automated, complex, pre-payment, and/or post-payment reviews based on analyses of their contractor-specific improper payment data. This data is also used to develop strategies to reduce the number of improper claims submitted by providers and suppliers, such as educational outreach efforts. One important source of this information is the CMS Comprehensive Error Rate Testing (CERT) program.

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

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## Statutory Background

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

Under the IPIA, the Department of Health and Human Services is required to:

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments in those programs;
- Report the estimates to Congress and the public; and
- Describe the actions HHS is taking to reduce improper payments in those programs.<sup>6</sup>

One of the key tenets of the IPIA was that improper payment rate measurement programs should be incorporated as a critical part of a Federal agency's internal controls. Agencies were instructed to use these key internal controls to inform decision makers about program vulnerabilities and drive corrective actions for reducing future improper payments.

## History of Improper Payment Measurement

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

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<sup>6</sup> OMB M-06-23, Appendix C to OMB Circular A-123, August 10, 2006.

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

When improper payment measurement transitioned to CMS in 2003, CMS increased the sample size substantially. Currently, the sample size is approximately 50,000 claims. This sample size allows CMS to calculate a national improper payment rate and also contractor- and service-specific improper payment rates. Calculating these additional rates provides CMS and its contractors with valuable information to assist in the development of specific, robust corrective actions to prevent improper payments from occurring in the future.

## **The Medicare FFS Improper Payment Rate Throughout the Years**

Each year the Medicare FFS improper payment rate is reported in the CMS and HHS annual financial reports. The HHS Agency Financial Reports are located at <http://www.hhs.gov/afr>. Table 1 summarizes the overpayments, underpayments, and improper payment rates by year. Table 1 also displays the adjusted and unadjusted improper payment rates as well as the corresponding overall improper payment figures. Adjusted improper payment rates and amounts were calculated only for 2009, 2010, and 2011.

**Table 1: National Improper Payment Rates by Year (Dollars in Billions)<sup>7</sup>**

Year	Total Dollars Paid	Overpayments		Underpayments		Overpayments + Underpayments			
		Payment	Rate	Payment	Rate	Unadjusted Improper Payments	Adjusted Improper Payments	Unadjusted Rate	Adjusted Rate
1996	\$168.1	\$23.5	14.0%	\$0.3	0.2%	\$23.8		14.2%	
1997	\$177.9	\$20.6	11.6%	\$0.3	0.2%	\$20.9		11.8%	
1998	\$177.0	\$13.8	7.8%	\$1.2	0.6%	\$14.9		8.4%	
1999	\$168.9	\$14.0	8.3%	\$0.5	0.3%	\$14.5		8.6%	
2000	\$174.6	\$14.1	8.1%	\$2.3	1.3%	\$16.4		9.4%	
2001	\$191.3	\$14.4	7.5%	\$2.4	1.3%	\$16.8		8.8%	
2002	\$212.8	\$15.2	7.1%	\$1.9	0.9%	\$17.1		8.0%	
2003	\$199.1	\$20.5	10.3%	\$0.9	0.5%	\$12.7		6.4%	
2004	\$213.5	\$20.8	9.7%	\$0.9	0.4%	\$21.7		10.1%	
2005	\$234.1	\$11.2	4.8%	\$0.9	0.4%	\$12.1		5.2%	
2006	\$246.8	\$9.8	4.0%	\$1.0	0.4%	\$10.8		4.4%	
2007	\$276.2	\$9.8	3.6%	\$1.0	0.4%	\$10.8		3.9%	
2008	\$288.2	\$9.5	3.3%	\$0.9	0.3%	\$10.4		3.6%	
2009	\$285.1	\$34.2	12.0%	\$1.2	0.4%	\$35.4	\$30.8	12.4%	10.8%
2010	\$326.4	\$33.2	10.2%	\$1.1	0.3%	\$34.3	\$29.7	10.5%	9.1%
2011	\$336.4	\$28.0 <sup>8</sup>	8.4%	\$0.8 <sup>9</sup>	0.2%	\$33.3	\$28.8	9.9%	8.6%

Table 1 shows a significant increase in the improper payment rate from 2008 to 2009. This increase was attributed to a significant change in the claim review methodology implemented in 2009. Specifically, (1) professional medical judgment could no longer be used to find a claim properly paid if a policy requirement was not met, (2) claims history could no longer be used as a valid source of review information, and (3) medical record documentation created by a supplier was no longer sufficient to support payment of a claim. These review changes were made based on recommendations from the Office of the Inspector General, which has responsibility for review of the CERT program. CMS continued using this review methodology in 2010 and 2011 and has been successful in reducing the improper payment rate.

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

<sup>8</sup> Overpayment numbers and rates are adjusted.

<sup>9</sup> Underpayment numbers and rates are adjusted.

# THE COMPREHENSIVE ERROR RATE TESTING PROGRAM

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## CERT Program Objectives

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

To meet this objective, CERT evaluates a random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the category of error at issue. The CERT program ensures a statistically valid random sample. Therefore, the improper payment rate calculated from this sample is considered to be reflective of all of the paid claims in the Medicare FFS program during the year.

Because the IPIA requires the CERT program to use random claim selection, reviewers cannot identify provider billing patterns or trends that may indicate potential fraud. Therefore, the CERT program cannot label a claim fraudulent. The CERT program measures the improper payment rate, and not the rate of fraud.

## CERT Improper Payment Rate Calculation Process

### *Claims Selection*

The first step in the CERT process is the selection of claims for the random sample. Specifically, a stratified random sample is taken by claim type: Part A (excluding acute inpatient hospital services), Part A (acute inpatient hospital services only), Part B, and DMEPOS. On a daily basis, a random sample of claims, stratified by service, is selected from all of the claims submitted to Medicare claims processing contractors (e.g. MACs). A small portion of the claims sampled from the universe are unreviewable because they never completed the claim adjudication process (e.g., the claim was returned to the provider). The final CERT sample is comprised of claims that were either paid or denied by the Medicare claims processing contractor. This sampling methodology complies with all statutory requirements and OMB implementing guidance.

For the 2011 reporting period, CERT randomly sampled approximately 51,000 claims, less than was sampled in previous years due to increased efficiency in the sampling strategy. The aggregate number of claims sampled and the number of claims reviewed for each claim type is provided in Table 2.

**Table 2: Sample Sizes by Claim Type**

<b>Claim Type</b>	<b>Number of Claims Reviewed</b>
Part A (Excluding Acute Inpatient Hospital)	15,765
Part A (Acute Inpatient Hospital)	3,872
Part B	20,494
DMEPOS	8,110
<b>Total</b>	<b>48,241</b>

### *Medical Record Requests*

After a claim is identified as part of the sample, CERT requests the associated medical records and other pertinent documentation from the provider or supplier that submitted the claim. The initial request for medical records is made via letter. If the provider or supplier fails to respond to the initial request within 30 days, CERT sends at least three subsequent letters. The CERT contractor and CMS personnel also place phone calls to the providers and suppliers to collect the documentation.

For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), additional documentation requests are also made to the referring provider who ordered the item or service. There are often instances associated with these claim types in which the billing provider or supplier does not have documentation to support the medical necessity of the services billed but the referring provider has the complete medical records.

If no documentation is received within 75 days of the initial request, the claim is classified as a “no documentation” claim and counted as an error. Any documentation received after the 75th day is considered late documentation. If late documentation is received by CERT prior to the documentation cut-off date for the report period<sup>10</sup>, the records are reviewed in the same fashion as if the documentation was submitted timely. Moreover, if late documentation is received after the cut-off date, CERT makes every effort to complete the review process before the final production of the report. If this is not possible, the documentation is still reviewed and an error/non-error determination is made after the rate is reported. The results of improper payment determination reversals based upon late documentation are tracked by the CERT program.

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<sup>10</sup> May 2, 2011 was the cut-off date in which late documentation was subjected to the full CERT review process for inclusion in this report.

## *Review of Claims*

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

In 2009, an improved review methodology was implemented in the CERT program. This change included more strict enforcement of Medicare payment policies, resulting in a corresponding increase in the improper payments identified during subsequent years. Most of the increase is due to strict adherence to Medicare policy regarding documentation and signature requirements; the removal of claims history as a valid source for review information; and the determination that medical record documentation received only from a supplier, as opposed to an ordering provider, is insufficient to substantiate a claim. These revised review criteria continued to be followed during the 2011 reporting period.

## *Assignment of Error Categories*

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

**No Documentation**—Claims are placed into this category when either the provider fails to respond to repeated requests for the medical records or the provider responds that they do not have the requested documentation.

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

**Medical Necessity**—Claims are placed into this category when the medical reviewers receive adequate documentation from the medical records submitted and can make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies.

**Incorrect Coding**—Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.

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

### *Appeals of Claims*

Providers and suppliers have the right to appeal any improper payment decision made by CERT. There are three levels of claim appeals under which CERT claims are typically adjudicated: (1) redeterminations, which are conducted at the claims processing contractor level; (2) reconsiderations, which are conducted at the Qualified Independent Contractor (QIC) level; and (3) administrative hearings, which are conducted by Federal Administrative Law Judges (ALJs). Appeals are tracked by the CERT program throughout the appeal levels to ensure the accuracy of the improper payment rate. Once a final decision is made to pay or deny the claim, this appeal decision is incorporated into the calculation of the Medicare FFS improper payment rate. At the cutoff date for the calculation of the final improper payment rate, the last decision made regarding payment of the claim (by CERT or during any level of appeal) is considered final for reporting purposes.

Late appeal decisions continue to be tracked after the official improper payment calculation is reported. Adjustments to the improper payment rate are then made on a periodic basis based upon this information. There are common causes for the appeal reversals that occur after the improper payment rate is reported, such as the acquisition of additional supporting documentation by the appeal entities and expert (third-party) testimony establishing that the denied services were reasonable and necessary.

