Improper Medicare Fee-For-Service Payments Report - May 2007

EXECUTIVE SUMMARY

Background

CMS established two programs to monitor the accuracy of payments made in the Medicare Fee-for-Service (FFS) program: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The national paid claims error rate is a combination of error rates calculated by the CERT program and HPMP; the CERT program represents approximately 60% of the payments upon which the error rate is calculated while the HPMP represents the remaining 40%. The CERT program calculates the error rates for Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs). HPMP calculates the error rate for the Quality Improvement Organizations (QIOs). More information on the differences between Carriers/DMERCs/FIs/QIOs may be found in later sections of this report.

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates from 1996 to 2002. The OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Carriers/DMERCs/FIs/QIOs erroneously allowed to be paid). To better measure the performance of the Carriers/DMERCs/FIs/QIOs and to gain insight about the causes of errors, CMS decided to calculate a number of additional rates. The additional rates include provider compliance error rates (which measure how well providers prepared claims for submission) and paid claims error rates (which measure how accurately Carriers/DMERCs/FIs made coverage, coding, and other claims payment decisions) for specific contractors, service types, and provider types. CMS began producing error rates and estimates of improper payments for publication in November 2003.

CMS calculated the Medicare FFS error rate and improper payment estimate for Carriers/DMERCs/FIs/QIOs for this report using a methodology approved by the OIG. This methodology includes:

- CERT randomly selecting a sample of 144,345 claims submitted to Carriers/DMERCs/FIs during the reporting period.
- HPMP randomly selecting a sample of 39,840 acute care inpatient hospital discharges.
- Requesting medical records from the health care providers that submitted the claims in the sample.
- Where medical records were submitted by the provider, reviewing the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules, and, if not, assigning errors to the claims.
- Where medical records were not submitted by the provider, classifying the case as a no documentation claim and counting it as an error.
- Sending providers overpayment letters/notices or making adjustments for claims that were overpaid or underpaid.

Both programs are designed to be a measurement of improper payments. Any claim that was paid when it should not have been is an improper payment. This includes claims that may have been fraudulent.

Neither program can be considered a measure of fraud. Since both programs use random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent; however, one scenario of *potential* fraud that the CERT program *is* able to identify occurs when the CERT documentation contractor is unable to locate a provider or supplier when requesting medical record documentation. This lack of provider or supplier response results in *no documentation* errors. For more information about the impact of this form of potential fraud on the no documentation error rate, see the "No Documentation Errors" section in the body of this report.

Reporting Periods

CMS calculated error rates in this report by reviewing claims that providers submitted during specific *reporting periods*. The following table outlines the reporting periods to date for improper payment reports as well as any changes planned for upcoming reports.

Report	CERT (Carriers/DMERCs/FIs)	HPMP (QIOs)
November 2003	Claims submitted in the 12 month period ending December 31, 2002	Discharges occurring in the 12 month period ending March 31, 2002
November 2004	Claims submitted in the 12 month period ending December 31, 2003	Discharges occurring in the 12 month period ending June 30, 2003
November 2005	Claims submitted in the 12 month period ending December 31, 2004	Short-term Acute Care: Discharges occurring in the 12 month period ending June 30, 2004 Long-term Acute Care and Denied Claims: Claims processed in the 12 month period ending December 31, 2004
November 2006	Claims submitted in the 12 month period ending March 31, 2006	Discharges occurring in the 12 month period ending December 31, 2005
May 2007	Claims submitted in the 12 month period ending September 30, 2006	Discharges occurring in the 12 month period ending June 30, 2006
November 2007 (planned)	Claims submitted in the 12 month period ending March 31, 2007	Discharges occurring in the 12 month period ending December 31, 2006

Impact of Improper Payments Information Act (IPIA)

To promote consistency in improper payment reporting across federal agencies, the IPIA requires agencies to follow a number of methodological requirements when calculating error rates and improper payment estimates. One requirement is the use of gross figures when reporting improper payment amounts and rates. A gross improper payment amount is calculated by **adding** underpayments to overpayments. Unless labeled otherwise, figures in this report are gross figures; historical figures that were originally reported as net numbers have been converted for consistency.
The IPIA also requires the inclusion of denied claims in the sample. The CERT program includes denied claims in its sample for both the May and November reports. The HPMP samples denied claims only for the November report. Therefore, the HPMP denied claims data from the November 2006 report was used to make calculations for this May report. For more information please see "Two Measurement Programs: CERT and HPMP".

Summary of Findings

National Error Rate

This report shows that 4.2% of the dollars paid nationally did not comply with one or more Medicare coverage, coding, billing, and payment rules. Projected overpayments were $9.4 B and the underpayments were $1.0 B. Thus, gross improper payments were projected as $10.4 B (i.e., $9.4 B **plus** $1.0 B).

Contractor Type Error Rates

The following table displays the error rates and improper payment amounts for the Medicare FFS Program for this reporting period.

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$72.9B	$3.3B	4.6%	$0.2B	0.2%	$3.5B	4.8%
DMERC	$9.2B	$0.9B	10.0%	$0B	0.0%	$0.9B	10.0%
FI	$63B	$0.8B	1.2%	$0.2B	0.2%	$0.9B	1.4%
QIOs	$101.8B	$4.4B	4.3%	$0.6B	0.6%	$5.1B	5.0%
All Medicare FFS	**$246.9B**	**$9.4B**	**3.8%**	**$1B**	**0.4%**	**$10.4B**	**4.2%**

Other Error Rates

This report also describes the other error rates in order to provide the most specific information available to target problem areas. Other error rates include error rates by specific contractor, error rates by service type, and error rates by provider type.

The following table lists the contractor, provider, and service type with the highest error rates and improper payments. When comparing contractors, services, or provider types, it is important to note that the highest error rate does not necessarily indicate the highest projected improper payments. For example, the reported error rate is higher for chiropractic services than for E&M services, but the projected improper payments associated with claims submitted for E&M are higher than those for chiropractic services. Therefore, efforts focused on reducing improper payments may focus on E&M services despite the higher error rate in chiropractic services.

Report Section	Highest Paid Claims Error Rates			Highest Projected Improper Payments		
	Entity	Paid Claim Error Rate	Projected Improper Payments	Entity	Projected Improper Payments	Paid Claim Error Rate
Error Rates by Specific Contractors	Palmetto Region C	16.8%	$680.9 M	First Coast Service Options FL, Carrier	$863.3 M	11.1%
Error Rates by Service Type	Negative Pressure Wound Therapy	49.5%	$122.0 M	Other Drugs	$523.1 M	10.5%
Error Rates by Provider Type	Unknown Supplier/Provider	47.0%	$47.5 M	Internal Medicine	$620.5 M	7.8%

Goals

One of the performance goals for CMS is the reduction of improper payments made under the FFS program to 4.3% or less by the November 2007 reporting period. The findings in this report indicate that CMS has made progress toward its November 2007 goal.

Corrective Actions Taken to Date

CMS is working with the **QIOs** to implement the following efforts to lower the paid claims error rate:

1. Using the First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) that generates state-specific hospital billing reports to help QIOs analyze administrative claims data and target interventions with hospitals,
2. Continuing one-on-one educational contacts with providers with indicators of high levels of payment errors,
3. Developing projects with the QIOs addressing state-specific admissions necessity, coding, and billing concerns,
4. Distributing FATHOM generated hospital-specific reports,
5. Developing and distributing QIO-specific payment error cause analyses,
6. Conducting national training on the use of FATHOM reports in compliance efforts, and
7. Providing monthly updates to QIO-specific and national error rates.

CMS is working with each **Carrier/DMERC/FI** to develop a plan that addresses the cause of the contractor's errors, the steps the contractor will take to fix the problems, and other recommendations that will ultimately lower the error rate.

CMS is working with the **CERT contractors** to:

1. Reduce the lag time between the end of a reporting period and the production of the CERT report for that period, thereby providing Carriers/DMERCs/FIs with more timely error rates. CMS has accelerated the sampling and review process; beginning in 2006 the interval between the last sampled claim for a report and it's publication has been reduced from 11 months to 8 months.
2. Perform a small area variation analysis to produce maps of the United States that display CERT error rates and improper payment amounts geographically (available at www.CMS.HHS.gov/cert).
3. Reduce the no documentation errors by:
    - Having CERT contractors make direct contact with every provider that has not provided a medical record or other requested information.
    - Publishing a quarterly newsletter to all Carriers/DMERCs/FIs for redistribution to their providers.
    - Providing a website (http://www.certprovider.org/) to help providers understand the importance of providing an address from which CERT can obtain the provider's medical records.
    - Encouraging providers to use http://www.certprovider.org/ to correct address errors in CERT records.
4. Decrease the insufficient documentation errors by:
    - Improving the processes of requesting and receiving medical records. For example, the CERT Documentation Contractor uses fax servers to capture images of incoming faxes. In addition, they manually image all hardcopy medical records they receive.
    - Modifying the medical record request letters to clarify the components of the record needed for CERT review and to encourage the billing provider to forward the request to the appropriate location. The full impact of this change will not be seen until the November 2007 report.
    - Encouraging Carriers/DMERCs/FIs to educate providers about the importance of submitting thorough and complete documentation, including signing all plans of care, etc.

OVERVIEW

Background

The Social Security Act established the Medicare program in 1965. Medicare currently covers health care needs of people aged 65 and over, the disabled, people with End Stage Renal Disease (ESRD), and certain others that elect to purchase Medicare coverage. Both Medicare costs and the number of Medicare beneficiaries has increased dramatically since 1965. In fiscal year (FY) 2005, more than 43 million beneficiaries were enrolled in the Medicare program, and the total Medicare benefit outlays (both Medicare Fee-for-Service (FFS) and managed care payments) was estimated at about $339.4 B.[1] The Medicare budget represents almost 15% of the total federal budget.

CMS uses several types of contractors to prevent improper payments from being made for Medicare claims and admissions including Carriers, Durable Medical Equipment Regional Carriers (DMERCs), Fiscal Intermediaries (FIs), and Quality Improvement Organizations (QIOs).

The primary goal of each Carrier/DMERC/FI is to "Pay it Right" – that is, to pay the right amount to the right provider for covered and correctly coded services. Budget constraints limit the number of claim reviews these contractors can conduct; thus, they must choose carefully which claims to review. To improve provider compliance, Carriers/DMERCs/FIs must also determine how best to educate providers about Medicare rules and implement the most effective methods for accurately answering coverage and coding questions. As part of its Improper Payments Information Act (IPIA) compliance efforts, and to help all Medicare FFS contractors better focus review and education, CMS has established the Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program (HPMP) to randomly sample and review claims submitted to Medicare.

Both programs are designed to be a measurement of improper payments. Any claim that was paid when it should not have been is an improper payment. This includes claims that may have been fraudulent.

Neither program can be considered a measure of fraud. Since both programs use random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent; however, one scenario of *potential* fraud that the CERT program *is* able to identify occurs when the CERT documentation contractor is unable to locate a provider or supplier when requesting medical record documentation. This lack of provider or supplier response results in *no documentation* errors. For more information about the impact of this form of potential fraud on the no documentation error rate, see the "No Documentation Errors" section.

[1] 2006 CMS Statistics: U.S. Department of Health and Human Services, CMS pub. No 03455, October 2006

History of Error Rate Production

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) estimated the Medicare FFS error rate from 1996 through 2002. The OIG designed their sampling method to estimate a national Medicare FFS paid claims error rate. Due to the sample size – approximately 6,000 claims – the OIG was unable to produce error rates by contractor type, specific contractor, service type, or provider type. The confidence interval for the national paid claims error rates during these years was +/- 2.5%. Following recommendations from the OIG, CMS increased the sample size for the CERT program when production began on the Medicare FFS error rate for the November 2003 Report. The sample size for error rates concerning Carriers/DMERCs/FIs in this reporting period was 144,345 paid and denied claims. The sample size for error rates concerning QIOs for the reporting period was 39,840 discharges.

Types of Error Rates Produced

To better measure the performance of the Carriers/DMERCs/FIs and to gain insight into the causes of errors, CMS decided to calculate not only a national Medicare FFS paid claims error rate but also a provider compliance error rate.

Paid Claims Error Rate

This rate is based on dollars paid after the Medicare contractor made its payment decision on the claim. This rate includes fully denied claims for Carriers/DMERCs/FIs/QIOs. The paid claims error rate is the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied and is a good indicator of how claim errors in the Medicare FFS Program impact the trust fund. CMS calculated the gross rate by adding underpayments to overpayments and dividing that sum by total dollars paid.

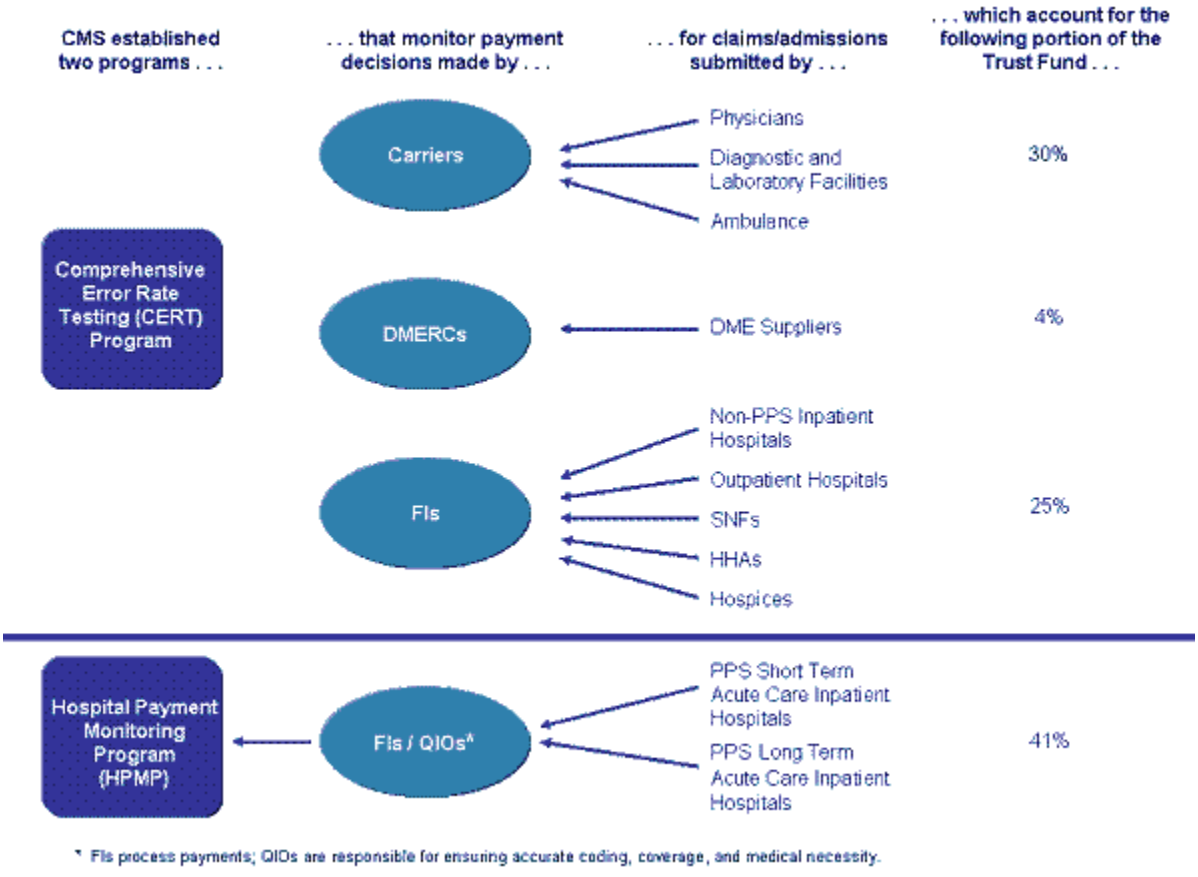
Provider Compliance Error Rate

This rate is based on how the claims looked when they first arrived at the Carrier/DMERC – before the Carrier/DMERC applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the Carrier/DMERC is educating the provider community since it measures how well providers prepared claims for submission. CMS does not collect covered charge data from FIs; therefore, current FI data is insufficient for calculating a provider compliance error rate. This rate is not generated for QIOs.

Two Measurement Programs: CERT and HPMP

CMS established two programs to monitor the accuracy of the Medicare FFS Program: the CERT program and HPMP. The main objective of these programs is to measure the degree to which CMS and its contractors are meeting the goal of *Paying It Right*. The HPMP monitors prospective payment system (PPS) short-term and long-term acute care inpatient hospital discharges. The CERT program monitors all other claims. The following figure (Figure 1) depicts the types of claims/admissions involved in each monitoring program.

Figure 1: Types of Claims/Admissions Reviewed By CERT and HPMP



The following table (Table 1) summarizes the data that is presented in this report.

Table 1: Error Rates Available in this Report

Monitoring Program	Type of Error Rate(s) Produced	Paid Claims Error Rate	Provider Compliance Error Rate
CERT+HPMP	Medicare FFS	✓	Not Produced
CERT	Carrier/DMERC/FI	✓	✓
	Carrier-Specific	✓	✓
	DMERC-Specific	✓	✓
	FI-Specific	✓	Not Produced
	Type of Service	✓	✓
	Type of Provider	✓	✓
HPMP	QIO Specific	✓	Not Produced
	Type of Service	✓	Not Produced
	Type of Provider	✓	Not Produced

The CERT Program

CMS established the CERT program to monitor the accuracy of Medicare FFS payments made by Carriers/DMERCs/FIs. The main objective of the CERT program is to measure the degree to which CMS and Carriers/DMERCs/FIs are meeting the goal of "Paying it Right". See Appendix H for additional details about the sample used for this report.