### *Determining the Unadjusted Improper Payment Rate*

The next step in the CERT process is to calculate the unadjusted improper payment rate. To complete this calculation, proper weighting must be applied. The improper payment amount for each Medicare claims processing contractor is weighted by its proportion of national total allowed charges. This weighting assures that each contractor's contribution to the overall improper payment rate is proportional to the percent of expenditures for which they were responsible during that year. After this weighting is complete, the Medicare FFS improper payment rate is calculated, the findings are projected to the universe of Medicare FFS claims submitted during the study year, and determinations of overall financial impact are made based upon Medicare FFS expenditures.

Confidence intervals are calculated to reflect the numeric range of values within which CMS is either 90 or 95 percent certain that the actual improper payment rate falls (i.e., what the calculated rate would be if every Medicare FFS claim underwent the CERT process). The range of the confidence intervals should always be considered when evaluating estimated improper payment rates.

### *Application of the Improper Payment Rate Adjustment*

The next step in the CERT process is the calculation and application of a rate adjustment to account for late resolution of appeals and the receipt of late documentation. This adjustment factor is applied to provide a more accurate estimate of improper payments in the Medicare FFS program.

Each year, CERT receives appeals data and supporting documentation after the improper payment rate is reported. It is common for appeal decisions to occur after the improper payment rate is reported because there are three levels to the appeals process. In addition to utilizing the formal appeals process, providers and suppliers may submit late documentation to CERT supporting that the claim was paid properly. Given that providers and suppliers have an interest in reversing improper payment determinations, the late documentation and appeals activity continues to occur after the cutoff date for reporting the improper payment rate.

When late documentation and appeal decisions reverse a CERT determination, this information is entered into the CERT database. Traditionally, the improper payment rate calculation was updated on a periodic basis after the end of the official reporting period for CMS' internal tracking purposes. These late recalculations resulted in a decrease in the improper payment rate each year after the official rate was reported. The actual effect of these factors on the reported rate resulted in a downward adjustment of 1.6 percentage points in 2009 and 1.4 percentage points in 2010. This translated to the actual improper payment rates being lower than those officially reported in 2009 and 2010.

Beginning in 2011, CMS began developing an adjustment factor to prospectively account for this late activity. The adjustment factor for 2011 replicates the downward effect that late documentation and appeal results had on reported improper payment rates in past years. CMS used the actual reduction observed with the 2010 improper payment rate to adjust the 2011 rate. This methodology was chosen because the 2010 adjustment was believed to be more representative and conservative than 2009 or earlier data. For instance, the 2009 improper payment rate of 12.4 percent was based on approximately 3 months of claims reviewed using the stringent criteria implemented in the middle of the sample year. However, the 2010 rate was based on a full 12 months of claim reviews under the same, stringent criteria used for the 2011 review and was therefore most similar to 2011 data. Despite these sample differences, the actual downward adjustments observed in 2009 (1.6 percent) and 2010 (1.4 percent) were similar. CMS believed that using the 2010 adjustment factor alone was a more conservative, and therefore preferable, approach than blending the 2009 and 2010 factors. CMS will continue

reviewing and refining the adjustment methodology in future years to ensure the most accurate reporting of the Medicare FFS improper payment rate.

The estimated impact of documentation received and appeals processed after the cutoff date for the 2011 report period is included in this year's 8.6 percent improper payment rate. Without this adjustment, the improper payment rate would have been 9.9 percent.<sup>11</sup> The adjustment is reflected in the national and claim type improper payment rates listed in this report. As 2011 was the first year to prospectively use this adjustment factor, it was only applied to the overall Medicare FFS improper payment rate and high-level claim types (Parts A, B, and DMEPOS). The service-specific improper payment rates are unadjusted.

### *Reporting the Results: Net and Gross Improper Payment Rates*

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

The gross improper payment rate is calculated by adding together the total amount of underpayments and total amount of overpayments and dividing that result by the total dollars paid in the CERT sample. Therefore, improper overpayments and underpayments are counted equally in calculating the gross improper payment rate. The gross improper payment rate accounts for the percentage of total dollars that all Medicare FFS claims processing contractors either improperly paid or denied. This rate is a quality indicator of how both types of improper payment decisions (payments and denials) impact the Medicare Trust Funds. The gross rate is the improper payment rate historically reported by the CERT program.

The net improper payment rate is calculated by subtracting the total underpayments from the total overpayments and dividing that result by the total dollars paid in the CERT sample. As the overpayment amount in the Medicare FFS program is larger than the underpayment amount, the net improper payment rate accounts for the amount of improper payments remaining after the underpayments are deducted.

### *Reconciling Improper Payments Identified by the CERT Program*

The last step in the CERT process is correcting the improper payments identified by CERT, either through recovery of overpayments or reimbursement of underpayments. The Medicare

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<sup>11</sup> Although this appears to be a 1.3 percent downward adjustment, as opposed to the 1.4 percent reduction reported, this is due to rounding. All numbers herein are reported to the first decimal.

FFS claims processing contractors are notified of overpayments and underpayments identified by CERT so that necessary payment adjustments can be implemented. Claims processing contractors are only allowed to recover the actual overpayments identified in the CERT sample. In other words, the projections made to the claims universe by the CERT program cannot be used as the basis for recovering projected overpayments nationally.

Most of the actual overpayments identified by the CERT program are recovered. In 2011, the CERT program identified \$5,821,154 in actual overpayments and, as of the publication date of this report, CMS collected \$5,358,617, or 92 percent of actual identified overpayments. CMS and its contractors will never collect a small amount of the identified overpayments. Some identified overpayments are not collected because the CERT decision was appealed and overturned after the improper payment rate was finalized. In addition, CMS cannot collect overpayments if the provider has gone out of business and CMS cannot locate the provider after multiple attempts. The Medicare FFS claims processing contractors are diligent in their attempts to collect the overpayments identified during the CERT process.

# 2011 MEDICARE FEE-FOR-SERVICE IMPROPER PAYMENT RATE ANALYSIS AND SUMMARY OF RESULTS

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The 2011 Medicare FFS improper payment rate was 8.6 percent,<sup>12</sup> representing \$28.8 billion in improper payments. For purposes of comparison in this report, CMS also adjusted the 2009 and 2010 improper payment rates. In 2009, the improper payment rate was reported as 12.4 percent, while the adjusted rate was calculated as 10.8 percent.<sup>13</sup> In 2010, the improper payment rate was reported as 10.5 percent, while the adjusted rate was calculated as 9.1 percent. When comparing the adjusted rates, the 8.6 percent improper payment rate for 2011 represents a 0.5 percentage point reduction in the improper payment rate from 2010. CMS calculated an adjusted rate for the overall Medicare FFS improper payment rate and high-level claim types (Parts A, B, and DMEPOS). The service-specific improper payment rates provided in this report are unadjusted.

A large proportion of the 2011 improper payments (over 20 percent) resulted because the inpatient claim was denied, yet would have been payable had the services been billed in the outpatient setting (e.g., observation services or medical procedures that should have been billed as an outpatient claims). This trend has been observed and reported in past years as well. . CMS will be implementing a demonstration program that allows a limited number of hospitals to rebill denied inpatient claims that would have been payable in an outpatient setting. Further information regarding incorrect hospital setting errors may be found on page 20 (*Incorrect Setting*) and page 34 (*Corrective Actions to Reduce Improper Payments*)

Table 3 summarizes the adjusted improper payment rates by claim types: Part A (Acute Inpatient Hospital Services), Part A (Excluding Acute Inpatient Hospital Services), Part B (Outpatient Services), and DMEPOS. Claims for DMEPOS supplies have the highest improper payment rate of 61.0 percent, while Part A has the most dollars in error, \$15.1 billion in improper payments.

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<sup>12</sup> Adjusted to reflect the outcome of appeal decisions and the receipt of late documentation.

<sup>13</sup> The HHS 2009 Agency Financial Report (AFR) reported the Medicare FFS improper payment rate as 7.8 percent, representing \$24.1 billion in improper payments. However, this rate reflected a combination of two different review methodologies. Under the first methodology, in which most of the 2009 claims were reviewed, the previous review process was used. Under the second methodology, a new, more stringent review process was used. After publication of the 2009 AFR, HHS decided to continue using the newer, more stringent review process in calculating the improper payment rate.

**Table 3: Adjusted Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions)<sup>14</sup>**

Claim Type	Total Paid Amount	Overall Improper Payment		
		Improper Payment (In Billions)	Improper Payment Rate	95% Confidence Interval
<b>Part A (Total)</b>	\$242.2	\$15.1	6.2%	5.4% - 7.0%
Part A (Excluding Acute Inpatient Hospital)	\$116.7	\$5.1	4.4%	3.7% - 5.0%
Part A (Acute Inpatient Hospital)	\$125.5	\$10.0	7.9%	6.6% - 9.3%
<b>Part B</b>	\$84.4	\$7.8	9.2%	7.9% - 10.6%
<b>DMEPOS</b>	\$9.7	\$5.9	61.0%	57.5% - 64.6%
<b>Overall</b>	\$336.4	\$28.8	8.6%	7.9% - 9.2%

Table 4 summarizes the unadjusted improper payment rates by claim types: Part A (Acute Inpatient Hospital Services), Part A (Excluding Acute Inpatient Hospital Services), Part B (Outpatient Services), and DMEPOS. As previously described (see *Application of the Improper Rate Adjustment*, pg. 14), because 2011 was the first year CMS calculated a prospective adjustment factor for the outcome of late appeals and receipt of late documentation, it was only applied to the overall Medicare FFS improper payment rate and high-level claim types (Parts A, B, and DMEPOS). The common causes of errors, which are described in the following sections of this report, are based upon these unadjusted improper payment rates.

**Table 4: Unadjusted Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions)<sup>15</sup>**

Claim Type	Total Paid Amount	Overall Improper Payment		
		Improper Payment	Improper Payment Rate	95% Confidence Interval
<b>Part A (Total)</b>	\$242.2	\$18.0	7.4%	6.6% - 8.3%
Part A (Excluding Acute Inpatient Hospital)	\$116.7	\$6.0	5.1%	4.5% - 5.8%
Part A (Acute Inpatient Hospital)	\$125.5	\$12.0	9.6%	8.2% - 11.0%
<b>Part B</b>	\$84.4	\$8.9	10.5%	9.6% - 11.5%
<b>DMEPOS</b>	\$9.7	\$6.6	67.4%	64.2% - 70.6%
<b>Overall</b>	\$336.4	\$33.5	9.9%	9.3% - 10.6%

<sup>14</sup> Some columns and/or rows may not sum correctly due to rounding.

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

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## Inpatient Hospital Services

As in previous years, inpatient hospital services were a large driver of the improper payment rate. For the 2011 reporting period, inpatient hospital PPS claims had an unadjusted improper payment rate of 9.6 percent, accounting for 36 percent of overall Medicare FFS improper payments. The projected improper payment amount for inpatient hospital services was approximately \$12 billion.

An inpatient is defined as a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Medicare covers an inpatient stay only if the inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay.<sup>16</sup> In making this determination, it must be established whether the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive environment than an inpatient setting. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. Absent these requirements, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, and/or factors that may cause the beneficiary to worry, do not justify a continued hospital stay.<sup>17</sup>

Moreover, CMS has also designated a select number of procedures as “inpatient-only procedures” that are reimbursable only when provided in an inpatient setting.<sup>18</sup> Even if a procedure is not on the inpatient only list, it still may be reasonable and necessary for the patient to be admitted to the hospital as an inpatient. The decision whether to admit the patient as an inpatient will depend on the medical needs of the particular patient and the expectations of the admitting physician. Unless the procedure is on the Inpatient Only List, beneficiaries should generally be admitted as inpatients when the physician expects that the patient will need hospital care for 24 hours or more. The decision to admit is a complex medical judgment and the criteria the physician uses are described in Publication 100-02, Medicare Benefit Policy Manual, Chapter 1, section 10.

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<sup>16</sup> Medicare Program Integrity Manual, CMS Pub. 100-8, §6.5.2.

<sup>17</sup> Medicare Program Integrity Manual, CMS Pub. 100-8, §6.5.2.

<sup>18</sup> Federal Register November 24, 2010; page 72545.

To receive Medicare payment for an inpatient hospital stay, hospitals must meet all documentation requirements specified in the Local Coverage Determinations (LCDs) issued by the Medicare claims processing contractors and the National Coverage Determinations (NCDs) issued by CMS. The NCDs and LCDs require that hospitals maintain a variety of documents that support the beneficiary's need for, and appropriateness of, the hospital services provided.

Part A inpatient hospital claims are covered under the Inpatient Prospective Payment System (IPPS). Under the IPPS, claims are reimbursed through the Medicare Severity Diagnosis Related Groups (MS-DRG) coding scheme, whereby hospitals are reimbursed for entire hospital stays based upon the procedures performed, the severity of the beneficiary's condition, and other factors. The dollar amounts for IPPS claims are generally much higher than other Part A claims. As a result, the amount improperly paid through the IPPS system is nearly twice as high as that for other Part A claims. Because of the large amount of improper payments stemming from errors identified with IPPS claims, a focus on reducing errors with IPPS claims is a key component of reducing the improper payment rate.

### *Incorrect Setting*

Claims are often submitted for beneficiaries who were admitted as inpatients but the medical care and/or procedures should have been provided in an outpatient or other non-hospital based setting. Under longstanding Medicare policy, these claims must be denied in full, even if the claim would be potentially payable in another setting. CMS policy prohibits claims processing contractors from partially denying the claim or allowing the provider to rebill the service as an outpatient claim. However, as discussed later in this report, CMS will be implementing a demonstration program to allow a limited number of hospitals to rebill denied inpatient claims that would have been payable in an outpatient setting (see *Corrective Actions to Reduce Improper Payments*, pg. 34).

CMS determined that there were 370 inpatient hospital claims in the CERT sample that were denied in full because the services provided in an inpatient setting were medically appropriate in an outpatient setting. These sampled errors totaled \$2.46 million in actual overpayments, which projected to approximately \$7.4 billion in overpayments for the universe of Medicare FFS claims.

*Example:* The beneficiary had a history of end-stage renal disease and required dialysis. He was admitted as an inpatient electively for the insertion of an arteriovenous shunt, which is not listed on the inpatient-only procedure list. The procedure was completed with no immediate complications and no post-procedure interventions were required. The inpatient claim was scored as an improper payment due to a medical necessity error, as the episode of care should have been billed in the outpatient setting.

## *Inpatient Hospital Short Stays*

A majority of the short stay improper payments were due to the incorrect setting problem (see preceding section entitled *Incorrect Setting*). These trends have been observed in past reports as well.

The frequency of claim errors was positively correlated with decreasing lengths of stay of inpatient hospital PPS claims.

- Stays of one day or less had an improper payment rate of 34.2 percent, resulting in projected improper payments of approximately \$4.1 billion.
- Two day stays had a projected improper payment rate of 17.3 percent, resulting in projected improper payments of approximately \$2 billion.
- Three day stays had an improper payment rate of 11.8 percent, resulting in projected improper payments of approximately \$2 billion.

## *Joint Replacements*

Medicare covers medically necessary major joint replacements in addition to the inpatient hospital services related to these procedures. The services related to major joint replacements had an improper payment rate of 11.5 percent, accounting for 2.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for joint replacements during the 2011 report period was approximately \$686.7 million.

Medical necessity errors accounted for all of these improper payments, meaning that the records submitted did not support that the major joint replacement was reasonable and necessary. CERT reviewers look at the totality of the medical documentation to make the determination of whether the total joint replacement was medically necessary. Information considered when making a medical necessity determination includes: (1) beneficiary signs and symptoms, (2) rationale for joint replacement versus non-surgical therapies, (3) history of joint disease, (4) pre-operative outpatient treatments, (5) joint exam findings, and (6) other supporting pre-, intra-, and post-operative findings. The most common pieces of information missing from the medical record are the pre-operative condition of the joint ailment and the history of non-surgical therapies to treat the ailment.

The following document types often provide the information needed to support the medical necessity of a total joint replacement, but are frequently missing from the submitted record. This list is not exhaustive, nor is the presence or absence of this documentation dispositive in the decision of whether the joint replacement was medically necessary.

- Admission history and physical exam
- Pre-operative physical or occupational therapy notes
- Nursing notes with pre-operative assessments of mobility and function
- Pre-operative outpatient notes

- Intra-operative findings documented in the operative notes
- Gross pathology findings from joint samples

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

### *Cardiovascular Stents*

Cardiovascular stents may be placed in narrowed arteries in order to improve blood flow, such as in the coronary (heart) vessels. Several cardiovascular stent placement procedure DRGs were identified as having a sizeable impact on the Medicare FFS improper payment rate. These DRGs had an improper payment rate of 19.7 percent, accounting for 3.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for cardiovascular stent procedures during the 2011 report period was approximately \$1.2 billion.

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

*Example:* The beneficiary had a heart catheterization that showed significant plaque buildup in one of the heart arteries, requiring the need for a stent placement in the near future. She underwent an elective stent placement at a later date. She experienced no complications and had no concerning co-morbidities, yet she was admitted to the hospital as an inpatient overnight. This claim was considered as an improper payment due to a medical necessity error, as the submitted documentation did not support that the post-procedure course could not have been provided in an outpatient setting.

### *Cardiac Pacemakers*

Cardiac pacemakers are self-contained, battery-operated units that send electrical stimulation to the heart. They are generally implanted to alleviate symptoms of decreased cardiac output related to an abnormal heart rate and/or rhythm. The services related to cardiac pacemakers had an improper payment rate of 37.0 percent, accounting for 2.2 percent of the overall Medicare FFS improper

payment rate. The projected improper payment amount for pacemakers during the 2011 report period was approximately \$740.1 million.

Medicare coverage criteria related to the implantation of permanent pacemakers are dictated by an NCD. The NCD outlines the specific medical indications that support the medical necessity of either a single-chamber or dual-chamber pacemaker, along with those medical conditions in which the placement of either type would be non-covered.

All of the improper payments identified for cardiac pacemaker-related services were medical necessity errors. Most of these medical necessity errors occurred when a dual-chamber pacemaker was inserted but the condition of the beneficiary required the insertion of a single-chamber pacemaker under Medicare coverage guidelines.

*Example:* A beneficiary underwent placement of a dual-chamber pacemaker during a medically necessary inpatient admission. A heart catheterization done on an earlier admission showed that the beneficiary did not have any of the indications for the placement of a dual-chamber pacemaker under the NCD guidelines. As the dual-chamber pacemaker was deemed not reasonable and necessary, the inpatient stay DRG was revised after the procedure code was removed. The improper payment was the difference between the amount allowed under the originally paid DRG and the amount allowed under the recalculated DRG.

## **Skilled Nursing Facility Services**

The Medicare skilled nursing facility (SNF) benefit pays for certain services provided in various settings, including nursing homes, hospitals, and other freestanding facilities. Covered SNF services require the skills of qualified technical or professional health personnel. Examples of skilled care include performing professional assessments of a beneficiary's condition, teaching a beneficiary how to manage their treatment regimen, medication injections, and tube feedings. Custodial services alone are not covered by the SNF benefit, which include assistance with activities of daily living such as bathing, dressing, and using the bathroom. SNF services had an improper payment rate of 4.7 percent, accounting for 3.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2011 report period was approximately \$1.1 billion.