Sampling and Medical Record Requests

For this report, the CERT Contractor randomly sampled 144,345 claims from Carriers/DMERCs/FIs. The CERT Contractor randomly selected about 194 claims each month from each Carrier/DMERC/FI. CERT designed this process to pull a blind, electronic sample of claims each day from all of the claims providers submitted that day.

The CERT Contractor requested the medical record associated with the sampled claim from the provider that submitted the claim. The CERT Contractor sent the initial request for medical records via letter. If the provider failed to respond to the initial request after 30 days, the CERT Contractor sent up to three subsequent letters in addition to follow-up phone calls to the provider.

In cases where the CERT Contractor received no documentation from the provider once 90 days had passed since the initial request, the CERT Contractor considered the case to be a no documentation claim and counted it as an error. The CERT Contractor considered any documentation received after the 90th day "late documentation." If the CERT Contractor received late documentation prior to the documentation cut-off date for this report, they reviewed the records and, if justified, revised the error in each rate throughout the report. If the CERT Contractor received late documentation after the cut-off date for this report, they attempted to

complete the review process before the final production of the report. Claims that completed the review process were included in the report. Claims for which the CERT contractor received no documentation were counted as no documentation errors.

Beginning November 1, 2006, CMS revised the timeframe for providers to submit medical records from 90 days to 75 days.

Review of Claims

Upon receipt of medical records, the CERT Contractor's clinicians conducted a review of the claims and submitted documentation to identify any improper payments. They checked the Common Working File to see if the person receiving the services was an eligible Medicare beneficiary, to see if the claim was a duplicate and to make sure that no other insurer was responsible for paying the claim. When performing these reviews, the CERT contractor followed Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective Carrier/DMERC/FI Local Coverage Determinations (LCDs), and articles.

Appeal of Claims

In the November 2003 reporting period, the CERT Contractor did not remove an error from the error rate if a provider appeal (using the normal appeals process) of a CERT initiated denial resulted in a reverse decision. In the November 2004 Report, the CERT Contractor implemented an appeals tracking system and began to back out overturned CERT initiated denials from the error rate; however, some contractors did not enter all the appeals information into the new tracking system before the cut-off date for the report. Therefore, CERT only backed out some of the determination reversals from the error rate in the November 2004 Report. As of the November 2005 report, all Carriers/DMERCs/FIs have the opportunity to ensure that all overturned appeals are entered into the appeals tracking system in sufficient time for production of the error rates.

Variation from the General Methodology

Readers should note that the CERT sample spans from October 2005 to September 2006 while CMS payment data is reported by calendar year. Therefore, the CERT program used payment data from calendar year 2005 to generate the projected improper payments in this report.

For May 2007, the target sample size was approximately 2,000 reviewable claims per cluster. Since there are 62 clusters, the number of reviewable claims for the report period was targeted to be approximately 124,000. A mid-year assessment revealed that, with the existing sampling strategy, some clusters would have sampled less than 2000. A standard adjustment would have been to change the sampling pattern such that each cluster attains their target 2000 sampled claims. Historically, most of the clusters attain the IPIA precision requirement of plus or minus three percentage points and have low error rates. Instead of changing the sampling scheme to obtain 2000 claims for every cluster, the “extra” claims were distributed among those clusters

which historically have had trouble meeting the IPIA precision requirements. This method increases precision for theses historically poor performing clusters. The resulting sample had some clusters with less than 2000 claims sampled and some clusters with more than 2000 claims. Readers should note that a constant weight was assigned for every claim in the cluster for the given year; this assumes little if any seasonality exists in the occurrence of errors in claims.

Naming Conventions

From time to time, a Carrier/DMERC/FI will choose to leave the Medicare program. When this occurs, CMS selects a replacement contractor to take over claims processing, error rate reduction efforts, etc. The *cutover date* is the term used to describe the date that the incoming contractor begins to receive and process claims while the outgoing contractor ceases operations. When preparing these improper payment reports, CMS has adopted a policy of listing the name of the contractor who processed claims from that jurisdiction for more than 6 months of the reporting period.

The following jurisdictions transitioned contractors during the reporting period:

- Medicare NW UT/OR/ID to Noridian UT/OR/ID
- Regence UT to Noridian UT

HPMP

The CMS established the HPMP to measure, monitor, and reduce the incidence of improper PPS acute care inpatient Medicare payments. FIs process these payments; QIOs are responsible for ensuring accurate coding, admission necessity, and coverage. HPMP operates through the QIO program as QIOs have responsibility for ascertaining the accuracy of these payments through the physician peer review process. QIOs work with acute care hospitals to identify and prevent payment errors.

Sampling

Each month a CMS contractor selected a random sample of paid short-term acute care inpatient claims for each state from a clinical data warehouse that mirrors the National Claims History (NCH) database. To allow time for hospital claims submission, HPMP sampled claims after the completion of three months from the month of discharge; claims are 97.5% complete at this time. Beginning with the November 2005 report, HPMP also sampled paid long-term acute care and FI-denied claims (both short-term and long-term). For long term acute care claims, a national random sample not stratified by state was selected monthly. Claims that had been denied at the FI were selected as a single, national random sample. The HPMP sampled a total of 39,840 claims from 52 states and jurisdictions (all 50 states plus Puerto Rico and Washington, D.C.).

Review of Claims

The CMS contractor that performed the sampling of PPS short-term acute care sample claims provided the sampled claims to the Clinical Data Abstraction Centers (CDACs) for screening.

The CDACs validated Diagnosis Related Groups (DRGs), performing independent recoding and admission necessity screening based upon the information provided in the submitted record. Qualified coding specialists performed DRG coding validation. CDAC nurse reviewers performed admission necessity screening. Admission screening involved a detailed examination of each medical record using specific modules of the InterQual admission appropriateness criteria set. In addition, Maryland records were screened for length of stay (Maryland is the only waivered non-PPS state); Maryland length of stay errors are included under medically unnecessary services.

The CDACs did not follow-up with providers; the CDAC referred records that failed screening as well as those that were not received in a timely manner to the responsible QIO for case review. Under the case review process, records are again validated for coding and screened for admission necessity. Those records failing admission necessity screening are sent to peer physician review under which hospitals have further opportunity to supply documentation.

The long-term acute care sample was sent directly to QIOs and was not screened by the CDAC. Denied claims were handled only by the CDAC and were not sent to the QIOs.

Weighting and Determining the Final Results

The error rates were weighted so that each Carrier/DMERC/FI/QIO contribution to the error rate was in proportion to its size (as measured by the percent of allowed charges for which they were responsible). The confidence interval is an expression of the numeric range of values for which CMS is 95% certain that the mean values for the improper payment estimates will fall. As required by the IPIA, the CERT program has included an additional calculation of the 90% confidence interval for the national error rate calculation.

All national improper payment estimates from 1996 to present EXCLUDE coinsurance, deductibles and reductions to recover previous overpayments. When CMS began calculating the additional error rates for contractor-specific, service-type and provider-type in the November 2003 and November 2004 reports, these types INCLUDED coinsurance, deductibles and reductions. The CERT program was unable to exclude them from the improper payment amounts due to system limitations. CMS has since implemented new systems and revised methodology that has allowed for the EXCLUSION of coinsurance, deductibles and reductions from all improper payment amounts beginning with the November 2005 reporting period. As a result, the improper payment estimates from the November 2005 report and forward can not be compared to previously published estimates for contractor-specific, service-type, or provider-type calculations. However, since error rate estimates are unaffected, they can be compared across all reports.

Since error rates are calculated as the sum of overpayments and underpayments divided by the original dollars paid, estimated error rates >100% are possible. In particular, this situation can occur when very large underpayments are found among sampled records. The size of the associated confidence interval which represents the extent of variability should always be considered when evaluating estimated payment error rates.

Table 2: Summary of Inclusion vs. Exclusion

	National Rate	Contractor Specific	Service Type	Provider Type
1996 - 2002	**EXCLUDES** coinsurance, deductibles, and reductions	N/A	N/A	N/A
Nov 2003	**EXCLUDES** coinsurance, deductibles, and reductions	Carrier/DMERC/FI improper payment estimates **INCLUDE** coinsurance, deductibles, and reductions. QIO contractor-specific improper payment estimates **EXCLUDE** coinsurance, deductibles, and reductions.		
Nov 2004	**EXCLUDES** coinsurance, deductibles, and reductions	Carrier/DMERC/FI improper payment estimates **INCLUDE** coinsurance, deductibles, and reductions. QIO contractor-specific improper payment estimates **EXCLUDE** coinsurance, deductibles, and reductions.		
From Nov 2005 Forward	**EXCLUDES** coinsurance, deductibles, and reductions	Carrier/DMERC/FI/QIO improper payment estimates **EXCLUDE** coinsurance, deductibles, and reductions.		

Outcome of Sampled Claims

In the CERT program, Carriers/DMERCs/FIs are notified of detected overpayments so that they can implement the necessary adjustments. Carriers/DMERCs/FIs are also notified of underpayments but they are not currently required to make payments to providers for underpayments identified in the CERT program. Carriers/DMERCs/FIs are encouraged to make payments to providers in underpayment cases identified by the CERT program. For more information about overpayments see Appendix F, for underpayments, see Appendix G. Sampled claims for which providers failed to submit documentation were considered overpayments.

QIOs in the HPMP notified FIs of adjustments necessary due to overpayment and underpayment errors identified by the program. When a QIO determined that a DRG coding change was required, the FI was also informed of the appropriate DRG. In addition, the FI was informed when: a stay was found to be inappropriate, the requested medical records were not supplied, or insufficient documentation was provided. In each case, the stay was denied and was considered an overpayment. FIs were responsible for determining payment adjustments for claims found to be in error. The QIOs did not determine adjustment amounts nor did they implement payment adjustments.

Providers can appeal denials (including no documentation denials) following the normal appeal processes by submitting documentation supporting their claims. For the November 2003 Report, the CERT program did not consider the outcome of appeal determinations. However, beginning

with the claims in the November 2004 Report, the CERT program considered the outcome of any appeal determinations that reversed the CERT program's decision when computing the error rates. The CERT program deducted $351.7 M in appeals reversals from the error rates contained in this report. Under the QIO case review process, hospitals have multiple opportunities to appeal a QIO decision. Cases are not included as payment errors for all HPMP calculations until all hospital case review appeals are complete. All known appeal determinations that reversed a QIO's decision are considered when computing error rates.

The CERT program identified $797,798 in actual overpayments and, as of the final cut-off date for this report, Carriers/DMERCs/FIs had collected $540,738 of those overpayments. The HPMP identified $14,722,375 in overpayments and, as of the final cutoff date for this report, the FIs had processed $11,961,261 in HPMP adjustments. CMS and its contractors will never collect a small proportion of the identified overpayments because:

- The responsible provider appealed the overpayment and the outcome of the appeal overturned the CERT decision.
- The provider has gone out of business.

However, for all other situations, the Carrier/DMERC/FI will continue their attempts to collect the overpayments.

GPRA Goals

CMS aims to accomplish three error rate goals under the Government Performance and Results Act (GPRA).

1. Reduce the National Medicare FFS Paid Claims Error Rate.

- By November 2007, reduce the percent of improper payments under Medicare FFS to 4.3%.
- By November 2008, reduce the percent of improper payments under Medicare FFS to 4.2%.
- By November 2009, reduce the percent of improper payments under Medicare FFS to 4.1%.

2. Reduce the Contractor-Specific Paid Claim Error Rate

- By November 2007, 75% of Medicare claims will be processed by contractors with an error rate less than or equal to the national error rate for November 2006.
- By November 2008, every Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for November 2007.

3. Decrease the Provider Compliance Error Rate

- This goal is developmental for 2007.
- In November 2008, CMS will set a measurement baseline for this goal.

How Error Rates Will be Used

CMS will use the error rate findings described in this report to determine underlying reasons for claim errors and to adjust its action plans to improve compliance in payment, documentation, and provider billing practices. The tracking and reporting of error rates also helps CMS identify emerging trends and implement corrective actions designed to accurately manage all Medicare FFS contractors' performance. In addition, the error rates will provide all Medicare FFS contractors with the guidance necessary to direct claim review activities, provider education efforts, and data analysis. Carriers/DMERCs/FIs also use the error rate findings to adjust their Error Rate Reduction Plans. CMS evaluates QIOs under their contract on payment error rates.

FINDINGS

National Medicare FFS Error Rate

The national paid claims error rate in the Medicare FFS program for this reporting period is 4.2% (which equates to $10.4 B). The 95% confidence interval for Medicare FFS program paid claims error rate was 4.0% - 4.4%. The 90% confidence interval (required to be reported by IPIA) was 4.0% - 4.4%.

Table 3a summarizes the overpayments, underpayments, improper payments, and error rates by contractor type.

Table 3a: Error Rates and Projected Improper Payments by Contractor Type

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$72.9B	$3.3B	4.6%	$0.2B	0.2%	$3.5B	4.8%
DMERC	$9.2B	$0.9B	10.0 %	$0B	0.0%	$0.9B	10.0%
FI	$63B	$0.8B	1.2%	$0.2B	0.2%	$0.9B	1.4%
QIOs	$101.8B	$4.4B	4.3%	$0.6B	0.6%	$5.1B	5.0%
All Medicare FFS	**$246.9B**	**$9.4B**	**3.8%**	**$1B**	**0.4%**	**$10.4B**	**4.2%**

Table 3b summarizes the overpayments and underpayments, improper payments and error rates by year.

Table 3b: National Error Rates by Year[2]

Year	Total Dollars Paid	Overpayments		Underpayments		Overpayments + Underpayments	
		Payment	Rate	Payment	Rate	Improper Payments	Rate
1996	$168.1 B	$23.5B	14.0%	$0.3 B	0.2%	$23.8 B	14.2%
1997	$177.9 B	$20.6B	11.6%	$0.3 B	0.2%	$20.9 B	11.8%
1998	$177.0 B	$13.8B	7.8%	$1.2 B	0.6%	$14.9 B	8.4%
1999	$168.9 B	$14.0B	8.3%	$0.5 B	0.3%	$14.5 B	8.6%
2000	$174.6 B	$14.1B	8.1%	$2.3 B	1.3%	$16.4 B	9.4%
2001	$191.3 B	$14.4B	7.5%	$2.4 B	1.3%	$16.8 B	8.8%
2002	$212.8 B	$15.2B	7.1%	$1.9 B	0.9%	$17.1 B	8.0%
2003	$199.1 B	$20.5B	10.3%	$0.9 B	0.5%	$12.7 B	6.4%
2004	$213.5 B	$20.8B	9.7%	$0.9 B	0.4%	$21.7 B	10.1%
2005	$234.1 B	$11.2 B	4.8%	$0.9 B	0.4%	$12.1 B	5.2%
2006	$246.8 B	$9.8 B	4.0%	$1.0 B	0.4%	$10.8 B	4.4%
May 2007	$246.9 B	$9.4 B	3.8%	$1.0 B	0.4%	$10.4 B	4.2%

[2] The 2003 entries were adjusted to account for high non-response rates. Including non-response, the national projected improper payments would have been $21.5B and the national paid claims error rate would have been 10.8%.

Paid Claims Error Rate by Error Type

Table 3c summarizes the percent of the total dollars improperly allowed by error category for this and previous reports.

Table 3c: Summary of Error Rates by Category[3]

Type Of Error	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	May 2007
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross	Gross
No Doc Errors	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%	0.6%
Insufficient Doc Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%	0.5%
Medically Unnecessary Errors	5.1%	4.2%	3.9%	2.6%	2.9%	2.7%	3.6%	1.1%	1.6%	1.6%	1.4%	1.5%
Incorrect Coding Errors	1.2%	1.7%	1.3%	1.3%	1.0%	1.1%	0.9%	0.7%	1.2%	1.5%	1.6%	1.5%
Other Errors	1.1%	0.5%	0.7%	0.9%	0.4%	-0.2%	0.0%	0.1%	0.2%	0.2%	0.2%	0.2%
IMPROPER PAYMENTS	**13.8 %**	**11.4 %**	**7.1%**	**8.0%**	**6.8%**	**6.3%**	**6.3%**	**9.8%**	**10.1%**	**5.2%**	**4.4%**	**4.2%**
CORRECT PAYMENTS	86.2 %	88.6 %	92.9 %	92.0 %	93.2 %	93.7 %	93.7 %	90.2 %	89.9%	94.8%	95.6%	95.8%

Table 3d summarizes the percent of total dollars improperly allowed by error category and contractor type.

Table 3d: Type of Error Comparison for 2006 and May 2007 [4]

Type of Error	Nov 2006 Report	May 2007 Report				
	Total	Total	Carrier	DMERC	FI	QIO
No Documentation Errors	0.6%	0.6%	0.3%	0.2%	0.0%	0.0%
Insufficient Documentation Errors	0.6%	0.5%	0.3%	0.0%	0.1%	0.0%
Medically Unnecessary Errors	1.4%	1.5%	0.0%	0.1%	0.0%	1.3%
Incorrect Coding Errors	1.6%	1.5%	0.7%	0.0%	0.2%	0.6%
Other Errors	0.2%	0.2%	0.0%	0.0%	0.0%	0.1%
Improper Payments	4.4%	4.2%	1.4%	0.4%	0.4%	2.0%

[3] The 2003 entries were adjusted to account for high non-response rates. Including non-response, the national projected improper payments would have been $21.5B and the national paid claims error rate would have been 10.8%.