The majority of improper payments for SNF services were due to insufficient documentation errors. Providers of SNF services are required to submit certain pieces of documentation to support the medical necessity of the SNF services. If any of these are missing, such as a certification that the beneficiary needed daily skilled care that could only be provided in a SNF setting, a plan of care to support the medical necessity of SNF services, or therapy times to support the therapy services billed, these are counted as insufficient documentation errors. Other improper payments for SNF services were due to medical necessity errors. In many of these cases, the medical record showed that the care provided was purely custodial, rather than restorative to improve the beneficiary's condition.

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

## Home Health Services

The Medicare home health benefit pays for certain health care services in the home setting if the services are considered reasonable and necessary for the treatment of an illness or injury and certain other criteria are met. Covered services include skilled nursing care; medical social services; medical supplies; and physical, occupational, and speech-language therapies. Home health services had a projected improper payment rate of 7.0 percent, accounting for 4.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during the 2011 report period was approximately \$1.5 billion.

Home health services coverage is dependent on various factors, such as the beneficiary being homebound and requiring skilled services for a minimum time period. There are several documentation elements that must be submitted with a home health service claim to support that the beneficiary was eligible for coverage, including, but not limited to: (1) therapy notes; (2) physician certification of homebound status and the need for home health services; and (3) the Outcome and Assessment Information Set (OASIS), which includes a comprehensive assessment of an adult home care patient.

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

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

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

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## Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Medicare FFS provides coverage for medically necessary DMEPOS items under Part B. Medicare pays for DMEPOS items only if the patient's medical record contains sufficient documentation of the patient's medical condition to support the need for the type or quantity of items ordered. In addition, all required documentation elements outlined in Medicare policies must be present for the claim to be paid. While the overall Medicare FFS expenditures for DMEPOS items accounted for less than 3 percent of all Medicare FFS expenditures in the 2011 reporting period, the impact of the DMEPOS improper payments on the overall improper payment rate was significant. DMEPOS had an unadjusted improper payment rate of 67.4 percent, accounting for 20 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for DMEPOS during the 2011 report period was approximately \$6.6 billion.

Approximately 91 percent of the DMEPOS improper payments were due to insufficient documentation errors. Therefore, for most of these improper payment claims, the provider or supplier did not submit a complete medical record to support that the services or supplies billed were actually provided, provided at the level billed, and/or were medically necessary. In other cases, required documentation elements that are required as a condition of payment or by a specific LCD were missing, such as a documented face-to-face physician evaluation within required timeframes or a physician signature on a supplier form that is required to be completed in its entirety.

Under Medicare requirements, documentation created by the DMEPOS supplier alone is insufficient to warrant payment of the claim. It is often difficult to obtain proper documentation for DMEPOS claims because the DMEPOS supplier that billed for the item must obtain detailed documentation from the medical professional who ordered the item. As such, the involvement of multiple parties can contribute to the frequency of missing or incomplete documentation and delays in the receipt of documentation. Given the importance of receiving medical record documentation to substantiate the necessity for DMEPOS items billed, beginning in 2011, CMS began notifying the ordering physician when an item is selected for CERT review. The notification reminds physicians of their responsibilities to maintain documentation of medical necessity for the DMEPOS item and to submit requested documentation to the supplier.

Approximately 7 percent of the improper payments for DMEPOS items and services were classified as medical necessity errors. Such errors were found when the medical records submitted contained adequate documentation to make a definitive determination that the services or supplies claimed were not medically necessary under Medicare coverage guidelines, and therefore the service or supply should not have been paid by the claims processing contractor.

Oxygen supplies, glucose monitoring supplies, and nebulizers with related drugs had the highest incidence of improper payments within the realm of DMEPOS, accounting for 4.1 percent, 3.3 percent, and 1.4 percent of the total Medicare FFS projected improper payments, respectively. These three DMEPOS groups accounted for approximately 45 percent of the DMEPOS improper payments in the 2011 reporting period. The improper payments associated with these items, along with the improper payments associated with power wheelchairs and breathing supplies for beneficiaries with obstructive sleep apnea (two other DMEPOS categories particularly susceptible to improper payments), are discussed below.

### *Oxygen Supplies*

Medicare FFS provides coverage for home and portable oxygen supplies for beneficiaries with severe lung disease or symptoms related to low oxygen levels that can be improved with oxygen therapy. The improper payment rate for oxygen supplies was 77.1 percent, accounting for 4.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for oxygen supplies during the 2011 report period was approximately \$1.4 billion.

Given the critical nature of these supplies, it is essential that the beneficiary be closely monitored by a physician and that the related physician documentation supports the continued medical necessity of the oxygen supplies. For Medicare coverage, the patient's medical record must contain sufficient documentation of the patient's medical condition to support the need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as: physician orders for the oxygen supplies; blood oxygenation results; physician evaluations demonstrating oversight of the beneficiary and their continued need for oxygen supplies; and the appropriateness of home and/or portable oxygen supplies.

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

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

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

### *Glucose Monitoring Supplies*

Medicare FFS provides coverage for glucose monitors and accompanying supplies (i.e., test strips and lancets) for Medicare beneficiaries with diabetes at a frequency of testing that is medically necessary. The improper payment rate for glucose monitoring supplies was 84.1 percent, accounting for 3.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for glucose monitoring supplies during the 2011 report period was approximately \$1.1 billion.

Given the critical nature of these supplies, it is essential that the beneficiary be closely monitored by a physician and that the related physician documentation supports the continued medical necessity of the glucose monitoring supplies. For Medicare coverage, the patient's medical record must contain sufficient documentation of the patient's medical condition to support the need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as a physician order for the glucose monitoring supplies and evaluations demonstrating physician oversight of the beneficiary, along with the continued need for glucose monitoring supplies.

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

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

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

*Example:* The order for blood glucose test strips submitted by the supplier was signed by the physician in 2007 and valid for one year. In addition, documentation was not submitted by either the supplier or ordering provider that supported clinical management and oversight of the beneficiary's diabetes. This claim was scored as an improper payment due to an insufficient documentation error.

### *Nebulizer Machines and Related Drugs*

Medicare FFS provides coverage for medically necessary nebulizer machines and related drugs for those beneficiaries with various diagnoses affecting lung function and breathing capacity. Nebulizer machines and related drugs had an improper payment rate of 57.4 percent, accounting for 1.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for nebulizer machines and related drugs during the 2011 report period was approximately \$472 million.

Over 90 percent of the errors are caused by insufficient documentation. There must be an order from the treating physician that specifies the type of solution to be dispensed and the administration instructions including the frequency of use. Medicare also requires authenticated documentation from the treating physician that supports the medical necessity of the nebulizer and inhalation drugs and documents that the patient is using the medication as ordered. If any of the documentation requirements are not met, the nebulizer drug is denied as insufficiently documented. The primary cause of insufficient documentation errors for nebulizer drugs was a lack of documentation regarding nebulizer use in the submitted physician's notes. Other insufficient documentation errors were caused by missing physician notes to support use of the nebulizer, the failure of the physician notes to indicate the frequency of use, and a missing physician order for the nebulizer.

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

### *Power Mobility Devices (PMDs)*

The power mobility device (PMD) group of DMEPOS consists of such devices as power wheelchairs and power operated vehicles (scooters), along with accompanying accessories. Medicare FFS provides coverage for PMDs when a beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living within the home, the limitation cannot be sufficiently and safely resolved by the use of a cane or walker, and the beneficiary does not have sufficient arm strength to use a manual wheelchair. In addition, the beneficiary must meet additional medical necessity requirements for specific PMD categories. PMDs had an improper payment rate of 81.8 percent, accounting for

1.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for PMDs during the 2011 report period was approximately \$492 million.

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

Among all claim types, insufficient documentation errors were most notable for PMD claims. If any of the required elements were not documented in the record submitted for review, the claim was considered an improper payment due to insufficient documentation. In addition, because Medicare's coverage of a PMD is determined solely by the patient's mobility needs within the home, the examination must clearly distinguish the patient's abilities and needs within the home from any additional needs for use outside the home. In many cases, the submitted documentation did not specifically validate that the beneficiary needed a PMD to support their activities of daily living within their home.

Example:

The beneficiary's medical record showed that she had a physical condition that led to leg weakness and falls at home. However, as required by the LCD, the face-to-face exam did not address why the beneficiary's mobility limitations could not be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. This claim was scored as an improper payment due to an insufficient documentation error.

*Positive Airway Pressure Devices (CPAP/BiPAP)*

Medicare FFS provides coverage for continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) devices for beneficiaries with sleep apnea. Sleep apnea occurs when a beneficiary stops breathing while sleeping because of obstructions or other issues with his or her airway. CPAP and BiPAP devices help to keep the airway open by blowing air into the airway through a mask worn during sleep. CPAP/BiPAP supplies had an improper payment rate of 63.0 percent, accounting for 1.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for CPAP/BiPAP supplies during the 2011 report period was approximately \$383 million.

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

evaluation by the treating physician, performed within a specified period of time, showing the beneficiary is benefitting from the therapy and is adhering to specified usage guidelines.

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

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

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

## **Evaluation and Management Services**

Evaluation and Management (E&M) services refer to visits and consultations furnished by physicians and other qualified providers to Medicare beneficiaries. E&M services made up a large proportion of the Part B improper payments and were 50 percent more likely to be in error compared to other Part B services. E&M services had an unadjusted improper payment rate of 13.9 percent, accounting for 12.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for E&M services during the 2011 report period was approximately \$4.1 billion.

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

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

Most of the improper payments for E&M services were due to incorrect coding and insufficient documentation errors. Incorrect coding errors for E&M services were commonly found when the provider submitted medical documentation that supported a different E&M code than the code billed. This has been an ongoing issue, as the improper payments for E&M services were largely driven by incorrect coding. E&M service coding was more problematic for some provider types than others during the 2011 reporting period. For example, an increase in errors for initial hospital visits was seen during this time period. This increase was likely the result of the CY 2010 Medicare FFS rule entitled “Revisions to Payment Policies under the Physicians Fee Schedule and Part B for CY 2010” (CMS-1413-FC), which specified that consultation codes, including hospital consultation codes, would no longer be recognized for payment under the Medicare FFS program. The requirements for an initial hospital visit code, which was the code frequently billed instead of the hospital consultation code, were often not met by the type of examination performed on a beneficiary in the hospital.

Another major driver of E&M improper payments during the 2011 reporting period was insufficient documentation. Many of these claims were identified as errors because the submitted records lacked physician authentication or the physician did not obtain the records for the billed E&M services that were not performed in their office (e.g., E&M services that were provided to a beneficiary in the hospital, rather than in the provider’s clinic).

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

# ELIMINATING IMPROPER PAYMENTS IN THE MEDICARE FEE-FOR-SERVICE PROGRAM

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

Under the Government Performance and Results Act (GPRA) and the IPIA, improper payment rate goals are set for Federal agencies. Pursuant to the President's directive to reduce improper payments, CMS established the goal of reducing the 2009 improper payment rate by half by 2012. The goal for the 2012 reporting period is to reduce the Medicare FFS improper payment rate to 5.4 percent. The 5.4 percent goal is based on the adjusted 2009 rate of 10.8 percent and represents a shift to reporting the adjusted improper payment rate each year.

## Corrective Actions to Eliminate Improper Payments

CMS strives to eliminate improper payments in the Medicare FFS program in order to sustain the Medicare Trust Funds while protecting beneficiaries. As previously described, CMS refined the CERT process in 2009 by requiring stricter adherence to CMS policies related to claim submissions in order to more accurately identify improper payments. CMS continues improving the improper payment rate measurement process and has redesigned the CERT sampling methodology to provide additional improper payment information on high risk areas, in accordance with the President's Executive Order 13520 entitled "Reducing Improper Payments and Eliminating Waste in Federal Programs," issued in November 2009.<sup>19</sup>

CMS continuously analyzes the improper payment data gathered from the CERT program and makes changes in areas that show programmatic weakness. CMS also uses the results from CERT to provide feedback to the Medicare FFS claims processing contractors, informing them of ways to enhance their medical review efforts, develop education and outreach efforts, and improve their overall operations. CMS has several corrective actions in place or under development to reduce improper payments stemming from insufficient documentation and medical necessity errors. Additionally, CMS plans to make several programmatic changes that are expected to decrease improper payments and ensure the authenticity of the services billed by providers and suppliers.

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<sup>19</sup> The White House, Office of the Press Secretary, Executive Order-- Reducing Improper Payments and Eliminating Waste in Federal Programs, November 23, 2009 (<http://www.whitehouse.gov/the-press-office/executive-order-reducing-improper-payments>)

Reducing the incidence of improper payments in the Medicare FFS program is essential to protect the fiscal health of the Medicare trust funds. Through the formulation of corrective actions, CMS is working diligently to reach this goal. Specifically, CMS is initiating several projects described below to reduce improper payments.

- **Recovery Auditor Prepay Review Demonstration**  
Expanding the use of Medicare Recovery Auditors in the Medicare FFS program. In fiscal year (FY) 2011, Recovery Auditors recovered \$939.4 million in improperly paid claims. This Medicare program demonstration will allow Recovery Auditors to review claims before they are paid, which will prevent improper payments from happening in the first place.
- **A/B Rebilling Demonstration**  
Allowing a limited number of hospitals to rebill denied inpatient claims that would have been payable in an outpatient setting. Permitting participating hospitals to rebill will allow them to obtain reimbursement for medically necessary services while also protecting beneficiaries, encouraging hospitals to make proper inpatient admission determinations, and reducing appeals. The demonstration will be limited to a representative sample of hospitals nationwide that volunteered to be part of the program.
- **Power Mobility Device Prior Authorization Demonstration**  
Establishing a limited demonstration program that tests whether a prior authorization requirement can reduce fraud and improper payments for certain power mobility devices.

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

**Improper Payments Due to Documentation Errors** - CMS implemented improvements to the Medicare FFS improper payment rate measurement program to ensure that providers and suppliers submit the required documentation, as follows.

- CMS commenced DMEPOS and A/B MAC provider outreach and education task forces in 2010. These task forces consist of claims processing contractor medical review professionals who meet regularly to develop strategies addressing provider education in areas prone to improper payments. The task forces held several open door forums to discuss documentation requirements and answer provider and supplier questions. The task forces also issued several informational articles that have been distributed on an as-needed basis to promote education among providers. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by any member of the public.

- CMS simultaneously contacts both the DMEPOS supplier and the provider who ordered the DMEPOS to advise them of their responsibility to provide medical documentation in support of the supplier's DMEPOS claim.
- CMS revises the medical record request letters as needed to clarify the components of the medical record that are required for a CERT review. The letter serves as a checklist for the provider or supplier to ensure that their record submission is complete. CMS also revised follow-up medical record request letters to include information about the documentation that is missing to ensure the provider or supplier fully understands what documentation needs to be submitted.
- CMS contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by the third party. For example, a third party provider may be a hospital that maintains the evaluation and management notes written by the billing physician.
- To make a more accurate accounting of improper payments, CMS staff members regularly contact providers and suppliers directly for missing documentation.
- CMS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This involves national training sessions, individual meetings with providers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- CMS implemented the Electronic Submission of Medical Documentation (esMD) program into the CERT review process to create greater program efficiencies; allow a quicker response time to documentation requests; and provide better communication between the providers and suppliers, CERT contractors, and CMS. The first phase of esMD went live on September 15, 2011. As more Health Information Handlers (HIHs) begin to offer esMD gateway services to providers, and CMS and HIH provider outreach efforts take hold, CMS expects provider participation to increase. For more information on esMD, see [www.cms.gov/esMD](http://www.cms.gov/esMD).

**Improper Payments Due to Medical Necessity and Coding Errors** - CMS is dedicated to reducing medical necessity errors and is conducting the following corrective actions.

- CMS formed a workgroup of CMS staff to analyze the perpetually high inpatient hospital improper payment rate, identify contributing factors, and recommend corrective actions beyond provider education and increased review.
- Some MACs identified individual hospitals with higher than average improper payments for inpatient hospital claims. The contractors conducted onsite one-on-one education to explain coding and coverage rules for these claims.
- CMS implemented a National Fraud Prevention System (FPS) on June 30, 2011, as required by the Small Business Jobs Act of 2010. The FPS is an innovative risk scoring technology that applies proven predictive models to nationwide Medicare FFS claims on

a pre-payment basis. The risk scores identify highly suspect claims and help target resources to the areas of Medicare's greatest risk.

- CMS is implementing enhanced medical review policies, including new face-to-face physician assessment requirements for some services, as required under the Affordable Care Act (ACA) (Pub. L. 111-148). CMS published a final rule that implemented face-to-face encounter requirements for Medicare home health services on November 17, 2010 as required by Section 6407 of the ACA.
- CMS developed Comparative Billing Reports (CBRs), which provide administrative claims data enabling Medicare non-hospital providers to compare their billing patterns for various procedures or services to their peers on a state and national level. CMS also provides the Program for Evaluating Payment Patterns Electronic Report (PEPPER), which allows Medicare inpatient hospital providers to analyze their billing patterns through a comparison to other providers in the state and in the nation.
- CMS is developing a Program Vulnerability Tracking System (PVTs) that will track vulnerabilities identified by internal and external sources, including the National Fraud Prevention system, the Recovery Auditors, and the HHS Office of the Inspector General. CMS will use the PVTs to inventory and prioritize vulnerabilities and track corrective actions.
- CMS requires Medicare FFS claims processing contractors to develop Error Rate Reduction Plans, which identify the specific causes of the improper payments in their jurisdiction and outline corrective actions for the errors.
- CMS requires the Medicare FFS claims processing contractors to review and validate the CERT results within their jurisdiction in order to determine the education needed to reduce medical necessity and incorrect coding errors.
- CMS developed and installed new correct coding edits in the claims processing systems.
- In October 2010, CMS issued the first Medicare Quarterly Provider Compliance Newsletter to providers and suppliers to educate them on the common causes of improper payments found in the Medicare program and actions they can take to prevent improper payments from occurring in the future. The CMS continues to publish these newsletters on a quarterly basis.
- CMS developed medically unlikely auto-deny edits in the claims processing systems to catch those instances where the service level billed exceeds clinically acceptable limits. These edits are updated quarterly.
- CMS approved additional areas for Medicare FFS Recovery Auditors review, including inpatient hospital stays and DMEPOS. CMS also increased medical record request limits for Recovery Auditors. Information about the results of the Recovery Audit program provides valuable information to providers and suppliers about areas where improvements are needed.
- CMS continually updates Medicare FFS manuals to clarify review requirements in order to promote uniform application of CMS policies across all medical reviews performed by Medicare contractors.