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

No Documentation Errors

No documentation means the provider did not submit any medical record documentation to support the services provided.[5] No documentation errors accounted for 0.6% of the total dollars all Medicare FFS contractors allowed during the reporting period. QIO data is categorized in a different manner than the data for Carriers/DMERCs/FIs; therefore, the QIO no documentation estimates include claims that are categorized as *insufficient documentation* for Carriers/DMERCs/FIs. This data breaks down by contractor type as follows[6]:

Carrier	DMERC	FI	QIO	Total
0.3%	0.2%	0.0%	0.0%	0.6%

Table 4a is a combined list of the services with the highest projected improper payments due to no documentation errors for all contractor types. All series 4 tables are sorted in descending order by projected improper payments.

Table 4a: Top 20 Services with No Documentation Errors: Carriers/DMERCs/FIs/QIOs

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	No Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Budesonide, non-compounded (J7626)	26.7%	$49,756,692	9.1% - 44.3%
EF spec metabolic noninherit (B4154)	28.3%	$46,138,649	6.5% - 50.2%
Neg pres wound ther drsg set (A6550)	68.3%	$38,088,031	36.2% -100.4%
Methylprednisolone 80 MG inj (J1040)	78.2%	$35,132,137	54.2% -102.2%
Levalbuterol unit dose (J7614)	11.0%	$34,949,934	(1.1%) - 23.1%
Powered pres-redu air mattrs (E0277)	27.0%	$26,902,977	7.5% - 46.5%
HEART FAILURE & SHOCK	0.7%	$22,509,229	(0.1%) - 1.4%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$18,356,653	0.0% - 0.2%
Enteral feed supp pump per d (B4035)	10.1%	$18,311,167	0.2% - 20.0%
Office/outpatient visit, est (99213)	0.4%	$15,728,656	0.2% - 0.6%
Psytx, off, 45-50 min (90806)	5.2%	$13,788,655	(4.5%) - 14.8%
Subsequent hospital care (99232)	0.6%	$13,590,583	0.1% - 1.1%
G.I. HEMORRHAGE W CC	0.9%	$12,693,170	(0.4%) - 2.3%
Albuterol non-compounded (J7620)	7.2%	$9,894,430	(0.1%) - 14.5%
Blood glucose/reagent strips (A4253)	0.9%	$8,864,056	0.3% - 1.5%
Mri brain w/o & w/dye (70553)	2.0%	$8,497,503	(1.8%) - 5.8%
Psy dx interview (90801)	5.0%	$8,290,348	(1.7%) - 11.8%

[5] Due to the extremely low insufficient documentation error rate for QIOs, any insufficient documentation errors have been added to the no documentation rate rather than the insufficient documentation category.
[6] Some columns and/or rows may not sum correctly due to rounding.

O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	0.5%	$7,786,211	(0.5%) - 1.6%
OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	1.2%	$7,695,627	(1.1%) - 3.4%
Ct thorax w/dye (71260)	3.4%	$6,368,234	(3.1%) - 10.0%
Overall	**0.6%**	**$1,442,096,660**	**0.4% - 0.7%**

The following are examples of No Documentation errors:

- A Fiscal Intermediary (FI) paid $144.80 for an Outpatient Clinic Visit. After multiple attempts to obtain supporting documentation, the provider sent the following statement: "Last documented visit on file 08/05. No records for date requested". As a result, the CERT Contractor counted the entire payment as an error.
- A Carrier paid $446.16 for an office visit and an injection of Epoetin. After multiple attempts to obtain documentation, no documentation was ever received from provider. As a result, the CERT Contractor counted the entire payment as an error.
- A hospital submitted a short-term acute care inpatient claim for $3,640.91, which was paid. However, when the substantiating medical record was requested, the hospital failed to provide the record. Thus, the entire payment was recouped.

An unusual number of the claims sampled in Florida resulted in no documentation errors during the May report period. The no documentation errors in Florida accounted for 0.4% of the 0.6% national no documentation error rate. About three quarters of the claims with no documentation errors were submitted by DME suppliers while the remaining quarter was submitted by Part B providers.

For most of the DMERC claims scored as no documentation errors, the DME supplier was unreachable after their claims were sampled for the CERT program. This is attributable, at least in part, to the continued efforts of CMS and contractors finding and disabling or revoking provider numbers for providers not in compliance with CMS policies. Most of the providers who did not respond during the May report period were associated with provider numbers that were revoked some time during the sampling process.

A smaller number of Carrier claims in the sample resulted in no documentation errors due, in part, to ongoing fraud fighting efforts. In several cases, these claims were associated with provider numbers revoked in direct response to ongoing CMS efforts in Florida.

Based on findings in this report and observations from other monitoring activities, CMS is developing safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments. CMS plans to implement these actions over the next few months and include an update in the November 2007 report.

Insufficient Documentation Errors

Insufficient documentation means that the provider did not include pertinent patient facts (e.g., the patient's overall condition, diagnosis, and extent of services performed) in the medical record documentation submitted.[7]
Insufficient documentation errors accounted for 0.5% of the total dollars allowed during the reporting period. This data breaks down as follows:[8]

Carrier	DMERC	FI	QIO	Total
0.3%	0.0%	0.1%	0.0%	0.5%

In several cases of insufficient documentation, it was clear that Medicare beneficiaries received services, but the physician's orders or documentation supporting the beneficiary's medical condition were incomplete. While these errant claims did not meet Medicare reimbursement rules regarding documentation, CMS could not conclude that the services were not provided.

In some instances, components of the medical documentation were located and 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 failed to contact the third party or the third party failed to submit the documentation to the CERT Contractor, CMS counted the claim as a full or partial insufficient documentation error.

Table 4b is a combined list of the services with the highest insufficient documentation paid claims error rates for Carriers/DMERCs/FIs. This table does not include QIOs.

Table 4b: Top 20 Services with Insufficient Documentation: Carriers/DMERCs/FIs

Carriers (HCPCS), DMERCs (HCPCS), and FIs (Type of Bill)	Insufficient Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	1.0%	$187,114,175	0.7% - 1.3%
Subsequent hospital care (99232)	4.0%	$93,876,185	2.9% - 5.1%
Subsequent hospital care (99233)	3.9%	$47,595,817	2.2% - 5.5%
Therapeutic exercises (97110)	5.7%	$33,695,669	3.5% - 7.8%
ESRD related svs 4+mo 20+yrs (G0317)	6.0%	$28,478,302	0.1% - 11.8%
Subsequent hospital care (99231)	5.6%	$24,755,648	3.8% - 7.5%
Office/outpatient visit, est (99213)	0.5%	$22,383,800	0.3% - 0.7%
Office/outpatient visit, est (99214)	0.6%	$21,797,741	0.3% - 0.9%
Critical care, first hour (99291)	3.2%	$21,298,239	0.4% - 6.1%

[7] Due to the extremely low insufficient documentation error rate for QIOs, any insufficient documentation errors have been added to the no documenation rate rather than the insufficient documentation category.
[8] Some columns and/or rows may not sum correctly due to rounding.

Clinic-hospital based or independent renal dialysis facility (72)	0.4%	$19,444,997	0.1% - 0.7%
Initial hospital care (99223)	2.9%	$19,431,876	0.8% - 5.1%
Chiropractic manipulation (98941)	4.4%	$14,861,397	1.8% - 7.0%
Office/outpatient visit, est (99211)	9.6%	$14,515,692	6.8% - 12.5%
Initial inpatient consult (99255)	2.5%	$13,131,730	(0.3%) - 5.3%
Manual therapy (97140)	5.8%	$12,274,545	3.2% - 8.5%
Initial inpatient consult (99254)	1.8%	$11,929,103	0.4% - 3.2%
Neuromuscular reeducation (97112)	11.1%	$11,147,286	5.1% - 17.2%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.6%	$10,601,159	0.3% - 0.9%
Therapeutic activities (97530)	8.7%	$10,089,401	2.0% - 15.5%
SNF-outpatient (HHA-A also) (23)	6.2%	$10,070,494	(2.1%) - 14.4%
All Other Codes	0.5%	$506,891,181	0.4% - 0.6%
Overall	**0.8%**	**$1,135,384,438**	**0.7% - 0.9%**

The following are examples of insufficient documentation errors:

- An FI paid $1,120.20 for Physical Therapy, in a skilled nursing facility SNF), Part B stay. The nurse reviewer was missing the documentation for the physician's order, therapy evaluation and plan of care, certified by the ordering physician. After multiple attempts to obtain the documentation, the CERT reviewer determined there was insufficient documentation to support the services billed and the CERT Contractor counted the entire payment as an error.
- A Carrier paid $139.69 for an inpatient consultation. Multiple attempts were made to obtain the documentation. Documentation received consisted of multiple copies of the discharge summary only. As a result, the CERT Contractor counted the claim line in error and recouped the entire amount.

Medically Unnecessary Services

Medically Unnecessary Services includes situations where the CERT or HPMP claim review staff identifies enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary. In the case of inpatient claims, determinations are also made with regard to the level of care; for example, in some instances another setting besides inpatient care may have been more appropriate. If a QIO determines that a hospital admission was unnecessary due to not meeting an acute level of care, the entire payment for the admission is denied.
Medically Unnecessary Service errors accounted for 1.5% of the total dollars allowed during the reporting period. This data breaks down as follows:[9]

Carrier	DMERC	FI	QIO	Total
0.0%	0.1%	0.0%	1.3%	1.5%

For QIOs, this is predominantly related to hospital stays of short duration where services could have been rendered at a lower level of care. A smaller, but persistent amount of medically unnecessary payment errors is due to unnecessary inpatient admissions associated with discharges to a skilled nursing facility.

Table 4c lists the top twenty medically unnecessary services for Carriers/DMERCs/FIs/QIOs.

Table 4c: Top 20 Medically Unnecessary Services: Carriers/DMERCs/FIs/QIOs

Service Billed to Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	Medically Unnecessary Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	11.5%	$155,477,249	8.4% - 14.6%
CHEST PAIN	21.9%	$137,901,470	17.0% - 26.8%
MEDICAL BACK PROBLEMS	28.9%	$94,450,100	18.8% - 38.9%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	8.3%	$80,439,494	5.5% - 11.0%
Blood glucose/reagent strips (A4253)	8.1%	$77,623,499	6.6% - 9.6%
RENAL FAILURE	4.1%	$66,417,610	2.0% - 6.1%
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	3.5%	$62,692,556	(1.3%) - 8.3%
OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	9.2%	$62,148,918	0.9% - 17.5%
SYNCOPE & COLLAPSE W CC	10.8%	$54,672,803	6.1% - 15.6%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	12.9%	$54,222,498	6.0% - 19.9%

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

PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	6.7%	$51,185,644	(0.3%) - 13.7%
HEART FAILURE & SHOCK	1.4%	$49,091,546	0.8% - 2.1%
SNF-inpatient or home health visits (Part B only) (22)	4.7%	$46,719,085	3.2% - 6.1%
DIABETES AGE >35	15.1%	$45,733,220	8.0% - 22.2%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	17.8%	$43,961,453	10.1% - 25.4%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	7.0%	$43,720,059	0.4% - 13.5%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	4.5%	$42,564,061	2.4% - 6.7%
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.2%	$39,853,914	0.2% - 2.2%
EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.4%	$39,051,720	(2.8%) - 9.5%
G.I. HEMORRHAGE W CC	2.9%	$38,800,251	1.2% - 4.6%
Overall	**1.5%**	**$3,670,955,693**	**1.4% - 1.6%**

The following are examples of medically unnecessary services:

- An FI paid $91.56 for daily glucose monitor checks in a SNF, Part B stay. After review of the documentation, the nurse reviewer determined that there was no medical necessity for the daily testing. The CERT contractor counted the claim in error and the entire amount was recouped.
- An FI denied a CAT scan of the thorax with contrast as not medically necessary, based on their local coverage determination (LCD). The nurse reviewer determined that as a result of the FI denial, the low Osmolar contrast billed which paid $109.20 should also have been denied as not medically necessary. The money was recouped.
- A Medicare beneficiary with symptoms of abdominal pain and vomiting was admitted. No documentation to substantiate the medical necessity for inpatient admission was submitted to the QIO for review. Thus, an adjustment for the full payment of $6,077.76 was submitted.

Incorrect Coding

Providers use standard coding systems to bill Medicare. For most of the coding errors, the medical reviewers determined that providers submitted documentation that supported a lower code than the code submitted (in these cases, providers are said to have *overcoded* claims). However, for some of the coding errors, the medical reviewers determined that the documentation supported a higher code than the code the provider submitted (in these cases, the providers are said to have *undercoded* claims).

Incorrect Coding errors accounted for 1.5% percentage of the total dollars allowed during the reporting period. This data breaks down as follows:[10]

Carrier	DMERC	FI	QIO	Total
0.7%	0.0%	0.2%	0.6%	1.5%

A common error involved overcoding or undercoding E&M codes by one level on a scale of five code levels. Published studies suggest that under certain circumstances, experienced reviewers may disagree on the most appropriate code to describe a particular service. This may explain some of the incorrect coding errors in this report. CMS is investigating procedures to minimize the occurrence of this type of error in the future.

Table 4d lists the services with the highest paid claims error rates due to incorrect coding for Carriers/DMERCs/FIs/QIOs. Table 4e includes only undercoding errors for Carriers/DMERCs/FIs.

Table 4d: Top 20 Services with Incorrect Coding Errors: Carriers/DMERCs/FIs/QIOs

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	Incorrect Coding Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Office/outpatient visit, est (99214)	5.4%	$198,172,288	4.9% - 6.0%
Subsequent hospital care (99233)	14.8%	$181,228,406	12.5% - 17.1%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.9%	$161,358,304	0.6% - 1.2%
SNF-inpatient (including Part A) (21)	0.8%	$117,166,010	0.5% - 1.1%
Office consultation (99244)	13.0%	$100,231,929	10.5% - 15.4%
Initial inpatient consult (99255)	18.7%	$98,795,120	14.3% - 23.2%
Office/outpatient visit, est (99215)	15.4%	$98,404,431	13.2% - 17.6%
Initial inpatient consult (99254)	14.4%	$95,560,483	12.0% - 16.7%
Initial hospital care (99223)	12.1%	$80,693,350	9.2% - 15.0%
SEPTICEMIA AGE >17	2.7%	$78,353,714	1.4% - 4.1%
Office/outpatient visit, new (99204)	20.7%	$67,948,875	16.4% - 25.0%
Office consultation (99245)	17.5%	$65,649,590	13.0% - 21.9%
Subsequent hospital care (99232)	2.5%	$58,273,086	1.7% - 3.3%
Office/outpatient visit, est (99213)	1.3%	$55,943,974	1.1% - 1.6%
RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	1.8%	$52,562,397	0.3% - 3.4%
Office/outpatient visit, new (99203)	12.2%	$51,920,884	9.8% - 14.6%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	4.1%	$42,081,617	(1.7%) - 9.9%

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

Office consultation (99243)	8.7%	$41,788,659	6.7% - 10.7%
MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6%	$39,408,597	0.2% - 3.1%
STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	6.0%	$38,282,926	(2.3%) - 14.4%
Overall	**1.5%**	**$3,628,890,224**	**1.4% - 1.6%**

Table 4e: Top 20 Services with Underpayment Coding Errors: Carriers/DMERCs/FIs

Carriers (HCPCS), DMERCs (HCPCS), and FIs (Type of Bill)	**Underpayment Coding Errors**		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.3%	$57,691,535	0.2% - 0.5%
Office/outpatient visit, est (99213)	0.6%	$26,505,847	0.4% - 0.8%
Office/outpatient visit, est (99212)	3.3%	$21,330,250	2.4% - 4.1%
Darbepoetin alfa, non-esrd (J0881)	2.8%	$18,381,454	(1.3%) - 6.9%
HHA-outpatient (HHA-A also) (33)	0.4%	$15,212,490	0.0% - 0.7%
SNF-inpatient (including Part A) (21)	0.1%	$12,096,177	(0.0%) - 0.2%
Subsequent hospital care (99231)	1.4%	$6,246,991	0.7% - 2.1%
Clinic-hospital based or independent renal dialysis facility (72)	0.1%	$4,987,231	0.0% - 0.2%
Office/outpatient visit, est (99211)	3.1%	$4,736,040	1.2% - 5.1%
Emergency dept visit (99283)	1.9%	$4,290,407	0.1% - 3.6%
Chiropractic manipulation (98940)	2.3%	$3,080,703	0.5% - 4.0%
Special facility or ASC surgery-rural primary care hospital (eff 10/94) (85)	0.2%	$2,826,064	0.1% - 0.3%
HHA-inpatient or home health visits (Part B only) (32)	0.0%	$2,636,845	0.0% - 0.1%
Nursing fac care, subseq (99307)	3.1%	$2,254,949	0.8% - 5.3%
Initial inpatient consult (99255)	0.4%	$2,088,037	(0.4%) - 1.2%
ESRD related svs 2-3 mo 20+y (G0318)	1.6%	$2,083,944	1.2% - 2.1%
Subsequent hospital care (99232)	0.1%	$2,083,001	(0.0%) - 0.2%
Eye exam established pat (92012)	0.5%	$1,545,498	(0.0%) - 0.9%
Hospital-other (Part B) (14)	0.2%	$1,361,392	(0.0%) - 0.4%
Initial inpatient consult (99254)	0.2%	$1,338,956	(0.2%) - 0.6%
All Other Codes	0.1%	$43,847,139	0.0% - 0.1%
Overall	**0.2%**	**$236,624,950**	**0.1% - 0.2%**

The following are examples of coding errors:

- An FI paid $324.44 to a provider for three injections of Iron Sucrose. The provider had billed J1756, Iron sucrose, 1mg, 40 units. The nurse reviewer determined that the actual amount of the drug injected was 200 mg, thus 200 units. This coding error resulted in an underpayment to the provider of an additional $203.52.
- A Carrier paid $200.88 to a provider for an inpatient consult CPT code 99255 which requires 3 of 3 key components: a comprehensive history, a comprehensive exam, and high complexity medical decision making (MDM). Upon review it was determined that documentation supported downcode to CPT 99252 by meeting/ exceeding 3 of 3 components with detailed history, expanded problem focused (EPF) exam, and moderate complexity MDM. The overpayment collected was $126.10.
- A hospital submitted an inpatient admission claim coded for aspiration pneumonia and hypernatremia. The correct code for admission was dehydration and hypernatremia as the patient aspirated after admission; the payment difference between the two DRGs was $3,595.40.

The OIG and CMS have noted problems with certain procedure codes for the past several years. These problematic codes include CPT codes 99214 (office or other outpatient visit), 99232 (subsequent hospital care level 2) and 99233 (subsequent hospital care level 3). See Appendix E for more information on problematic codes.

Table 4f provides information on the impact of 1 level disagreement between Carriers and providers when coding evaluation and management codes.

Table 4f: Impact of One Level E&M (Top 20)

Final E&M Code	Incorrect Coding Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
Office/outpatient visit, est (99214)	4.5%	$162,682,526	4.0% - 4.9%
Subsequent hospital care (99233)	11.9%	$145,366,765	9.7% - 14.1%
Office/outpatient visit, est (99215)	9.2%	$58,452,849	7.5% - 10.8%
Subsequent hospital care (99232)	2.2%	$51,306,117	1.5% - 2.9%
Initial inpatient consult (99254)	7.5%	$49,819,053	5.8% - 9.2%
Office/outpatient visit, est (99213)	1.2%	$48,275,536	0.9% - 1.4%
Office/outpatient visit, new (99203)	8.2%	$35,036,281	6.5% - 10.0%
Office consultation (99244)	4.2%	$32,293,854	3.0% - 5.3%
Initial hospital care (99222)	7.5%	$25,060,862	5.0% - 10.0%
Emergency dept visit (99285)	3.3%	$24,787,677	2.1% - 4.5%

Office consultation (99243)	4.6%	$22,056,809	3.3% - 5.8%
Office/outpatient visit, new (99204)	5.7%	$18,646,491	3.7% - 7.7%
Office/outpatient visit, est (99212)	2.5%	$16,657,781	2.0% - 3.1%
Nursing fac care, subseq (99309)	8.2%	$15,646,234	5.4% - 11.0%
Initial inpatient consult (99253)	4.4%	$10,793,384	2.8% - 5.9%
Office consultation (99245)	1.9%	$6,962,165	0.7% - 3.0%
Initial hospital care (99223)	1.0%	$6,574,231	0.4% - 1.6%
Subsequent hospital care (99231)	1.4%	$6,295,542	0.7% - 2.1%
Emergency dept visit (99284)	1.4%	$5,971,055	0.5% - 2.3%
Emergency dept visit (99283)	2.0%	$4,498,267	0.4% - 3.5%
All Other Codes	0.0%	$46,462,208	0.0% - 0.0%
Overall	**0.5%**	**$793,645,687**	**0.5% - 0.6%**

For more data pertaining to incorrect coding errors, see Appendix E.

Other Errors

Under CERT, *other errors* include instances when provider claims did not meet billing requirements such a those for not covered or unallowable services and duplicate claim submissions.

Under HPMP, other errors include quality of care and billing errors. Billing errors include payments for claims where the stay was billed as non-exempt unit but was exempt, outpatient billed as inpatient, and HMO bills paid under FFS. Most other errors occur on claims for which QIOs are responsible.

Other errors accounted for 0.2% of the total dollars allowed during the reporting period. This data breaks down as follows:[11]

Carrier	DMERC	FI	QIO	Total
0.0%	0.0%	0.0%	0.1%	0.2%

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

Table 4g lists the services with other errors and the associated paid claims error rate.

Table 4g: Top 20 Other Errors: Carriers/DMERCs/FIs/QIOs

Carriers (HCPCS), DMERCs (HCPCS), FIs (Type of Bill), and QIOs (DRG)	Other Errors		
	Paid Claims Error Rate	Projected Improper Payments	95% Confidence Interval
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	4.3%	$76,416,066	(1.2%) - 9.8%
SNF-inpatient (including Part A) (21)	0.3%	$42,214,971	(0.1%) - 0.7%
Special facility or ASC surgery-hospice (non-hospital based) (81)	0.5%	$28,534,154	(0.3%) - 1.4%
Hospital-outpatient (HHA-A also)(under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00) (13)	0.1%	$21,907,912	0.0% - 0.2%
OTHER KIDNEY & URINARY TRACT PROCEDURES	5.2%	$21,427,490	(3.9%) - 14.3%
Subsequent hospital care (99233)	1.0%	$11,941,358	(0.6%) - 2.5%
HEART FAILURE & SHOCK	0.3%	$11,100,790	(0.1%) - 0.7%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8%	$10,968,162	0.1% - 1.5%
CIRRHOSIS & ALCOHOLIC HEPATITIS	4.4%	$9,762,275	(4.1%) - 12.9%
Subsequent hospital care (99232)	0.4%	$9,555,142	(0.2%) - 1.1%
SYNCOPE & COLLAPSE W CC	1.7%	$8,669,329	(0.3%) - 3.8%
RENAL FAILURE	0.5%	$7,707,960	(0.1%) - 1.0%
NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.9%	$7,703,876	(1.0%) - 6.8%
LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	7.2%	$7,695,543	(4.2%) - 18.5%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	1.2%	$7,406,756	(0.4%) - 2.8%
TRANSURETHRAL PROCEDURES W CC	6.3%	$7,155,616	(5.9%) - 18.4%
Psy dx interview (90801)	3.4%	$5,662,836	(3.1%) - 10.0%
CHEST PAIN	0.9%	$5,403,542	(0.1%) - 1.8%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.2%	$4,944,956	(0.2%) - 2.6%
EXTRACRANIAL PROCEDURES W CC	1.1%	$4,770,447	(1.0%) - 3.2%
Overall	**0.2%**	**$492,894,353**	**0.1% - 0.3%**

The following are examples of other errors:

- **Not Covered or Unallowable Service error:** An FI paid $19.97 to a provider for Revenue Center Code 0250. Review of the medical record determined that the charge was actually for 3 Phenergan tablets administered in the Emergency Room. Oral medication administered meets the criteria for self-administered drugs and is statutorily excluded for payment by Medicare. The $19.97 was recouped from provider.
- **Duplicate Payment error:** An FI paid $102.84 to a provider for an emergency room visit and application of a short leg splint. Upon review of the Common Working File (CWF), the reviewer discovered that a claim identical to this claim had been paid 4 days prior. The entire claim amount was recouped.
- **Other error:** A Regional Home Health Intermediary (RHHI) paid $1554.88 for a Home Health episode of care. Upon review, the CERT nurse reviewer discovered that only 4 skilled nursing visits were performed and acknowledged as performed by the Home Health agency. It was determined that this claim should have fallen under a low utilization payment adjustment (LUPA) payment. The RHHI recouped $1,223.96 in overpayment to the provider.
- **Billing error:** A hospital billed for a short-term acute care inpatient stay. The case was determined to be a billing error and the payment was recouped because the provider billed this as an inpatient stay, however, the admission orders in the medical record indicated that an observation stay should have been billed. The dollars paid in error were $6,723.63.

Paid Claims Error Rate by Contractor Type

Figures 3 and 4 summarize the paid claims error rate and projected improper payments during the reporting period for each type of contractor. This data breaks down by contractor type as follows:[12]

Carrier	DMERC	FI	QIO	Total
1.4%	0.4%	0.4%	2.0%	4.2%

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

The following figures (Figures 3 and 4) detail the paid claim error rates and projected improper payments by contractor type.

Figure 3: Paid Claims Error Rates by Contractor Type

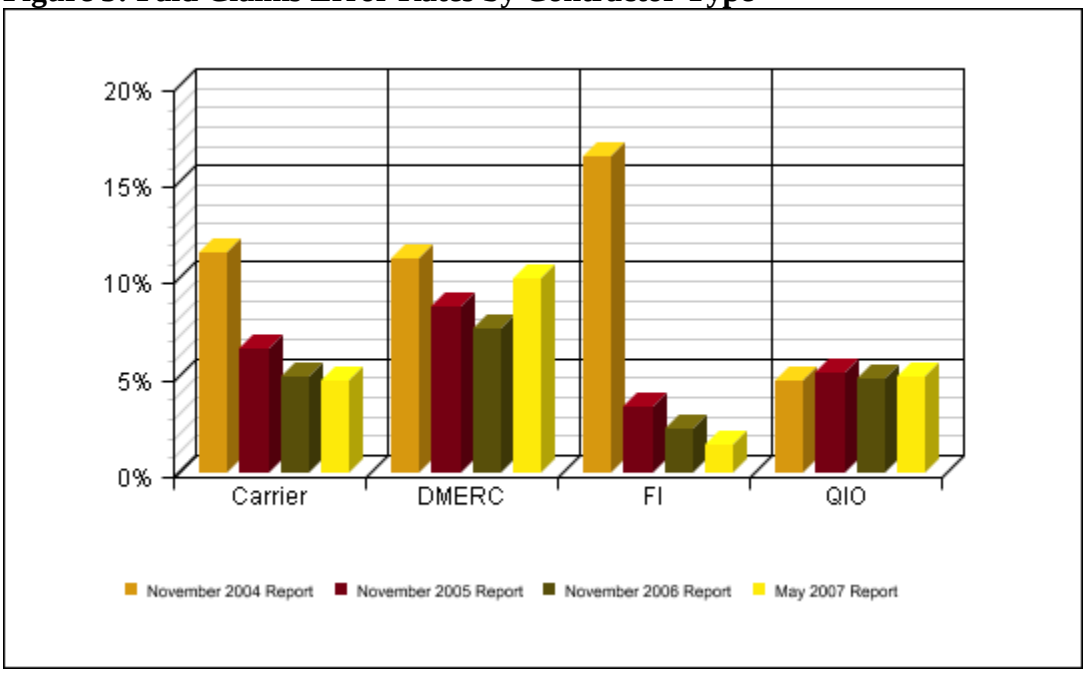
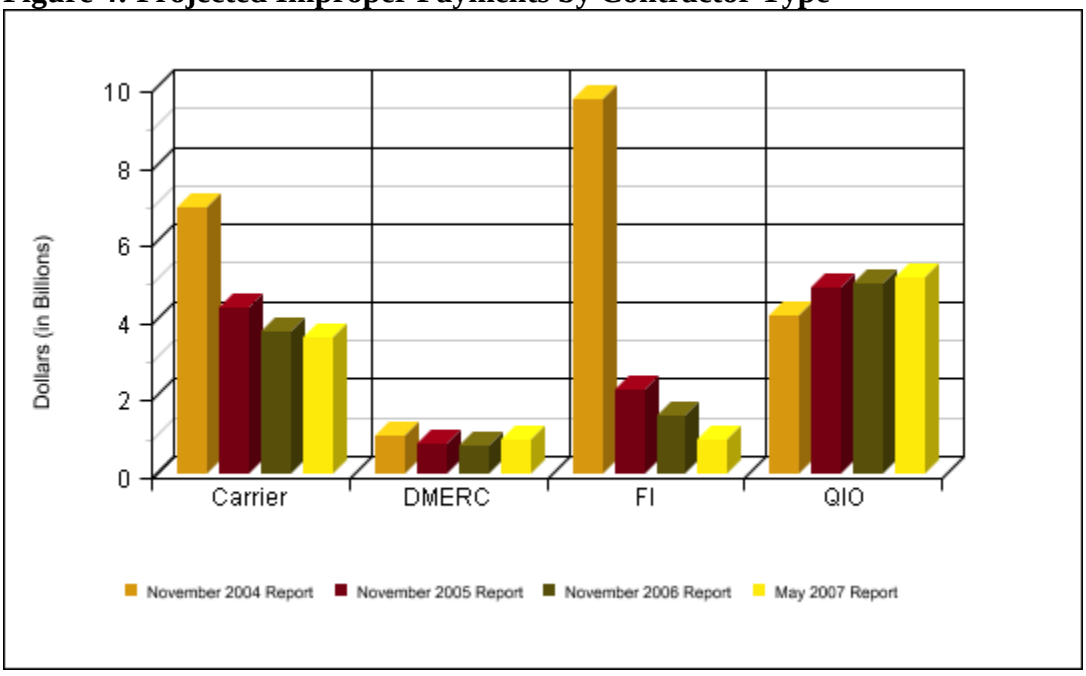


Figure 4: Projected Improper Payments by Contractor Type



Contractor-Specific Error Rates

Carrier-Specific Error Rates

Table 5 contains error rates and improper payment amounts for Carriers. It is sorted in descending order by error rate.

Table 5: Error Rates and Improper Payments: Carriers

Carrier	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval	
First Coast Service Options FL 00590	11.1%	$863,328,101	2.1%	6.9% - 15.3%	22.2%
Triple S, Inc. PR/VI 00973/00974	11.1%	$69,454,893	1.0%	9.1% - 13.1%	27.9%
Empire NY 00803	6.2%	$237,742,664	0.7%	4.9% - 7.5%	14.9%
Empire NJ 00805	6.1%	$143,501,182	0.8%	4.5% - 7.8%	17.7%
GHI NY 14330	5.0%	$17,598,886	0.6%	3.9% - 6.1%	26.6%
BCBS AR RI 00524	4.8%	$10,143,621	0.7%	3.5% - 6.1%	15.6%
Average=	**4.8%**				
Palmetto SC 00880	4.5%	$49,986,275	0.6%	3.3% - 5.7%	14.7%
Trailblazer TX 00900	4.4%	$233,471,159	0.6%	3.2% - 5.7%	15.8%
Palmetto OH/WV 00883/00884	4.4%	$147,175,563	0.5%	3.4% - 5.5%	17.1%
Cahaba AL/GA/MS 00510/00511/00512	4.2%	$163,845,422	0.7%	2.9% - 5.5%	16.3%
Noridian UT 00823	4.2%	$14,228,673	0.6%	3.0% - 5.3%	16.3%
Noridian AK/AZ/HI/NV/OR/WA 00831/00832/00833/00834/00835/00836	4.1%	$151,846,225	0.7%	2.7% - 5.5%	14.7%
CIGNA NC 05535	3.9%	$86,244,975	0.7%	2.6% - 5.3%	12.9%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.8%	$85,020,359	0.5%	2.8% - 4.8%	10.1%
WPS WI/IL/MI/MN 00951/00952/00953/00954	3.7%	$294,077,978	0.4%	2.9% - 4.6%	10.9%
NHIC CA 31140/31146	3.6%	$249,799,960	0.5%	2.7% - 4.5%	11.4%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	3.6%	$125,003,098	0.4%	2.8% - 4.3%	12.6%
First Coast Service Options CT 00591	3.5%	$38,991,869	0.4%	2.8% - 4.2%	9.7%
AdminaStar IN/KY 00630/00660	3.5%	$93,311,548	0.6%	2.3% - 4.6%	10.7%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	3.4%	$148,990,230	0.3%	2.8% - 4.1%	11.6%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	3.3%	$45,028,207	0.6%	2.1% - 4.6%	11.0%
HealthNow NY 00801	3.2%	$40,180,250	0.4%	2.4% - 4.0%	9.3%
BCBS KS/NE/W MO 00650/00655/00651	2.9%	$40,313,037	0.4%	2.1% - 3.6%	11.6%
CIGNA TN 05440	2.9%	$48,419,404	0.4%	2.0% - 3.7%	12.8%
HGSA PA 00865	2.5%	$80,688,189	0.4%	1.8% - 3.3%	10.0%
BCBS MT 00751	2.1%	$4,034,435	0.3%	1.5% - 2.7%	7.7%
CIGNA ID 05130	1.8%	$3,813,936	0.3%	1.3% - 2.3%	15.6%
Combined	**4.8%**	**$3,486,240,139**	**0.3%**	**4.3% - 5.3%**	**14.3%**

For paid claim error rates, provider compliance error rates and no resolution rates by contractor and provider type, see Appendix C.

DMERC-Specific Error Rates

Table 6 contains DMERC specific error rates and improper payment amounts. It is sorted in descending order by error rate.

Table 6: Error Rates and Improper Payments: DMERCs

DMERCs	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval	
Palmetto Region C 00885	16.8%	$680,884,375	2.3%	12.3% - 21.4%	27.2%
Average=	**10.0%**				
Tricenturion Region A 77011	6.0%	$82,135,042	2.0%	2.1% - 9.9%	13.4%
CIGNA Region D 05655	4.9%	$88,365,933	1.9%	1.3% - 8.6%	15.4%
AdminaStar Region B 00635	3.5%	$71,776,464	0.5%	2.6% - 4.5%	9.8%
Combined	**10.0%**	**$923,161,814**	**1.1%**	**7.8% - 12.2%**	**19.3%**

FI-Specific Error Rates

Table 7 contains error rates and improper payment amounts for FIs. It is sorted in descending order by error rate.