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

- CMS is undertaking numerous aggressive actions to tighten the provider enrollment process, provide more rigorous oversight and monitoring once a provider/supplier enrolls in the program, and strengthen the provider revocation process. CMS implemented a DMEPOS Accreditation program to ensure the legitimacy of the DMEPOS suppliers that bill Medicare FFS and to ensure those suppliers meet all the requirements for participation in the program.
- CMS established a surety bond requirement for most suppliers of DMEPOS.
- In December 2011, as required by the ACA, CMS implemented an automated screening solution to support the revalidation of 1.5 million providers. The enrollment screening solution automates the multiple database checks that were previously conducted manually, increasing the accuracy of results and decreasing application processing time.
- In collaboration with state provider groups, law enforcement, and the Senior Medicare Patrol, CMS hosted a series of events across California to educate physicians on medical identify theft, how to protect their professional and medical identity from fraud, and other fraud-related topics in September 2011.
- On February 2, 2011, CMS published a final rule with comment entitled “Medicare, Medicaid and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” (CMS-6028-FC). This final rule implemented many of the program integrity provisions in the ACA, including the requirement that state Medicaid programs terminate a provider or supplier who has been terminated from another state Medicaid program or from the Medicare program.
- On August 27, 2010, CMS published a final rule entitled “Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards” (CMS-6036-F). This final rule clarified and expanded the existing enrollment requirements that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.
- CMS has replaced the Program Safeguard Contractors (PSCs) with Zone Program Integrity Contractors (ZPICs), which cover seven zones throughout the United States. These zones are aligned with the Medicare claims processing contractors and cover areas that are considered “hot spots” for fraud within the United States.
- CMS has taken steps to fight DMEPOS fraud in the “high risk” states of Florida, California, Texas, Illinois, Michigan, North Carolina and New York. These efforts include more stringent reviews of new suppliers’ applications, unannounced site visits, extensive pre- and post-payment review of claims, interviews with high volume ordering/referring physicians, and visits to high risk beneficiaries to ensure they are appropriately receiving items and services for which Medicare is being billed.

- CMS implemented the first phase of the DMEPOS competitive bidding program, which will have a gradual impact on the DMEPOS improper payment rate.

## APPENDIX

### National Improper Payment Rate by Error Category

Since 2009, the national Medicare FFS improper payment rate has been higher than in previous years. These increases are due primarily to CMS' changes to medical review criteria implemented in 2009. These changes included revisions to the review criteria to more strictly enforce Medicare payment policies, resulting in a corresponding increase in identified improper payments. Table 5 shows the national improper payment rates by year and error category (unadjusted). The greatest increases in the improper payment rates are due to insufficient documentation and medical necessity errors. These are the types of improper payments that have been most impacted by the revised review criteria.

**Table 5: Summary of Improper Payment Rate by Year and by Error Category (Unadjusted)**

Year and Rate Type (Net/Gross)		No Documentation Errors	Insufficient Documentation Errors	Medical Necessity Errors	Incorrect Coding Errors	Other Errors	Improper Payment Rate	Correct Payment Rate
1996	Net <sup>1</sup>	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%	92%
2000	Net	1.2%	1.3%	2.9%	1%	0.4%	6.8%	93.2%
2001	Net	0.8%	1.9%	2.7%	1.1%	-0.2%	6.3%	93.7%
2002	Net	0.5%	1.3%	3.6%	0.9%	0%	6.3%	93.7%
2003	Net	5.4%	2.5%	1.1%	0.7%	0.1%	9.8%	90.2%
2004	Gross <sup>2</sup>	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%

<sup>1</sup>FY 1996-2003 Improper payments were calculated as Overpayments – Underpayments

<sup>2</sup>FY 2004-2011 Improper payments were calculated as Overpayments + absolute value of Underpayments

Table 6 summarizes the percentage of total dollars improperly paid by error category and claim type.

**Table 6: 2010 and 2011 Error Category Comparisons (Unadjusted)<sup>20</sup>**

Error Category	2010	2011				
	Total	Total	Part A excl. Acute Inpatient Hospital	Part A Acute Inpatient Hospital	Part B	DMEPOS
No Documentation	0.1%	0.2%	0.0%	0.0%	0.2%	0.0%
Insufficient Documentation	4.6%	5.0%	1.2%	0.4%	1.6%	1.8%
Medically Unnecessary	4.2%	3.4%	0.5%	2.7%	0.1%	0.1%
Incorrect Coding	1.6%	1.2%	0.1%	0.4%	0.7%	0.0%
Other	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%
Improper Payment Rate (Unadjusted)	10.5%	9.9%	1.8%	3.6%	2.6%	1.9%

Table 7 summarizes the overpayments, underpayments and improper payment rates by claim type and overall.

**Table 7: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions) (Unadjusted)<sup>21</sup>**

Claim Type	Total Paid Amount	Overall Improper Payment			Overpayment		Underpayment	
		Improper Payment	Improper Payment Rate	95% Confidence Interval	Improper Payment	Improper Payment Rate	Improper Payment	Improper Payment Rate
<b>Part A (Total)</b>	\$242.2	\$18.0	7.4%	6.6% - 8.3%	\$17.4	7.2%	\$0.6	0.2%
Part A (Excluding Acute Inpatient Hospital)	\$116.7	\$6.0	5.1%	4.5% - 5.8%	\$5.9	5.1%	\$0.1	0.1%
Part A (Acute Inpatient Hospital)	\$125.5	\$12.0	9.6%	8.2% - 11.0%	\$11.5	9.2%	\$0.5	0.4%
<b>Part B</b>	\$84.4	\$8.9	10.5%	9.6% - 11.5%	\$8.7	10.3%	\$0.2	0.2%
<b>DMEPOS</b>	\$9.7	\$6.6	67.4%	64.2% - 70.6%	\$6.6	67.4%	\$0.0	0.0%
<b>Overall</b>	\$336.4	\$33.5	9.9%	9.3% - 10.6%	\$32.7	9.7%	\$0.8	0.2%

<sup>20</sup> Some columns and/or rows may not sum correctly due to rounding.

<sup>21</sup> Some columns and/or rows may not sum correctly due to rounding.

## Summary of Error Categories

### *No Documentation Errors*

Claims are placed into this category when either the provider fails to respond to repeated attempts to obtain the supporting documentation or the provider responds that they do not have the requested records.

No documentation errors accounted for 0.2 percent of the total Medicare FFS payments made during the 2011 reporting period. The data breaks down by claim type as follows:

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.0%	0.0%	0.2%	0.0%	0.2% <sup>22</sup>

The following is an example of a no documentation error:

- A claims processing contractor paid \$172.00 to a hospital for an outpatient clinic visit. After multiple attempts to obtain the record, the CERT review contractor received a letter that stated “Medical information you are requesting does not exist in the patient’s medical record. No information available.” The claims processing contractor recouped the entire amount.

### *Insufficient Documentation Errors*

Claims are placed into this category when the medical documentation submitted is inadequate to support the billing of the claimed service. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or medically necessary. Claims are also placed into this category when specific documentation that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required as a condition of payment was not completely filled out.

Insufficient documentation errors accounted for 5.0 percent of the total Medicare FFS payments made during the 2011 reporting period. The data breaks down as follows:

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
1.2%	0.4%	1.6%	1.8%	5.0% <sup>23</sup>

<sup>22</sup> Some columns and/or rows may not sum correctly due to rounding.

The following is an example of an insufficient documentation error:

- A claims processing contractor paid \$2,766.87 to a provider for an inpatient hospital stay. After multiple attempts to obtain the documentation, the CERT contractor received an initial history and physical and a brief discharge summary only. The CERT reviewer determined there was insufficient documentation to support the inpatient hospital services billed. The claims processing contractor recouped the entire payment.

### *Medical Necessity Errors*

Claims are placed into this category when the CERT review staff receives adequate documentation from the medical records and can make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies.

Medical necessity errors accounted for 3.4 percent of the total Medicare FFS payments made during the 2011 reporting period. This data breaks down as follows:

<b>Part A (Excluding Acute Inpatient Hospital)</b>	<b>Part A (Acute Inpatient Hospital)</b>	<b>Part B</b>	<b>DMEPOS</b>	<b>Overall</b>
0.5%	2.7%	0.1%	0.1%	3.4% <sup>24</sup>

For inpatient hospital claims, medical necessity errors are often related to hospital stays of short duration where services could have been rendered at a lower level of care. A smaller, yet persistent, number of medical necessity errors occur for inpatient hospital stays of three to five days that resulted in a transfer to a skilled nursing facility (SNF). Some of these patients may have been admitted solely to satisfy the requirement for a minimum three day inpatient hospital stay in order to qualify for SNF services.

A portion of medical necessity errors for inpatient claims was related to the denial of an invasive procedure that affected the DRG payment. If an invasive procedure was deemed medically unnecessary because it did not meet Medicare coverage requirements and the invasive procedure affected the DRG payment, the invasive procedure was denied. In these cases, the DRG was reclassified after removing the medically unnecessary invasive procedure and the improper payment was attributable to the medically unnecessary service.

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<sup>23</sup> Some columns and/or rows may not sum correctly due to rounding.

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

The following is an example of a medical necessity error:

- A claims processing contractor paid \$140.46 for the monthly rental of a semi-electric hospital bed. Per the contractor’s LCD, semi-electric hospital beds are covered by Medicare if the patient’s medical condition requires one or more of the following: positioning of the body in ways not feasible with an ordinary bed, elevation of the head more than 30 degrees most of the time, traction equipment, or frequent changes in body position. The reviewer requested additional documentation from the supplier and ordering physician. The medical records received from the ordering physician failed to support the need for the hospital bed per Medicare requirements. The entire amount was recouped by the claims processing contractor.

### *Incorrect Coding Errors*

Claims are placed into this category when the provider or supplier submits medical documentation that supports (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim. Incorrect coding errors accounted for 1.2 percent of the total Medicare FFS payments made during the 2011 reporting period. The data breaks down as follows:

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.1%	0.4%	0.7%	0.0%	1.2% <sup>25</sup>

The following is an example of an incorrect coding error:

- A claims processing contractor paid a provider \$136.48 for the drug Remicade 10mg per unit, HCPCS code J1745. The beneficiary received 500 mg, or 50 units, but the hospital billed only 10 units. After CERT review, the underpayment of \$343.56 was paid to the hospital.