Table 7: Error Rates and Improper Payments: FIs

FIs	Paid Claims Error Rate			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Anthem NH/VT 00270	6.2%	$17,732,981	5.1%	(3.8%) - 16.3%
Noridian ID/OR/UT 00323/00325	4.7%	$34,149,626	2.6%	(0.3%) - 9.8%
COSVI PR/VI 57400	2.6%	$1,982,865	1.0%	0.7% - 4.5%
Highmark Medicare Services DC/MD 00366	2.6%	$100,707,922	0.9%	0.9% - 4.3%
Noridian AK/WA 00322	2.3%	$10,409,524	1.3%	(0.2%) - 4.8%
Trispan LA/MO/MS 00230	2.1%	$24,998,131	0.7%	0.7% - 3.4%
Riverbend NJ/TN 00390	1.9%	$49,734,750	0.7%	0.6% - 3.2%
UGS AS/CA/GU/HI/NV/NMI 00454	1.8%	$83,712,572	0.4%	1.0% - 2.6%
Anthem ME/MA 00180/00181	1.6%	$30,965,263	0.4%	0.8% - 2.5%
First Coast Service Options FL 00090	1.6%	$31,153,664	0.3%	1.0% - 2.3%
Mutual of Omaha (all states) 52280	1.6%	$103,568,646	0.4%	0.8% - 2.3%
BCBS AR AR 00020	1.5%	$4,380,785	0.6%	0.2% - 2.7%

Average=	**1.4%**			
BCBS WY WY 00460	1.3%	$557,728	0.4%	0.6% - 2.1%
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	1.3%	$71,096,701	0.3%	0.8% - 1.8%
Palmetto NC 00382	1.3%	$14,153,086	0.4%	0.4% - 2.1%
BCBS AZ AZ 00030	1.2%	$3,223,673	0.3%	0.7% - 1.7%
UGS WI/MI 00450/00452	1.2%	$64,882,102	0.4%	0.5% - 2.0%
BCBS KS KS 00150	1.2%	$4,160,626	0.6%	0.1% - 2.3%
Noridian MN/ND 00320/00321	1.2%	$9,793,985	0.5%	0.3% - 2.1%
Empire CT/DE/NY 00308	1.2%	$39,405,481	0.3%	0.6% - 1.7%
Veritus PA 00363	1.2%	$18,347,809	0.3%	0.6% - 1.7%
Trailblazer CO/NM/TX 00400	1.1%	$35,987,418	0.3%	0.5% - 1.8%
BCBS MT MT 00250	1.1%	$1,777,460	0.5%	0.1% - 2.1%
Palmetto SC 00380	1.1%	$106,273,111	0.3%	0.5% - 1.8%
UGS VA/WV 00453	1.1%	$12,377,168	0.3%	0.5% - 1.7%
BCBS AR RI 00021	1.0%	$1,158,678	0.4%	0.3% - 1.7%
BCBS GA GA 00101	0.9%	$14,927,788	0.3%	0.4% - 1.5%
BCBS NE NE 00260	0.9%	$1,632,149	0.5%	(0.1%) - 1.9%
Cahaba AL 00010	0.8%	$3,591,024	0.3%	0.2% - 1.4%
Chisholm OK 00340	0.5%	$1,113,844	0.1%	0.2% - 0.8%
Cahaba IA/SD 00011	0.3%	$9,186,581	0.1%	0.1% - 0.5%
Combined	**1.4%**	**$907,143,140**	**0.1%**	**1.2% - 1.7%**

QIO-Specific Error Rates

Table 8 contains QIO specific short-term PPS acute care hospital error rates and improper payment amounts, total short-term PPS acute care hospital error rates and improper payment amounts, total PPS long term acute care hospital error rates and improper payment amounts, and total error rates and improper payment amounts for all types of facilities for which QIOs are responsible. It is sorted alphabetically by state.

Table 8: Error Rates and Improper Payments: QIOs

QIOs	**Paid Claims Error Rate**			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Alaska	1.3%	$1,687,955	0.2%	0.8% - 1.8%
Alabama	6.5%	$115,432,600	1.7%	3.1% - 9.9%
Arkansas	4.9%	$49,952,839	0.6%	3.6% - 6.1%
Arizona	6.2%	$88,364,431	0.9%	4.5% - 7.9%
California	4.3%	$355,087,911	0.7%	3.0% - 5.6%
Colorado	4.2%	$36,921,930	0.7%	2.8% - 5.6%
Connecticut	3.8%	$55,863,762	0.6%	2.7% - 4.9%
District of Columbia	3.9%	$18,357,660	0.6%	2.8% - 5.1%
Delaware	4.5%	$15,313,808	0.5%	3.4% - 5.5%
Florida	7.7%	$503,298,555	1.1%	5.6% - 9.8%
Georgia	3.8%	$99,489,787	0.6%	2.6% - 5.0%
Hawaii	3.4%	$8,786,590	0.4%	2.7% - 4.2%

Iowa	4.1%	$35,830,383	0.7%	2.8% - 5.3%
Idaho	3.2%	$8,517,623	0.5%	2.3% - 4.2%
Illinois	5.3%	$237,445,102	0.8%	3.7% - 6.8%
Indiana	5.7%	$122,753,125	1.3%	3.2% - 8.3%
Kansas	3.4%	$28,101,173	0.6%	2.2% - 4.7%
Kentucky	7.2%	$127,677,545	0.9%	5.5% - 9.0%
Louisiana	3.0%	$42,065,424	0.5%	1.9% - 4.0%
Massachusetts	9.9%	$248,927,555	0.9%	8.1% - 11.7%
Maryland	5.3%	$142,606,182	1.1%	3.1% - 7.4%
Maine	5.1%	$24,299,098	0.7%	3.7% - 6.5%
Michigan	5.3%	$221,613,109	0.7%	3.9% - 6.8%
Minnesota	4.8%	$74,089,805	0.6%	3.6% - 6.0%
Missouri	4.4%	$99,689,240	1.0%	2.4% - 6.3%
Mississippi	5.6%	$61,536,277	0.9%	3.8% - 7.5%
Montana	1.1%	$2,834,983	0.3%	0.5% - 1.6%
North Carolina	1.2%	$37,807,217	0.3%	0.6% - 1.8%
North Dakota	2.5%	$5,811,639	0.4%	1.7% - 3.3%
Nebraska	1.2%	$7,062,359	0.3%	0.6% - 1.8%
New Hampshire	2.7%	$9,688,476	0.4%	1.9% - 3.5%
New Jersey	3.7%	$130,701,847	0.6%	2.5% - 4.8%
New Mexico	8.8%	$33,320,267	0.9%	7.1% - 10.5%
Nevada	7.1%	$37,402,868	0.9%	5.5% - 8.8%
New York	4.4%	$333,395,005	0.7%	3.0% - 5.7%
Ohio	2.6%	$109,054,324	0.5%	1.6% - 3.7%
Oklahoma	3.3%	$38,531,808	0.5%	2.2% - 4.3%
Oregon	6.0%	$44,682,767	0.8%	4.4% - 7.6%
Pennsylvania	6.6%	$299,630,308	0.8%	5.1% - 8.1%
Puerto Rico	7.7%	$23,792,346	1.0%	5.7% - 9.7%
Rhode Island	4.8%	$15,489,153	0.5%	3.7% - 5.9%
South Carolina	6.4%	$101,443,201	0.8%	4.9% - 7.9%
South Dakota	3.2%	$8,386,238	0.4%	2.3% - 4.0%
Tennessee	2.9%	$71,435,471	0.5%	1.9% - 4.0%
Texas	6.7%	$441,436,957	1.2%	4.4% - 9.1%
Utah	4.6%	$20,955,875	0.6%	3.5% - 5.7%
Virginia	4.1%	$91,183,426	0.6%	2.9% - 5.3%
Vermont	4.2%	$7,197,959	0.6%	3.0% - 5.4%
Washington	2.5%	$37,968,616	0.6%	1.3% - 3.7%
Wisconsin	2.4%	$39,000,855	0.5%	1.4% - 3.3%
West Virginia	5.5%	$44,168,438	0.7%	4.1% - 6.9%
Wyoming	1.1%	$1,147,914	0.2%	0.7% - 1.5%
Short-term Acute Paid Claims	**4.9%**	**$4,817,239,787**	**0.2%**	**4.6% - 5.3%**
Long-term Acute Paid Claims	**5.5%**	**$236,436,488**	**0.6%**	**4.3% - 6.6%**
Denied Claims	**N/A**	**$16,442,686**	**N/A**	**N/A**
Total	**5.0%**	**$5,070,118,961**	**0.2%**	**4.7% - 5.3%**

Error Rates by Type of Service

Table 9 displays the paid claims error rates for each type of service by type of error. This series of tables is sorted in descending order by projected improper payments. All estimates in this table are based on a minimum of 30 lines in the sample.

Table 9a: Top 20 Service Types with Highest Improper Payments: Carriers

Service Type Billed to Carriers (BETOS codes)	Projected Improper Payment	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Other drugs	$523,120,210	10.5%	4.6% - 16.5%	87.8%	2.7%	0.4%	9.1%	0.0%
Consultations	$493,186,803	14.8%	13.4% - 16.2%	1.7%	9.3%	0.6%	87.8%	0.6%
Office visits - established	$489,996,737	5.3%	4.9% - 5.6%	5.3%	14.4%	1.7%	77.5%	1.1%
Hospital visit - subsequent	$479,296,534	10.5%	9.2% - 11.7%	3.5%	38.6%	0.1%	53.3%	4.5%
All Other Codes	$318,006,415	1.2%	0.9% - 1.4%	29.5%	40.8%	6.9%	20.6%	2.3%
Minor procedures - other (Medicare fee schedule)	$171,436,522	6.7%	5.2% - 8.3%	12.6%	69.8%	6.6%	10.8%	0.2%
Office visits - new	$160,096,718	14.9%	12.8% - 17.0%	4.3%	0.6%	0.3%	94.4%	0.5%
Hospital visit - initial	$152,751,631	14.0%	11.5% - 16.5%	1.7%	23.7%	0.0%	73.3%	1.3%
Nursing home visit	$124,707,029	12.1%	10.2% - 14.1%	8.9%	21.6%	0.7%	68.8%	0.0%
Ambulance	$75,336,062	2.2%	1.0% - 3.3%	7.5%	24.0%	45.7%	22.3%	0.5%
Chemotherapy	$69,057,591	3.6%	0.0% - 7.3%	78.2%	0.0%	0.0%	0.0%	21.8 %
Hospital visit - critical care	$63,246,970	9.2%	3.5% - 14.9%	6.2%	33.7%	0.0%	54.1%	6.0%
Emergency room visit	$60,164,874	4.3%	3.1% - 5.4%	6.4%	13.6%	0.0%	80.0%	0.0%
Chiropractic	$59,846,427	10.8%	8.1% - 13.6%	2.4%	47.4%	32.2%	16.0%	2.1%
Other tests - other	$43,736,968	3.3%	1.1% - 5.4%	17.1%	75.4%	5.9%	0.8%	0.9%
All Codes With Less Than 30 Claims	$42,195,712	1.6%	(0.4%) - 3.7%	0.0%	95.4%	1.2%	3.4%	0.0%
Dialysis services (Non MFS)	$36,782,515	5.2%	1.1% - 9.3%	0.0%	77.4%	0.0%	22.6%	0.0%
Specialist - psychiatry	$35,307,007	3.9%	(0.1%) - 7.9%	62.5%	7.4%	0.0%	14.0%	16.0 %
Specialist - ophthalmology	$31,190,418	1.7%	0.9% - 2.5%	18.9%	51.6%	4.3%	25.2%	0.0%
Minor procedures - musculoskeletal	$28,614,225	3.1%	0.1% - 6.2%	2.9%	79.8%	10.3%	7.0%	0.0%
Lab tests - other (non-Medicare fee schedule)	$28,162,771	1.5%	0.9% - 2.1%	30.5%	51.2%	12.0%	4.0%	2.3%

All Type of Services (Incl. Codes Not Listed)	**$3,486,240,139**	**4.8%**	**4.3% - 5.3%**	**21.8%**	**24.7%**	**3.2%**	**48.3%**	**1.9%**

Table 9b: Top 20 Service Types with Highest Improper Payments: DMERCs

Service Type Billed to DMERCs (SADMERC Policy Group)	**Projected Improper Payment**	**Paid Claims Error Rate**	**95% Confidence Interval**	**Type of Error**				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
All Policy Groups with Less than 30 Claims	$246,504,738	20.4%	8.8% - 32.1%	48.5%	0.1%	49.9%	1.6%	0.0%
Nebulizers & Related Drugs	$144,761,592	14.5%	7.1% - 21.8%	67.1%	0.5%	17.3%	14.8%	0.3%
Negative Pressure Wound Therapy	$122,006,369	49.5%	24.8% - 74.2%	100.0%	0.0%	0.0%	0.0%	0.0%
Glucose Monitor	$112,876,731	10.0%	8.3% - 11.7%	10.1%	2.2%	75.3%	12.4%	0.0%
Enteral Nutrition	$103,052,495	16.8%	6.6% - 27.1%	85.1%	0.0%	9.4%	5.5%	0.0%
Support Surfaces	$27,132,843	22.0%	5.7% - 38.3%	100.0%	0.0%	0.0%	0.0%	0.0%
CPAP	$25,058,897	6.5%	3.9% - 9.1%	26.5%	0.0%	72.8%	0.8%	0.0%
Lower Limb Orthoses	$21,341,400	10.0%	(2.2%) - 22.1%	85.6%	0.0%	12.7%	1.7%	0.0%
Oxygen Supplies/Equipment	$20,912,645	1.0%	0.5% - 1.5%	31.4%	0.0%	52.5%	8.3%	7.8%
Ostomy Supplies	$19,890,015	13.9%	2.5% - 25.2%	46.7%	0.0%	50.1%	3.2%	0.0%
Wheelchairs Options/ Accessories	$13,220,081	7.0%	(0.5%) - 14.5%	11.4%	0.7%	78.1%	9.8%	0.0%
Immunosuppressive Drugs	$12,304,690	2.5%	0.1% - 4.9%	0.0%	31.2%	68.7%	0.0%	0.0%
Surgical Dressings	$9,321,921	11.8%	(1.0%) - 24.6%	88.1%	0.3%	11.6%	0.0%	0.0%
Wheelchairs Manual	$9,095,227	4.2%	2.5% - 5.9%	0.0%	4.8%	76.8%	12.6%	5.9%
All Other Codes	$9,030,426	1.7%	0.5% - 2.9%	10.0%	0.0%	90.0%	0.0%	0.0%
Urological Supplies	$6,599,720	12.1%	1.3% - 22.9%	62.6%	11.6%	18.4%	6.4%	1.0%
TENS	$4,969,009	27.2%	(1.7%) - 56.0%	60.8%	0.0%	39.2%	0.0%	0.0%
Respiratory Assist Device	$4,215,671	4.9%	(0.9%) - 10.6%	78.8%	0.0%	21.2%	0.0%	0.0%
Lenses	$3,984,533	6.2%	0.7% - 11.7%	0.0%	0.0%	100.0%	0.0%	0.0%
Walkers	$3,464,173	4.2%	0.7% - 7.8%	16.1%	0.0%	83.9%	0.0%	0.0%
Hospital Beds/ Accessories	$3,418,637	1.3%	0.1% - 2.4%	45.2%	0.0%	54.8%	0.0%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$923,161,814**	**10.0%**	**7.8% - 12.2%**	**57.3%**	**0.9%**	**36.0%**	**5.5%**	**0.3%**

Table 9c: Top 20 Service Types with Highest Improper Payments: FIs

Service Type Billed to FIs (Type of Bill)	Projected Improper Payment	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	$384,307,290	2.2%	1.7% - 2.6%	4.8%	45.2%	3.7%	41.7%	4.6%
SNF	$235,158,148	1.5%	1.0% - 2.0%	0.3%	8.9%	21.1%	51.8%	18.0 %
HHA	$78,401,077	0.8%	0.3% - 1.2%	0.0%	1.7%	36.3%	57.9%	4.1%
Other FI Service Types	$76,851,903	2.1%	1.0% - 3.1%	15.9%	26.6%	2.6%	52.2%	2.8%
Hospice	$61,048,433	1.0%	0.1% - 1.9%	0.0%	7.9%	43.6%	1.8%	46.7 %
ESRD	$37,181,187	0.7%	0.4% - 1.1%	1.3%	52.3%	0.0%	46.4%	0.0%
Non-PPS Hospital In-patient	$28,093,371	0.8%	0.3% - 1.4%	1.6%	68.1%	0.5%	12.3%	17.5 %
FQHC	$3,802,461	1.1%	0.1% - 2.1%	20.8%	79.2%	0.0%	0.0%	0.0%
RHCs	$2,292,100	0.5%	0.2% - 0.9%	32.4%	57.7%	9.9%	0.0%	0.0%
Free Standing Ambulatory Surgery	$7,169	0.0%	0.0% - 0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
All Type of Services (Incl. Codes Not Listed)	**$907,143,140**	**1.4%**	**1.2% - 1.7%**	**3.7%**	**29.1%**	**13.4%**	**42.9%**	**10.9%**

Table 9d: Top 20 Service Types with Highest Improper Payments: QIOs

Service Types for Which QIOs are Responsible (DRG)	Projected Improper Payment	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
				No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	$185,695,437	13.7%	10.5% - 17.0%	0.9%	N/A	83.7%	9.5%	5.9%
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	$162,106,762	9.1%	1.6% - 16.6%	0.0%	N/A	38.7%	14.2%	47.1%
CHEST PAIN	$147,773,061	23.4%	18.4% - 28.5%	0.3%	N/A	93.3%	2.7%	3.7%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	$119,233,591	12.2%	8.7% - 15.7%	5.3%	N/A	67.5%	25.4%	1.8%
RENAL FAILURE	$111,246,301	6.8%	4.4% - 9.2%	5.3%	N/A	59.7%	28.0%	6.9%
MEDICAL BACK PROBLEMS	$101,444,641	31.0%	20.9% - 41.2%	0.0%	N/A	93.1%	4.6%	2.3%
HEART FAILURE & SHOCK	$96,535,491	2.8%	1.7% - 3.9%	23.3%	N/A	50.9%	14.3%	11.5%
SEPTICEMIA AGE >17	$96,288,711	3.4%	1.9% - 4.9%	2.5%	N/A	16.1%	81.4%	0.0%
RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	$74,939,893	2.6%	0.5% - 4.8%	0.0%	N/A	29.9%	70.1%	0.0%
OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	$71,559,670	10.6%	2.1% - 19.1%	0.0%	N/A	86.8%	12.5%	0.7%
PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	$71,549,748	9.4%	1.8% - 17.1%	0.0%	N/A	71.5%	28.5%	0.0%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	$69,801,825	7.4%	4.1% - 10.8%	3.3%	N/A	61.0%	35.0%	0.7%

OTHER KIDNEY & URINARY TRACT PROCEDURES	$69,026,012	16.7%	3.7% - 29.7%	0.0%	N/A	25.4%	43.5%	31.0 %
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	$68,284,707	10.9%	3.4% - 18.4%	0.0%	N/A	64.0%	25.1%	10.8 %
SYNCOPE & COLLAPSE W CC	$67,973,240	13.5%	8.3% - 18.7%	0.0%	N/A	80.4%	6.8%	12.8 %
OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	$67,439,792	8.7%	5.0% - 12.4%	0.0%	N/A	53.9%	40.2%	5.9%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	$66,519,117	4.0%	1.7% - 6.3%	3.7%	N/A	54.9%	34.8%	6.6%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	$63,157,660	15.1%	7.9% - 22.2%	0.5%	N/A	85.9%	5.8%	7.8%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	$60,341,057	5.9%	(0.0%) - 11.8%	0.0%	N/A	23.4%	69.7%	6.9%
EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	$59,028,186	5.1%	(1.3%) - 11.5%	0.0%	N/A	66.2%	33.8%	0.0%
All HPMP	**$5,070,118,961**	**5.0%**	**4.7% - 5.3%**	**2.4%**	**N/A**	**61.4%**	**29.8%**	**6.4%**

Paid Claim Error Rates by Provider Type

The table 10 series presents error rates by provider type. The tables include the top provider types based on improper payments for providers that bill each type of contractor. All estimates are based on a minimum of 30 lines in the sample. This series of tables is sorted in descending order by projected improper payments.

The CERT program is unable to calculate provider compliance error rates for FIs due to systems limitations.

Table 10a: Error Rates and Improper Payments by Provider Type: Carriers

Provider Types Billing to Carriers	Paid Claims Error Rate				Provider Compliance Error Rate
	Error Rate	Projected Improper Payment Amount	Standard Error	95% Confidence Interval	
Internal Medicine	7.8%	$620,476,909	0.7%	6.4% - 9.2%	17.9%
General Practice	30.6%	$278,445,076	6.4%	18.1% - 43.0%	43.9%
Cardiology	4.5%	$277,657,146	0.4%	3.7% - 5.4%	15.1%
Obstetrics/Gynecology	35.1%	$242,204,327	14.4%	7.0% - 63.3%	38.8%
Family Practice	6.3%	$238,546,363	0.5%	5.3% - 7.2%	17.3%
Orthopedic Surgery	6.3%	$168,209,150	1.1%	4.1% - 8.5%	14.9%
Pulmonary Disease	8.0%	$119,150,729	1.2%	5.8% - 10.3%	14.0%
Nephrology	7.0%	$99,733,923	1.2%	4.6% - 9.4%	12.8%
General Surgery	4.8%	$94,935,835	0.8%	3.2% - 6.4%	14.4%
Gastroenterology	6.4%	$91,261,756	1.0%	4.4% - 8.4%	11.7%
Psychiatry	11.6%	$88,837,879	3.0%	5.7% - 17.4%	21.3%
Urology	3.9%	$81,338,395	0.9%	2.3% - 5.6%	10.5%
Hematology/Oncology	2.1%	$80,369,362	0.5%	1.2% - 3.0%	8.5%
Neurology	7.6%	$76,370,847	1.3%	5.0% - 10.1%	19.9%
Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)	2.2%	$75,336,062	0.6%	1.0% - 3.3%	13.2%
Ophthalmology	1.8%	$71,042,864	0.3%	1.2% - 2.5%	10.2%
Chiropractic	10.5%	$60,308,363	1.4%	7.8% - 13.1%	27.5%
Diagnostic Radiology	1.4%	$59,511,870	0.4%	0.5% - 2.3%	9.5%
Physical Therapist in Private Practice	6.1%	$58,793,854	1.1%	3.9% - 8.3%	16.7%
Emergency Medicine	3.8%	$54,782,988	0.6%	2.7% - 5.0%	13.0%
Physical Medicine and Rehabilitation	7.6%	$49,104,062	1.2%	5.3% - 9.9%	17.1%

Endocrinology	10.7%	$33,381,078	2.5%	5.8% - 15.6%	14.5%
Infectious Disease	8.8%	$33,020,850	2.0%	5.0% - 12.7%	27.7%
Podiatry	2.7%	$30,934,174	0.4%	2.0% - 3.4%	14.3%
Clinical Laboratory (Billing Independently)	1.1%	$27,247,625	0.2%	0.6% - 1.5%	9.4%
Thoracic Surgery	6.3%	$26,841,154	5.6%	(4.8%) - 17.4%	6.8%
Clinical Psychologist	8.0%	$26,781,031	5.1%	(2.1%) - 18.1%	19.8%
Nurse Practitioner	4.5%	$25,514,235	1.1%	2.4% - 6.7%	13.2%
Rheumatology	3.2%	$25,488,309	1.0%	1.2% - 5.2%	8.7%
Otolaryngology	3.8%	$25,201,090	0.6%	2.5% - 5.0%	11.1%
Neurosurgery	4.9%	$24,787,288	2.2%	0.6% - 9.3%	24.7%
Dermatology	1.7%	$23,831,311	0.3%	1.0% - 2.4%	8.7%
Anesthesiology	1.8%	$21,074,862	0.6%	0.6% - 3.0%	13.3%
Medical Oncology	1.6%	$20,041,330	0.5%	0.6% - 2.7%	8.5%
Geriatric Medicine	16.8%	$16,207,307	3.1%	10.8% - 22.8%	32.1%
Hematology	6.2%	$15,789,804	5.1%	(3.8%) - 16.3%	14.6%
Vascular Surgery	3.4%	$14,163,423	1.2%	1.0% - 5.8%	9.7%
Occupational Therapist in Private Practice	13.7%	$11,011,540	2.9%	8.1% - 19.4%	24.7%
Optometry	2.1%	$10,945,396	0.6%	0.9% - 3.2%	15.6%
Critical Care (Intensivists)	7.5%	$10,006,865	2.9%	1.9% - 13.2%	12.2%
Pathology	1.2%	$9,324,077	0.6%	0.0% - 2.4%	14.6%
Radiation Oncology	0.7%	$8,188,955	0.3%	0.0% - 1.4%	6.6%
Physician Assistant	2.3%	$7,838,169	0.6%	1.0% - 3.5%	10.2%
Plastic and Reconstructive Surgery	3.4%	$6,859,352	1.2%	0.9% - 5.8%	11.8%
Allergy/Immunology	3.4%	$6,854,085	1.3%	0.9% - 5.9%	21.1%
Pediatric Medicine	8.6%	$6,628,191	4.4%	0.0% - 17.1%	15.9%
Independent Diagnostic Testing Facility (IDTF)	0.5%	$6,570,855	0.3%	(0.0%) - 1.0%	15.6%
All Provider Types With Less Than 30 Lines	1.6%	$6,400,841	1.0%	(0.4%) - 3.6%	3.6%
Pain Management	3.3%	$3,485,006	1.8%	(0.3%) - 6.9%	16.2%
Colorectal Surgery (formerly proctology)	3.0%	$2,995,833	1.8%	(0.5%) - 6.5%	13.8%
Osteopathic Manipulative Therapy	6.0%	$2,553,932	2.0%	2.1% - 9.8%	7.0%
Hand Surgery	5.7%	$2,459,334	2.2%	1.5% - 10.0%	11.4%
Cardiac Surgery	0.4%	$1,966,284	0.1%	0.1% - 0.7%	4.4%
Interventional Pain Management	1.8%	$1,547,451	1.0%	(0.1%) - 3.8%	9.1%
Audiologist (Billing Independently)	9.0%	$1,040,791	1.1%	6.8% - 11.2%	4.7%
Portable X-Ray Supplier (Billing Independently)	0.4%	$847,927	0.2%	(0.0%) - 0.9%	10.5%
Certified Registered Nurse Anesthetist (CRNA)	0.1%	$600,041	0.1%	(0.1%) - 0.4%	9.6%
Gynecological/Oncology	0.4%	$462,521	0.1%	0.2% - 0.5%	4.3%
Nuclear Medicine	0.3%	$423,053	0.1%	0.1% - 0.4%	3.7%
Clinical Social Worker	0.1%	$179,658	0.1%	(0.1%) - 0.4%	9.2%
Interventional Radiology	0.1%	$145,519	0.1%	(0.1%) - 0.2%	3.9%
Multispecialty Clinic or Group Practice	0.6%	$86,724	0.6%	(0.6%) - 1.7%	10.1%
Public Health or Welfare Agencies (Federal, State, and local)	0.3%	$66,372	0.3%	(0.3%) - 0.8%	9.2%
Clinical Nurse Specialist	0.1%	$28,736	0.1%	(0.1%) - 0.3%	18.8%
Ambulatory Surgical Center	0.0%	$0	0.0%	0.0% - 0.0%	16.3%

Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)	0.0%	$0	0.0%	0.0% - 0.0%	11.8%
Radiation Therapy Centers	0.0%	$0	0.0%	0.0% - 0.0%	16.6%
All Provider Types	**4.8%**	**$3,486,240,139**	**0.3%**	**4.3% - 5.3%**	**14.3%**

Table 10b: Error Rates and Improper Payments by Provider Type: DMERCs

Provider Types Billing to DMERCs	**Paid Claims Error Rate**				**Provider Compliance Error Rate**
	Error Rate	Projected Improper Payment Amount	Standard Error	95% Confidence Interval	
Medical supply company not included in 51, 52, or 53	14.2%	$509,069,162	2.2%	9.9% - 18.5%	26.2%
Pharmacy	7.9%	$312,104,778	1.4%	5.1% - 10.8%	15.4%
Unknown Supplier/Provider	47.0%	$47,494,389	21.6%	4.7% - 89.4%	48.4%
All Provider Types With Less Than 30 Lines	23.6%	$26,794,794	14.3%	(4.5%) - 51.6%	28.5%
Medical Supply Company with Respiratory Therapist	1.9%	$15,290,500	0.5%	1.0% - 2.8%	9.3%
Skilled Nursing Facility	14.9%	$5,188,288	11.7%	(8.0%) - 37.8%	15.9%
Medical supply company with orthotic personnel certified by an accrediting organization	4.7%	$2,701,600	3.0%	(1.2%) - 10.6%	23.3%
Individual prosthetic personnel certified by an accrediting organization	1.3%	$1,769,557	0.9%	(0.3%) - 3.0%	5.2%
Optician	5.9%	$1,124,623	5.7%	(5.3%) - 17.2%	10.7%
Orthopedic Surgery	1.9%	$630,344	1.4%	(1.0%) - 4.7%	9.8%
Medical supply company with prosthetic personnel certified by an accrediting organization	1.4%	$574,151	1.5%	(1.6%) - 4.4%	28.7%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	0.4%	$419,629	0.3%	(0.2%) - 0.9%	11.3%

Individual orthotic personnel certified by an accrediting organization	0.0%	$0	0.0%	0.0% - 0.0%	3.2%
Ophthalmology	0.0%	$0	0.0%	0.0% - 0.0%	10.4%
Optometry	0.0%	$0	0.0%	0.0% - 0.0%	7.2%
Podiatry	0.0%	$0	0.0%	0.0% - 0.0%	5.0%
All Provider Types	**10.0%**	**$923,161,814**	**1.1%**	**7.8% - 12.2%**	**19.3%**

Table 10c: Error Rates and Improper Payments by Provider Type: FIs

Provider Types Billing to FIs	**Paid Claims Error Rate**			
	Error Rate	Projected Improper Payment Amount	Standard Error	95% Confidence Interval
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	2.2%	$384,307,290	0.2%	1.7% - 2.6%
SNF	1.5%	$235,158,148	0.3%	1.0% - 2.0%
HHA	0.8%	$78,401,077	0.2%	0.3% - 1.2%
Other FI Service Types	2.1%	$76,851,903	0.5%	1.0% - 3.1%
Hospice	1.0%	$61,048,433	0.5%	0.1% - 1.9%
ESRD	0.7%	$37,181,187	0.2%	0.4% - 1.1%
Non-PPS Hospital In-patient	0.8%	$28,093,371	0.3%	0.3% - 1.4%
FQHC	1.1%	$3,802,461	0.5%	0.1% - 2.1%
RHCs	0.5%	$2,292,100	0.2%	0.2% - 0.9%
Free Standing Ambulatory Surgery	0.0%	$7,169	0.0%	0.0% - 0.0%
Overall	**1.4%**	**$907,143,140**	**0.1%**	**1.2% - 1.7%**

Table 10d: Error Rates and Improper Payments by Provider Type: QIOs

Provider Types for Which QIOs are Responsible	**Paid Claims Error Rate**			
	Error Rate	Projected Improper Payments	Standard Error	95% Confidence Interval
Short-term Acute Paid Claims	4.9%	$4,817,239,787	0.2%	4.6% - 5.3%
Long-term Acute Paid Claims	5.5%	$236,436,488	0.6%	4.3% - 6.6%
Denied Claims	N/A	$16,442,686	N/A	N/A
Total	**5.0%**	**$5,070,118,961**	**0.2%**	**4.7% - 5.3%**

CORRECTIVE ACTIONS

No Documentation

CMS continues to make progress lowering the no documentation rate. Historically, the no documentation issue has been more pronounced in the CERT program than in HPMP. This difference is due to several factors: first, providers are more likely to respond to HPMP requests since the average claim value is much higher; second, the providers included in the HPMP were more familiar with that program; and third, HPMP pays PPS inpatient hospital providers separately for the cost of supplying medical records while CERT does not. The cost of supplying such medical records by non-PPS inpatient hospital providers is included in the fees they are paid for each service, and thus CERT is prohibited from paying the providers' cost of supplying medical records.

Reasons for no documentation errors include:

- The provider did not respond at all.
- The provider indicated that the beneficiary does not exist,
- The provider indicated that they submitted the claim for the wrong date of service,
- The provider responded but did not provide the medical record for some reason (such as fear of violating HIPAA or refusing to submit without separate payment for copying/mailing charges),
- The provider commented that they had gone out of business,
- The provider indicated that a third party is in possession of the needed medical record, or

In the past, CMS implemented the following corrective actions to address the no documentation problem:

1. The CERT contractor developed a Web-based mechanism to allow Carriers/DMERCs/FIs to see which providers respond to CERT documentation requests. CMS then encouraged Carriers/DMERCs/FIs to contact non-responding providers.
2. CMS revised the medical record request letters to emphasize that faxing is the most effective way to submit medical records.
3. CMS required the CERT Review Contractor to implement an appeals tracking system. The CERT Review Contractor used the appeals information to adjust the errors when the provider appealed a CERT decision and the appeals review concluded that the claim should have been paid. Since providers that initially failed to respond to CERT requests for medical records frequently appealed the denial, this change (adjusting the error rate to account for appeals decisions) lowered the percent of the error rate due to no documentation.
4. A new contractor was hired to specialize in requesting and receiving medical records reviewed by the CERT program. This new contractor, known as the CERT Documentation Contractor, has implemented new policies such as:
    - Calling providers before sending correspondence in order to verify contact information,
    - Offering to fax request letters to providers who can receive faxes,

- Developing a website that allows providers to customize the delivery address for CERT medical record request letters, and
- Developing a clear policy and documentation process to deal with medical records that are lost or damaged due to disaster.

CMS initiated several new corrective actions that will have an impact on future reports.

1. The CERT Documentation Contractor contacted third party providers to request documentation when the billing provider indicated that medical records were possessed by a third party.
2. CMS is implementing a Durable Medical Equipment Accreditation program to ensure the legitimacy of the DME suppliers that bill Medicare and to ensure those suppliers meet all the requirements for participation in the Medicare program.
3. CMS is conducting a pilot that uses claim attachment records to allow providers to submit electronic medical records (EMR). The pilot will help CMS test whether:
    - A Medicare FI can realize efficiencies in their medical review program and lower their error rate by accepting computerized and imaged medical records, and
    - It would be feasible for the CERT program to accept computerized or imaged medical records from providers using claim attachment records.