### *Other Errors*

This category includes claims that do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service).

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

Other errors accounted for 0.1 percent of the total Medicare FFS payments made during the 2011 reporting period. This data breaks down as follows:

Part A (Excluding Acute Inpatient Hospital)	Part A (Acute Inpatient Hospital)	Part B	DMEPOS	Overall
0.0%	0.0%	0.0%	0.0%	0.1% <sup>26</sup>

The following is an example of an ‘other’ error:

- A claims processing contractor paid \$152.95 for anesthesia used during a routine dental extraction for dental caries. As services associated with a non-covered service (dental extraction) are not allowed, the entire amount was recouped by the claims processing contractor.

## Types of Errors by Clinical Setting

Examining the types of CERT review errors and their impact on improper payments is a crucial step toward reducing improper payments in the Medicare FFS program. Table 8 shows that projected improper payments are driven by insufficient documentation errors, medical necessity errors, and, to a lesser extent, incorrect coding errors. The frequency of such errors varies according to clinical setting.

**Table 8: Projected Improper Payments (in Billions of Dollars) by Type of Error and Clinical Setting (Unadjusted)<sup>27</sup>**

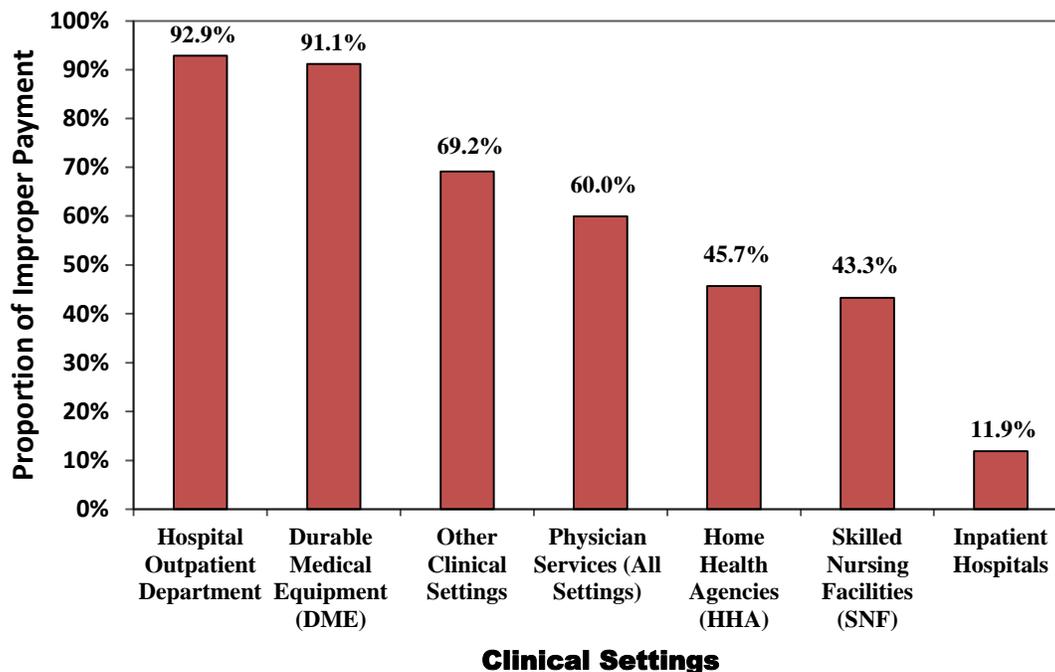
Error Category	DMEPOS	Home Health Agencies	Hospital Outpatient Department	Acute Inpatient Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	\$0.03	\$0.04	\$0.01	\$0.15	\$0.46	\$0.00	\$0.09	\$0.79
Insufficient Documentation	\$5.97	\$0.69	\$2.09	\$1.43	\$4.69	\$0.55	\$1.39	\$16.80
Medically Unnecessary	\$0.45	\$0.66	\$0.05	\$9.13	\$0.23	\$0.44	\$0.44	\$11.41
Incorrect Coding	\$0.03	\$0.08	\$0.09	\$1.30	\$2.44	\$0.20	\$0.06	\$4.20
Other	\$0.07	\$0.03	\$0.00	\$0.03	\$0.01	\$0.09	\$0.02	\$0.26
All Types of Errors	\$6.55	\$1.51	\$2.25	\$12.04	\$7.82	\$1.27	\$2.01	\$33.46

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

<sup>27</sup> Some columns and/or rows may not sum correctly due to rounding.

Figure 2 provides an analysis of the clinical settings where most insufficient documentation errors occurred.

**Figure 2: Proportion of Improper Payments Attributed to Insufficient Documentation, by Clinical Setting**



If the medical documentation submitted for all items or services on a claim was inconclusive to support the billed item or service, the entire payment amount was considered improper. If the submitted medical documentation supported some, but not all, of the billed items or services, only those that were insufficiently documented were considered improper payments.

In several cases of improper payments due to insufficient documentation, it was clear that the Medicare beneficiary received services, but the physician’s orders or documentation supporting the beneficiary’s medical condition was incomplete. These claims were counted as overpayments.

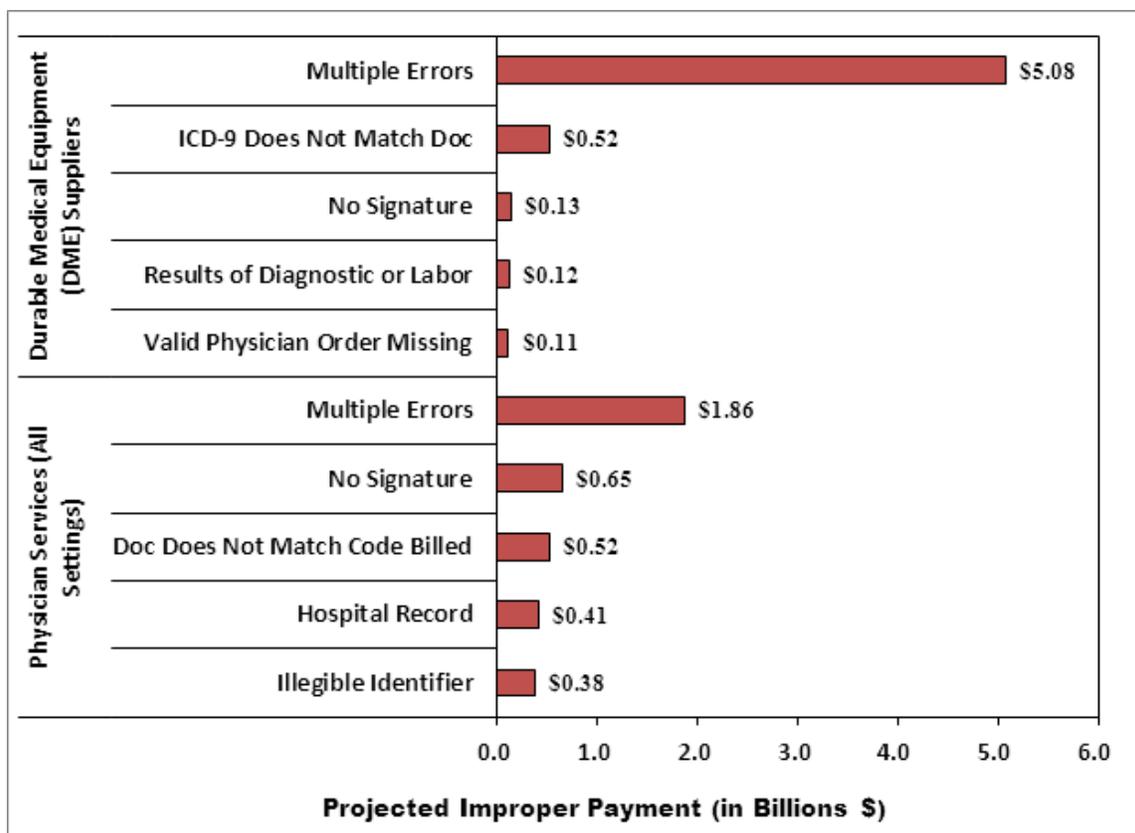
In other instances, components of the medical documentation were maintained at a third party facility. For instance, although a lab may have billed for a blood test, the physician who ordered the lab test maintained the medical record. If the billing provider did not submit records maintained by a third party, the CERT contractor contacted the third party directly to request the missing documentation. If the third party still failed to submit the documentation to the CERT contractor, CMS scored these claims improper payments due to insufficient documentation. Figure 3 displays projected improper payments due to insufficient documentation by the specific reason for the error for both physicians and DMEPOS. Physician services (all settings) and

DMEPOS suppliers accounted for 64 percent of the improper payments due to insufficient documentation. Within these two categories, the specific reasons for insufficient documentation are listed in descending order by improper payments.

Physicians have a multitude of specific reasons that contribute heavily to improper payments due to insufficient documentation. These include the documentation not describing the service rendered and missing signature, when required.

For DMEPOS, insufficient documentation errors are mainly categorized as “multiple errors” because the majority of the cases involved more than one reason for errors.

**Figure 3: Top 5 Reasons for Insufficient Documentation Errors in 2 Clinical Settings (in Billions of Dollars) (Unadjusted)**



The following are the subcategory descriptions for the physician service and DMEPOS insufficient documentation errors shown in Figure 3.

## **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies**

### **Multiple Errors**

- Represents claims that have more than one reason for error.

### **ICD-9 Does Not Match Documentation**

- Although a valid ICD-9-CM code (per the relevant LCD) was submitted, there was no documentation to otherwise support the medical necessity of the service.

### **No Signature**

- Medicare requires that services provided be ordered and authenticated by the ordering provider, either through a handwritten or electronic signature.