Insufficient Documentation

The insufficient documentation problem was caused by multiple factors, including:

- Some providers remain confused about exactly what they needed to submit to the CERT contractor.
- Portions of the medical record were at a location within the billing provider organization other than the location to which the CERT contractor sent the request and the provider did not forward the request to the appropriate location (e.g., the request was sent to the home office but the record was located in a field office).
- Portions of the medical record were located at a third party and the provider did not contact the third party (e.g., the request was sent to the billing physician but the record was located at the hospital).
- Providers failed to properly document the billed service in the medical record (e.g., the plan of care lacked the required physician signature).
- Providers misplaced portions of the medical record.

In the past, CMS undertook the following corrective actions aimed at reducing the insufficient documentation rate:

1. The CERT program now solicits improved addresses from Carriers/DMERC/FIs and providers themselves.
2. CMS modified the medical record request letters to clarify the components of the record needed for CERT review. The new letters also encourage the billing provider to forward the request to the appropriate location if the medical record is not on-site.

3. A new provider address customization website allows providers to supply the CERT program with alternate, third party addresses.
4. CMS now customizes the second chance letters to list the parts of the medical record that are needed to complete the review.
5. CMS encouraged Carriers/DMERCs/FIs to educate providers about the importance of submitting thorough and complete documentation.

CMS implemented the following new corrective actions in the past year that impacted the insufficient documentation error rate in this report:

1. The CERT program implemented a process to distribute an insufficient documentation report to all Carriers/DMERCs/FIs 60 days prior to the due date of an improper payment report. Carriers/DMERCs/FIs were encouraged to contact providers to obtain missing information that is needed for CERT review of claims.
2. The CERT Documentation Contractor contacted third party providers to request documentation when the billing provider indicated that a portion of the medical record was possessed by a third party.

CMS is implementing the following corrective action that will impact future reports:

1. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce insufficient documentation errors.

Medically Unnecessary Services

The QIOs were responsible for the largest portion of the improper payments due to medically unnecessary services.

CMS undertook the following actions to correct this problem:

1. CMS has developed a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data.
2. CMS has developed projects with the QIOs that address problems identified in state-specific hospital billing reports.
3. CMS provided hospitals with training on using comparative data reports to help them prioritize auditing and monitoring efforts with the goal of preventing payment errors.
4. CMS conducts an annual payment error cause analysis to discern sources of payment error. CMS developed and distributed QIO specific payment error cause analyses to improve targeting of QIO efforts to reduce payment errors.
5. CMS is working to address possible issues with observation versus inpatient admission that could be contributing to inappropriate inpatient admissions.
6. CMS has completed and distributed an extensive workbook designed to be a resource for hospitals in their compliance efforts and activities.
7. CMS has tasked each Carrier/DMERC/FI with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.

8. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce insufficient medical necessity errors.

Incorrect Coding

Incorrect coding errors occurred when providers submitted documentation that supported a higher or lower code than the code submitted on the claim.

CMS will continue the following corrective actions:

1. QIOs will continue to work with hospitals to reduce coding errors through educational efforts and the use of statewide and hospital specific reports from First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM). FATHOM is designed to identify emerging problem areas through data analysis. FATHOM includes reports on DRG-based target areas such as the ratio of the count of discharges with DRG 0079 (respiratory infections and inflammations age >17 with complications or comorbidity) to the count of discharges with DRGs 079, 080, 089, or 090 (lower paying pneumonia DRGs).
2. CMS considered a resolution passed by the American Medical Association (AMA), the owner of the physician coding system, that recommended CMS defer to the billing physician's judgment in evaluation and management cases where a reviewer and the billing physician disagree by only one coding level. CMS continues to evaluate this proposed policy and is conducting a study under MMA 941(d) to explore a simpler, alternative system of requirements for documentation accompanying E&M claims.
3. CMS has tasked each Carrier/DMERC/FI with developing an Error Rate Reduction Plan (ERRP) that targets incorrect coding errors in their jurisdiction.
4. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce incorrect coding errors.

Delay in Producing Error Rate Reports

The time delay in the production of the error rate reports are a result of the trade-off between data completeness and timeliness inherent in the current structure of the CERT and HPMP processes. The processes must allow sufficient time for providers to submit medical records, reviewers to examine the claims, and for the Carriers/DMERCs/FIs to re-price those claims that are found to be in error. In addition, claims in HPMP are sampled three months after discharge in order to allow for hospital claims submission times and for records that undergo QIO case review to go through multiple levels of physician review and appeals. CMS routinely conducts process reviews in orders to identify areas where the program can become more time efficient.

CMS has taken the following actions:

1. The CERT program now requests sampled claim information from the Carriers/DMERCs/FIs on a daily basis.
2. The CERT Documentation Contractor's medical record request letter asks the providers to respond in 30 days. However, claims are not marked as an error until day 90.

3. The CERT program has advanced the time period covered by each November report by three months to decrease the time lag between claim sampling and error reporting.

Due to issues related to claim submission and time to complete case review, it is difficult to decrease the lag time for HPMP without adversely affecting the accuracy of the estimate. However, by affecting when data is reported internally, HPMP will be able to decrease the lag time by two months to four months. Under their current contract, QIOs are investigating where efficiency in the case review process can be improved and this potentially will eliminate unnecessary time lags in the case review process and further reduce the lag time. It should be noted that for HPMP, short-term acute care claims were sampled by discharge date.

Miscellaneous

CMS continues to take the following general corrective actions:

1. CMS has directed Medicare contractors to develop local efforts to lower the error rate by submitting Error Rate Reduction Plans that address the cause of the errors, identify the steps they are taking to fix the problems, and provide recommendations to CMS. CMS closely monitors and evaluates the development and implementation of the Contractor Error Rate Reduction Plan for each each Carrier/DMERC/FI.
2. Contractors have implemented educational programs that entail both broad-based efforts and more focused communication with specific providers or provider groups concerning specific billing problems. These efforts include the use of a wide array of CMS-developed educational products (the Medicare Learning Network products can be viewed at http://www.cms.hhs.gov/MLNProducts) on coverage, payment and billing. In addition to these products, to assist providers in understanding Medicare program requirements, CMS offers national and local provider forums, national and local websites, and dedicated provider contact centers answering over 56M provider calls annually.
3. CMS has required its Carriers/DMERCs/FIs to develop annual medical review strategies to reduce the error rates. CMS ties contractor budgets to medical review strategies, evaluates contractor performance based on how well each contractor accomplishes the goals, and conforms to the procedures included in their strategies.
4. CMS will develop and install new Correct Coding Initiative edits to reduce improper payments.
5. CMS will use the contractor specific error rates in the contractor performance evaluation program.
6. CMS will continue to provide educational tools and resources that support the contractors' efforts to address provider billing/payment questions accurately and consistently.
7. CMS is implementing a major initiative to determine if Recovery Audit Contractors (RACs) can lower the error rate by identifying and recovering Medicare overpayments. CMS has begun a three-year demonstration in the states of California, New York, and Florida as required by Section 306 of the Medicare Modernization Act. For more information about this demonstration, see www.cms.hhs.gov/researchers/demos/MMAdemolist.asp. CMS will closely monitor provider compliance error rates and paid claim error rates in these three states to see if

providers in RAC states improve their provider compliance error rate faster than those in non-RAC states. In 2007, CMS will be looking to see if the Carriers/DMERCs/FIs in these states are able to lower their paid claim error rates more rapidly than other states by reducing post payment medical review and increasing provider education and prepayment medical review.

8. The CERT program completes a small area variation analysis of the Carrier/DMERC/FI error rates using data from the Improper Medicare Fee-for-Service report. This annual special study produces maps that depict local error rate problem areas. This study facilitates a better understanding of how error rates vary geographically and where CMS and the Carriers/DMERCs/FIs should focus corrective actions.
9. The Medicare Modernization Act requires that CMS publish a list of over-utilized codes. The list provides service type error rates for each CERT cluster group. The CERT program develops and distributes the list annually via the CERT public website (www.cms.hhs.gov/CERT).
10. The HPMP is developing national and state-specific models for predicting payment errors. This study facilitates a better understanding of areas prone to payment error and where QIOs should focus corrective actions.
11. CMS will form a workgroup to address the high provider compliance error rate. This workgroup will examine causes of the errors and develop recommendations for corrective actions.
12. CMS provided Carriers/DMERCs/FIs more detailed reports and information to enable them to better identify problem areas and target corrective actions.
13. Because CERT reviews the version of the claims as it appeared at the time of selection some claims have been scored as errors though the provider submitted a corrected claim sometime later. Beginning November 1, 2006, CMS is revising the CERT sampling schedule to allow additional time for provider adjustments or corrections.

SUPPLEMENTAL INFORMATION

The full copy of The Supplementary Appendices for the Improper Medicare Fee-for-Service Payments Report may be downloaded here. The full file is an Adobe PDF file of approximately 1.1 MB.

Error Rates by Type of Service

Table 11a: Top 20 Service Type Error Rates: Carriers

Service Type Billed to Carriers (BETOS codes)	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Office visits - new	14.9%	12.8% - 17.0%	4.3%	0.6%	0.3%	94.4%	0.5%
Consultations	14.8%	13.4% - 16.2%	1.7%	9.3%	0.6%	87.8%	0.6%
Hospital visit - initial	14.0%	11.5% - 16.5%	1.7%	23.7%	0.0%	73.3%	1.3%
Nursing home visit	12.1%	10.2% - 14.1%	8.9%	21.6%	0.7%	68.8%	0.0%
Chiropractic	10.8%	8.1% - 13.6%	2.4%	47.4%	32.2%	16.0%	2.1%
Other drugs	10.5%	4.6% - 16.5%	87.8%	2.7%	0.4%	9.1%	0.0%
Hospital visit - subsequent	10.5%	9.2% - 11.7%	3.5%	38.6%	0.1%	53.3%	4.5%
Hospital visit - critical care	9.2%	3.5% - 14.9%	6.2%	33.7%	0.0%	54.1%	6.0%
Minor procedures - other (Medicare fee schedule)	6.7%	5.2% - 8.3%	12.6%	69.8%	6.6%	10.8%	0.2%
Office visits - established	5.3%	4.9% - 5.6%	5.3%	14.4%	1.7%	77.5%	1.1%
Dialysis services (Non MFS)	5.2%	1.1% - 9.3%	0.0%	77.4%	0.0%	22.6%	0.0%
Emergency room visit	4.3%	3.1% - 5.4%	6.4%	13.6%	0.0%	80.0%	0.0%
Specialist - psychiatry	3.9%	(0.1%) - 7.9%	62.5%	7.4%	0.0%	14.0%	16.0%
Chemotherapy	3.6%	0.0% - 7.3%	78.2%	0.0%	0.0%	0.0%	21.8%
Other tests - other	3.3%	1.1% - 5.4%	17.1%	75.4%	5.9%	0.8%	0.9%
Minor procedures - musculoskeletal	3.1%	0.1% - 6.2%	2.9%	79.8%	10.3%	7.0%	0.0%
Ambulance	2.2%	1.0% - 3.3%	7.5%	24.0%	45.7%	22.3%	0.5%

Specialist - opthamology	1.7%	0.9% - 2.5%	18.9%	51.6%	4.3%	25.2%	0.0%
All Codes With Less Than 30 Claims	1.6%	(0.4%) - 3.7%	0.0%	95.4%	1.2%	3.4%	0.0%
Lab tests - other (non-Medicare fee schedule)	1.5%	0.9% - 2.1%	30.5%	51.2%	12.0%	4.0%	2.3%
All Other Codes	1.2%	0.9% - 1.4%	29.5%	40.8%	6.9%	20.6%	2.3%
All Types of Services	**4.8%**	**4.3% - 5.3%**	**21.8%**	**24.7%**	**3.2%**	**48.3%**	**1.9%**

Table 11b: Top 20 Service Type Error Rates: DMERCs

Service Type Billed to DMERCs (SADMERC Policy Group)	**Paid Claims Error Rate**	**95% Confidence Interval**	**Type of Error**				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Negative Pressure Wound Therapy	49.5%	24.8% - 74.2%	100.0%	0.0%	0.0%	0.0%	0.0%
TENS	27.2%	(1.7%) - 56.0%	60.8%	0.0%	39.2%	0.0%	0.0%
Support Surfaces	22.0%	5.7% - 38.3%	100.0%	0.0%	0.0%	0.0%	0.0%
All Policy Groups with Less than 30 Claims	20.4%	8.8% - 32.1%	48.5%	0.1%	49.9%	1.6%	0.0%
Enteral Nutrition	16.8%	6.6% - 27.1%	85.1%	0.0%	9.4%	5.5%	0.0%
Nebulizers & Related Drugs	14.5%	7.1% - 21.8%	67.1%	0.5%	17.3%	14.8%	0.3%
Ostomy Supplies	13.9%	2.5% - 25.2%	46.7%	0.0%	50.1%	3.2%	0.0%
Urological Supplies	12.1%	1.3% - 22.9%	62.6%	11.6%	18.4%	6.4%	1.0%
Surgical Dressings	11.8%	(1.0%) - 24.6%	88.1%	0.3%	11.6%	0.0%	0.0%
Glucose Monitor	10.0%	8.3% - 11.7%	10.1%	2.2%	75.3%	12.4%	0.0%
Lower Limb Orthoses	10.0%	(2.2%) - 22.1%	85.6%	0.0%	12.7%	1.7%	0.0%
Wheelchairs Options/Accessories	7.0%	(0.5%) - 14.5%	11.4%	0.7%	78.1%	9.8%	0.0%
CPAP	6.5%	3.9% - 9.1%	26.5%	0.0%	72.8%	0.8%	0.0%
Lenses	6.2%	0.7% - 11.7%	0.0%	0.0%	100.0%	0.0%	0.0%

Respiratory Assist Device	4.9%	(0.9%) - 10.6%	78.8%	0.0%	21.2%	0.0%	0.0%
Walkers	4.2%	0.7% - 7.8%	16.1%	0.0%	83.9%	0.0%	0.0%
Wheelchairs Manual	4.2%	2.5% - 5.9%	0.0%	4.8%	76.8%	12.6%	5.9%
Immunosuppressive Drugs	2.5%	0.1% - 4.9%	0.0%	31.2%	68.7%	0.0%	0.0%
All Other Codes	1.7%	0.5% - 2.9%	10.0%	0.0%	90.0%	0.0%	0.0%
Hospital Beds/Accessories	1.3%	0.1% - 2.4%	45.2%	0.0%	54.8%	0.0%	0.0%
Oxygen Supplies/Equipment	1.0%	0.5% - 1.5%	31.4%	0.0%	52.5%	8.3%	7.8%
All Types of Services	**10.0%**	**7.8% - 12.2%**	**57.3%**	**0.9%**	**36.0%**	**5.5%**	**0.3%**

Table 11c: Top 20 Service Type Error Rates: FIs

Service Type Billed to FIs (Type of Bill)	**Paid Claims Error Rate**	**95% Confidence Interval**	**Type of Error**				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	2.2%	1.7% - 2.6%	4.8%	45.2%	3.7%	41.7%	4.6%
Other FI Service Types	2.1%	1.0% - 3.1%	15.9%	26.6%	2.6%	52.2%	2.8%
SNF	1.5%	1.0% - 2.0%	0.3%	8.9%	21.1%	51.8%	18.0%
FQHC	1.1%	0.1% - 2.1%	20.8%	79.2%	0.0%	0.0%	0.0%
Hospice	1.0%	0.1% - 1.9%	0.0%	7.9%	43.6%	1.8%	46.7%
Non-PPS Hospital In-patient	0.8%	0.3% - 1.4%	1.6%	68.1%	0.5%	12.3%	17.5%
HHA	0.8%	0.3% - 1.2%	0.0%	1.7%	36.3%	57.9%	4.1%
ESRD	0.7%	0.4% - 1.1%	1.3%	52.3%	0.0%	46.4%	0.0%
RHCs	0.5%	0.2% - 0.9%	32.4%	57.7%	9.9%	0.0%	0.0%
Free Standing Ambulatory Surgery	0.0%	0.0% - 0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
All Types of Services	**1.4%**	**1.2% - 1.7%**	**3.7%**	**29.1%**	**13.4%**	**42.9%**	**10.9%**

Table 11d: Top 20 Service Type Error Rates: QIOs[13]

Service Types for Which QIOs are Responsible (DRG)	Paid Claims Error Rate	95% Confidence Interval	Type of Error				
			No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
FX, SPRN, STRN & DISL OF UPARM,LOWLE G EX FOOT AGE >17 W/O CC	51.1%	4.0% - 98.1%	0.0%	N/A	95.0%	2.8%	2.2%
INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	35.5%	(11.6%) - 82.7%	0.0%	N/A	39.4%	60.6%	0.0%
OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	32.6%	8.8% - 56.4%	0.0%	N/A	90.8%	9.2%	0.0%
SIGNS & SYMPTOMS W CC	32.1%	16.2% - 48.0%	9.3%	N/A	71.6%	18.1%	0.9%
MEDICAL BACK PROBLEMS	31.0%	20.9% - 41.2%	0.0%	N/A	93.1%	4.6%	2.3%
SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	28.8%	12.6% - 45.0%	0.0%	N/A	82.0%	13.5%	4.5%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	26.4%	3.3% - 49.4%	0.0%	N/A	60.0%	38.4%	1.7%
CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	24.5%	2.1% - 46.8%	0.0%	N/A	87.5%	12.5%	0.0%
ANGINA PECTORIS	23.8%	7.9% - 39.7%	0.0%	N/A	76.7%	16.4%	6.9%
CHEST PAIN	23.4%	18.4% - 28.5%	0.3%	N/A	93.3%	2.7%	3.7%
BONE DISEASES & SPECIFIC ARTHROPATHIE S W CC	23.1%	8.6% - 37.6%	0.0%	N/A	97.2%	2.8%	0.0%
ORGANIC DISTURBANCES & MENTAL RETARDATION	22.2%	(0.2%) - 44.6%	0.0%	N/A	92.1%	6.2%	1.6%

[13] Some error rates on this table may exceed 100%. For further information see "Weighting and Determining the Final Results".