### **Results of Diagnostic or Lab Tests Missing**

- The medical necessity for an item is based on the result of a diagnostic test (e.g., an arterial blood gas for home oxygen therapy), but the result is not included in the documentation.

### **Valid Physician Order Missing**

- For DMEPOS items, the supplier must have a detailed written order from the treating physician prior to submitting a claim. For certain items (e.g., power wheelchairs), the detailed written order is required prior to delivery.

## **Physician Services**

### **Multiple Errors**

- Represents claims that have more than one reason for error.

### **No Signature**

- Medicare requires that services provided be ordered and authenticated by the ordering provider, either through a handwritten or electronic signature.

### **Documentation Does Not Match Code Billed**

- The submitted information documents a service that is different from the service described by the billed procedure code.

### **Hospital Record**

- The medical record supporting the physician's billed services is part of the hospital record, which is often kept at a location away from the physician's office.

### **Illegible identifier**

- Medicare requires that services ordered be authenticated by the author through a handwritten or electronic signature. When written, the signature must be legible or

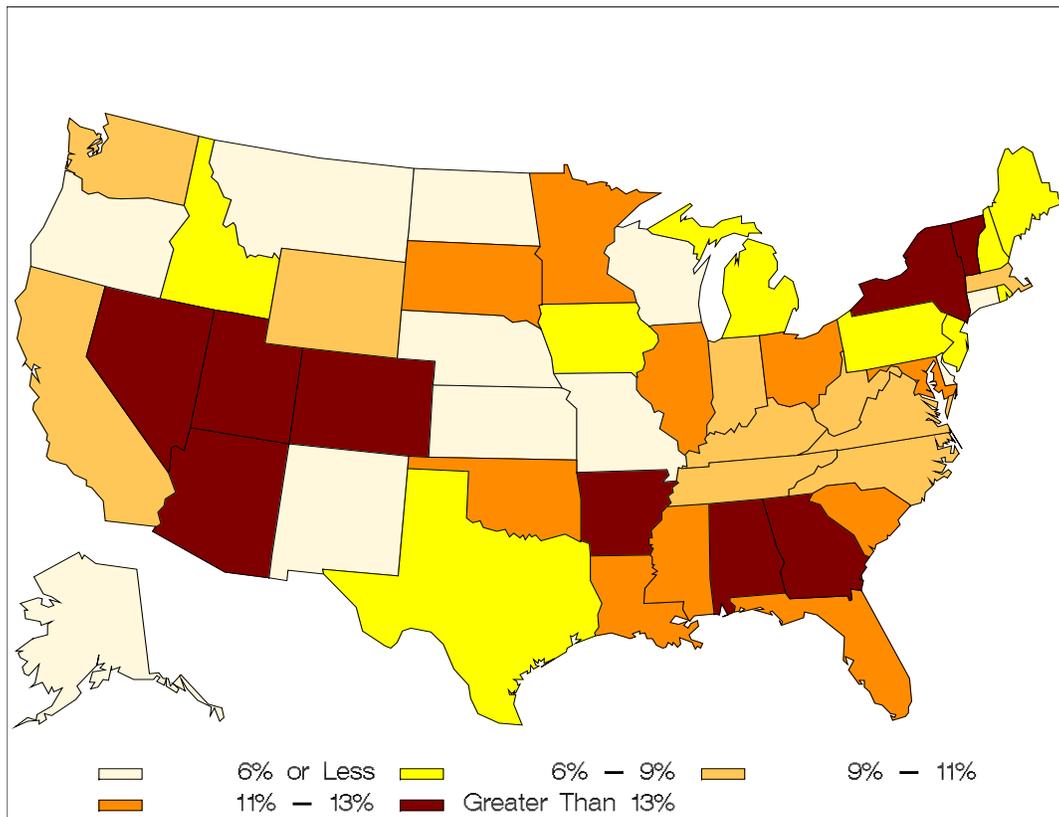
otherwise identifiable (e.g., signed over the physician's printed name or via signature log). If the signature is illegible or missing, CMS gives the provider an opportunity to attest to his or her signature. If the attestation is not returned, it is considered an insufficient documentation-illegible identifier error.

## Geographic Trends

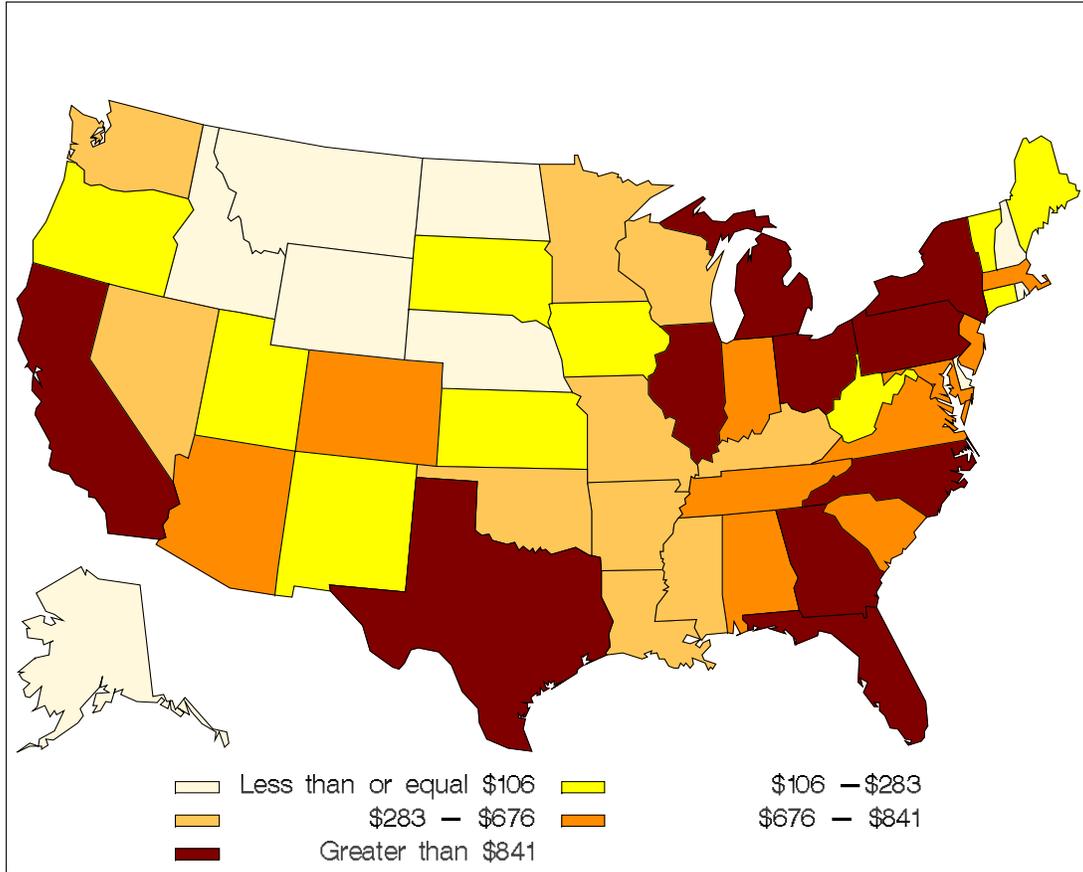
Improper payments vary greatly by geographic location. Identifying the most problematic areas and the differentiating characteristics of those geographic locations can be useful for targeting improper payment reduction efforts.

Figure 4 displays the improper payment rates by state and Figure 5 displays the projected improper payments by state. The states with high improper payment rates and extremely large expenditures are New York, Florida, California, and Texas. These four states constitute 32 percent of overall Medicare FFS payments and 35 percent of total improper payments. New York has the highest improper payment rate of 14.2 percent, with \$3.0 billion in improper payments. Florida has an 11.4 percent improper payment rate, with \$3.0 billion in improper payments. Lowering improper payments in these states is critical to lowering the national improper payment rate.

**Figure 4: Improper Payment Rates by State (Unadjusted)**



**Figure 5: Improper Payments (in Millions of Dollars) by State (Unadjusted)**



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Table 9 displays the improper payment amounts and rates for the top 10 states, as well as the breakdown by overpayments and underpayments. New York, California, Texas and Florida have very high overpayment amounts and improper payment rates.

**Table 9: Projected Improper Payments, Overpayment and Underpayments by State (in Millions of Dollars) (Unadjusted)<sup>28</sup>**

State	Overall		Overpayments		Underpayments	
	Improper Payment	Rate	Improper Payment	Rate	Improper Payment	Rate
<b>Overall</b>	<b>\$33,458.6</b>	<b>9.9%</b>	<b>\$32,686.5</b>	<b>9.7%</b>	<b>\$772.0</b>	<b>0.2%</b>
CA	\$3,289.4	10.4%	\$3,200.8	10.2%	\$88.6	0.3%
NY	\$2,982.7	14.2%	\$2,952.7	14.0%	\$30.1	0.1%
FL	\$2,973.2	11.4%	\$2,780.5	10.6%	\$192.7	0.7%
TX	\$2,401.4	8.2%	\$2,328.5	7.9%	\$72.8	0.2%
IL	\$1,558.6	10.6%	\$1,458.1	9.9%	\$100.5	0.7%
OH	\$1,351.7	11.6%	\$1,347.5	11.6%	\$4.2	0.0%
MI	\$1,141.2	8.4%	\$1,118.7	8.3%	\$22.5	0.2%
GA	\$1,094.6	13.5%	\$1,084.5	13.4%	\$10.0	0.1%
NC	\$1,027.1	9.3%	\$1,014.8	9.1%	\$12.3	0.1%
PA	\$911.2	7.0%	\$900.0	6.9%	\$11.2	0.1%

## CMS Contacts

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<sup>28</sup> Some columns and/or rows may not sum correctly due to rounding.