DYSEQUILIBRIUM	22.1%	9.2% - 34.9%	0.0%	N/A	93.5%	2.3%	4.2%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	21.5%	13.3% - 29.7%	2.2%	N/A	82.7%	9.6%	5.4%
NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	20.6%	(4.9%) - 46.1%	0.0%	N/A	94.4%	5.6%	0.0%
SEIZURE & HEADACHE AGE >17 W/O CC	20.6%	4.5% - 36.7%	0.0%	N/A	83.6%	16.4%	0.0%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	20.3%	11.4% - 29.2%	0.0%	N/A	66.4%	26.7%	7.0%
G.I. HEMORRHAGE W/O CC	19.0%	4.4% - 33.5%	0.0%	N/A	91.6%	7.7%	0.8%
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	18.9%	0.1% - 37.8%	0.0%	N/A	59.6%	35.9%	4.5%
OTITIS MEDIA & URI AGE >17 W CC	18.2%	5.2% - 31.1%	0.0%	N/A	58.6%	41.4%	0.0%
All HPMP	**5.0%**	**4.7% - 5.3%**	**2.4%**	**N/A**	**61.4%**	**29.8%**	**6.4%**

Error Rates by Type of Error

Table 12a: Error Rates for Each Cluster by Type of Error: Carriers

Carriers	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
First Coast Service Options FL 00590	11.1%	7.0%	1.5%	0.2%	2.3%	0.1%
Triple S, Inc. PR/VI 00973/00974	11.1%	0.4%	2.5%	1.5%	6.7%	0.0%
Empire NY 00803	6.2%	0.6%	2.2%	0.1%	3.2%	0.1%
Empire NJ 00805	6.1%	0.1%	1.3%	0.1%	4.6%	0.0%
GHI NY 14330	5.0%	0.2%	1.7%	0.2%	2.9%	0.0%
BCBS AR RI 00524	4.8%	0.1%	1.4%	0.4%	2.8%	0.2%
Palmetto SC 00880	4.5%	1.0%	1.4%	0.4%	1.7%	0.0%
Trailblazer TX 00900	4.4%	0.5%	1.3%	0.4%	2.2%	0.0%
Palmetto OH/WV 00883/00884	4.4%	0.4%	1.4%	0.0%	2.7%	0.0%
Cahaba AL/GA/MS 00510/00511/00512	4.2%	0.5%	1.2%	0.1%	2.0%	0.5%
Noridian UT 00823	4.2%	0.4%	2.3%	0.0%	1.4%	0.0%
Noridian AK/AZ/HI/NV/OR/WA	4.1%	0.2%	1.6%	0.4%	1.8%	0.0%

00831/00832/00833/00834/00835/008						
CIGNA NC 05535	3.9%	0.5%	1.0%	0.0%	1.8%	0.7%
NHIC ME/MA/NH/VT 31142/31143/31144/31145	3.8%	0.3%	0.7%	0.1%	2.4%	0.3%
WPS WI/IL/MI/MN 00951/00952/00953/00954	3.7%	0.4%	1.3%	0.0%	1.9%	0.1%
NHIC CA 31140/31146	3.6%	0.4%	0.6%	0.0%	2.6%	0.0%
Trailblazer MD/DE/DC/VA 00901/00902/00903/00904	3.6%	0.3%	0.8%	0.1%	2.4%	0.0%
First Coast Service Options CT 00591	3.5%	0.3%	1.0%	0.1%	2.2%	0.0%
AdminaStar IN/KY 00630/00660	3.5%	0.0%	0.6%	0.2%	2.6%	0.0%
BCBS AR AR/NM/OK/MO/LA 00520/00521/00522/00523/00528	3.4%	0.0%	0.9%	0.2%	2.2%	0.0%
Noridian ND/CO/WY/IA/SD 00820/00824/00825/00826/00889	3.3%	0.2%	1.5%	0.2%	1.5%	0.0%
HealthNow NY 00801	3.2%	0.1%	1.1%	0.1%	1.9%	0.0%
BCBS KS/NE/W MO 00650/00655/00651	2.9%	0.1%	0.9%	0.1%	1.6%	0.0%
CIGNA TN 05440	2.9%	0.3%	0.8%	0.3%	1.4%	0.0%
HGSA PA 00865	2.5%	0.2%	0.5%	0.1%	1.7%	0.1%
BCBS MT 00751	2.1%	0.1%	0.8%	0.1%	1.1%	0.0%
CIGNA ID 05130	1.8%	0.1%	0.5%	0.0%	1.2%	0.0%
Combined	**4.8%**	**1.0%**	**1.2%**	**0.2%**	**2.3%**	**0.1%**

Table 12b: Error Rates for Each Cluster by Type of Error: DMERCs

DMERC	**Paid Claims Error Rate**	**Type of Error**				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Palmetto Region C 00885	16.8%	12.5%	0.0%	3.5%	0.8%	0.1%
Tricenturion Region A 77011	6.0%	0.7%	0.1%	4.8%	0.4%	0.0%
CIGNA Region D 05655	4.9%	0.5%	0.3%	3.8%	0.3%	0.0%
AdminaStar Region B 00635	3.5%	0.4%	0.1%	2.8%	0.3%	0.0%
Combined	**10.0%**	**5.7%**	**0.1%**	**3.6%**	**0.5%**	**0.0%**

Table 12c: Error Rates for Each Cluster by Type of Error: FIs

FI	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
Anthem NH/VT 00270	6.2%	0.0%	0.3%	0.0%	5.7%	0.1%
Noridian ID/OR/UT 00323/00325	4.7%	0.0%	3.9%	0.0%	0.6%	0.3%
COSVI PR/VI 57400	2.6%	0.1%	1.3%	0.0%	1.2%	0.0%
Highmark Medicare Services DC/MD 00366	2.6%	0.0%	1.0%	0.0%	0.6%	0.9%
Noridian AK/WA 00322	2.3%	1.3%	0.2%	0.0%	0.7%	0.1%
Trispan LA/MO/MS 00230	2.1%	0.1%	0.2%	0.3%	1.4%	0.0%
Riverbend NJ/TN 00390	1.9%	0.0%	0.6%	0.1%	1.2%	0.0%
UGS AS/CA/GU/HI/NV/NMI 00454	1.8%	0.1%	0.5%	0.2%	1.0%	0.0%
Anthem ME/MA 00180/00181	1.6%	0.1%	0.3%	0.2%	1.0%	0.0%
First Coast Service Options FL 00090	1.6%	0.2%	0.8%	0.1%	0.5%	0.0%
Mutual of Omaha (all states) 52280	1.6%	0.0%	0.4%	0.0%	0.8%	0.3%
BCBS AR AR 00020	1.5%	0.0%	0.3%	0.0%	1.1%	0.0%
BCBS WY WY 00460	1.3%	0.2%	0.7%	0.0%	0.4%	0.0%
AdminaStar IN/IL/KY/OH 00130/00131/00160/00332	1.3%	0.0%	0.6%	0.1%	0.5%	0.0%
Palmetto NC 00382	1.3%	0.1%	0.7%	0.1%	0.4%	0.0%
BCBS AZ AZ 00030	1.2%	0.1%	0.4%	0.0%	0.7%	0.0%
UGS WI/MI 00450/00452	1.2%	0.1%	0.2%	0.3%	0.6%	0.0%
BCBS KS KS 00150	1.2%	0.0%	0.7%	0.3%	0.3%	0.0%
Noridian MN/ND 00320/00321	1.2%	0.0%	0.3%	0.1%	0.8%	0.0%
Empire CT/DE/NY 00308	1.2%	0.0%	0.4%	0.3%	0.5%	0.0%
Veritus PA 00363	1.2%	0.0%	0.3%	0.3%	0.5%	0.0%
Trailblazer CO/NM/TX 00400	1.1%	0.0%	0.5%	0.0%	0.4%	0.1%
BCBS MT MT 00250	1.1%	0.1%	0.7%	0.0%	0.3%	0.0%
Palmetto SC 00380	1.1%	0.0%	0.0%	0.5%	0.2%	0.3%
UGS VA/WV 00453	1.1%	0.0%	0.3%	0.2%	0.4%	0.2%
BCBS AR RI 00021	1.0%	0.0%	0.4%	0.0%	0.5%	0.0%
BCBS GA GA 00101	0.9%	0.0%	0.4%	0.0%	0.5%	0.0%
BCBS NE NE 00260	0.9%	0.0%	0.2%	0.0%	0.7%	0.0%
Cahaba AL 00010	0.8%	0.0%	0.2%	0.0%	0.6%	0.0%
Chisholm OK 00340	0.5%	0.0%	0.2%	0.0%	0.3%	0.0%
Cahaba IA/SD 00011	0.3%	0.0%	0.0%	0.1%	0.2%	0.0%
Combined	**1.4%**	**0.1%**	**0.4%**	**0.2%**	**0.6%**	**0.2%**

Table 12d: Error Rates for Each Cluster by Type of Error: QIOs

QIO	Paid Claims Error Rate	Type of Error				
		No Doc	Insufficient Doc	Medically Unnecessary Services	Incorrect Coding	Other
ALABAMA	6.5%	0.0%	N/A	3.1%	3.2%	0.2%
ALASKA	1.3%	0.0%	N/A	0.5%	0.2%	0.5%
ARIZONA	6.2%	0.8%	N/A	2.0%	3.0%	0.4%
ARKANSAS	4.9%	0.1%	N/A	3.1%	1.2%	0.5%
CALIFORNIA	4.3%	0.1%	N/A	2.2%	1.1%	0.9%
COLORADO	4.2%	0.2%	N/A	1.4%	1.8%	0.8%
CONNECTICUT	3.8%	0.0%	N/A	2.1%	1.6%	0.0%
DELAWARE	4.5%	0.0%	N/A	3.3%	1.2%	0.0%
DISTRICT OF COLUMBIA	3.9%	0.2%	N/A	2.7%	1.1%	0.0%
FLORIDA	7.7%	0.1%	N/A	5.1%	2.5%	0.0%
GEORGIA	3.8%	0.0%	N/A	1.2%	1.7%	0.8%
HAWAII	3.4%	0.0%	N/A	1.3%	1.8%	0.4%
IDAHO	3.2%	0.0%	N/A	2.2%	0.9%	0.2%
ILLINOIS	5.3%	0.3%	N/A	3.4%	1.5%	0.1%
INDIANA	5.7%	1.0%	N/A	4.5%	0.3%	0.0%
IOWA	4.1%	0.0%	N/A	2.2%	1.7%	0.2%
KANSAS	3.4%	0.3%	N/A	1.4%	1.6%	0.2%
KENTUCKY	7.2%	0.2%	N/A	6.5%	0.5%	0.0%
LOUISIANA	3.0%	0.2%	N/A	0.9%	1.1%	0.7%
MAINE	5.1%	0.0%	N/A	4.4%	0.5%	0.3%
MARYLAND	5.3%	0.0%	N/A	5.3%	0.0%	0.0%
MASSACHUSETTS	9.9%	0.0%	N/A	9.5%	0.2%	0.2%
MICHIGAN	5.3%	0.0%	N/A	3.1%	1.9%	0.4%
MINNESOTA	4.8%	0.0%	N/A	3.1%	1.3%	0.4%
MISSISSIPPI	5.6%	0.6%	N/A	2.8%	1.4%	0.8%
MISSOURI	4.4%	0.0%	N/A	2.6%	1.1%	0.7%
MONTANA	1.1%	0.0%	N/A	0.5%	0.1%	0.4%
NEBRASKA	1.2%	0.0%	N/A	0.6%	0.5%	0.1%
NEVADA	7.1%	0.2%	N/A	4.5%	1.9%	0.6%
NEW HAMPSHIRE	2.7%	0.0%	N/A	2.0%	0.5%	0.2%
NEW JERSEY	3.7%	0.1%	N/A	2.6%	0.8%	0.1%
NEW MEXICO	8.8%	0.2%	N/A	4.4%	3.4%	0.9%
NEW YORK	4.4%	0.2%	N/A	2.1%	2.0%	0.0%
NORTH CAROLINA	1.2%	0.0%	N/A	1.0%	0.2%	0.0%
NORTH DAKOTA	2.5%	0.1%	N/A	1.7%	0.7%	0.0%
OHIO	2.6%	0.0%	N/A	2.3%	0.2%	0.1%
OKLAHOMA	3.3%	0.4%	N/A	1.2%	1.2%	0.4%
OREGON	6.0%	0.0%	N/A	4.1%	0.7%	1.1%
PENNSYLVANIA	6.6%	0.1%	N/A	2.5%	3.9%	0.0%
PUERTO RICO	7.7%	0.2%	N/A	4.5%	2.9%	0.0%
RHODE ISLAND	4.8%	0.0%	N/A	3.9%	0.8%	0.1%
SOUTH CAROLINA	6.4%	0.2%	N/A	4.5%	1.7%	0.0%

SOUTH DAKOTA	3.2%	0.3%	N/A	2.5%	0.1%	0.3%
TENNESSEE	2.9%	0.1%	N/A	1.1%	1.5%	0.3%
TEXAS	6.7%	0.0%	N/A	3.6%	1.8%	1.3%
UTAH	4.6%	0.1%	N/A	2.1%	1.5%	1.0%
VERMONT	4.2%	0.0%	N/A	3.4%	0.5%	0.4%
VIRGINIA	4.1%	0.0%	N/A	3.1%	0.9%	0.0%
WASHINGTON	2.5%	0.0%	N/A	2.2%	0.3%	0.0%
WEST VIRGINIA	5.5%	0.0%	N/A	3.2%	2.2%	0.2%
WISCONSIN	2.4%	0.0%	N/A	1.0%	1.3%	0.1%
WYOMING	1.1%	0.2%	N/A	0.3%	0.2%	0.4%
Short-term Acute Paid Claims	**4.9%**	**0.1%**	**N/A**	**3.0%**	**1.5%**	**0.3%**
Long-term Acute Paid Claims	**5.5%**	**0.0%**	**N/A**	**3.8%**	**1.7%**	**0.0%**
Denied Claims	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**5.0%**	**0.1%**	**N/A**	**3.1%**	**1.5%**	**0.3%**

Paid Claims Error Rate by Service Type

Table series 13 displays the paid claims error rate by service type for each contractor type. Each table is sorted by projected improper payments from highest to lowest. All estimates are based on a minimum of 30 claims in the sample.

Table 13a: Paid Claims Error Rates by Service Type: Carriers

Service Types Billed to Carriers (BETOS)	Paid Claims Error Rate				
	Error Rate	Number of Line Items (Sample)	Projected Improper Payments	Standard Error	95% Confidence Interval
Other drugs	10.5%	2,183	$523,120,210	3.0%	4.6% - 16.5%
Consultations	14.8%	2,102	$493,186,803	0.7%	13.4% - 16.2%
Office visits - established	5.3%	14,956	$489,996,737	0.2%	4.9% - 5.6%
Hospital visit - subsequent	10.5%	5,736	$479,296,534	0.6%	9.2% - 11.7%
Minor procedures - other (Medicare fee schedule)	6.7%	6,189	$171,436,522	0.8%	5.2% - 8.3%
Office visits - new	14.9%	1,107	$160,096,718	1.1%	12.8% - 17.0%
Hospital visit - initial	14.0%	760	$152,751,631	1.3%	11.5% - 16.5%
Nursing home visit	12.1%	1,588	$124,707,029	1.0%	10.2% - 14.1%
Ambulance	2.2%	2,194	$75,336,062	0.6%	1.0% - 3.3%
Chemotherapy	3.6%	282	$69,057,591	1.9%	0.0% - 7.3%
Hospital visit - critical care	9.2%	279	$63,246,970	2.9%	3.5% - 14.9%
Emergency room visit	4.3%	1,306	$60,164,874	0.6%	3.1% - 5.4%
Chiropractic	10.8%	1,788	$59,846,427	1.4%	8.1% - 13.6%
Other tests - other	3.3%	1,746	$43,736,968	1.1%	1.1% - 5.4%
All Codes With Less Than 30 Claims	1.6%	466	$42,195,712	1.0%	(0.4%) - 3.7%
Dialysis services (Non MFS)	5.2%	231	$36,782,515	2.1%	1.1% - 9.3%
Specialist - psychiatry	3.9%	1,627	$35,307,007	2.0%	(0.1%) - 7.9%
Specialist - ophthalmology	1.7%	2,785	$31,190,418	0.4%	0.9% - 2.5%

Minor procedures - musculoskeletal	3.1%	907	$28,614,225	1.6%	0.1% - 6.2%
Lab tests - other (non-Medicare fee schedule)	1.5%	11,348	$28,162,771	0.3%	0.9% - 2.1%
Standard imaging - musculoskeletal	3.1%	2,412	$22,092,907	0.8%	1.6% - 4.6%
Other tests - electrocardiograms	4.4%	2,316	$17,441,128	0.7%	3.1% - 5.7%
Major procedure - Other	1.7%	222	$16,744,849	1.5%	(1.3%) - 4.8%
Ambulatory procedures - other	2.2%	607	$15,212,629	1.2%	(0.2%) - 4.5%
Advanced imaging - MRI: brain	2.1%	200	$14,778,320	1.7%	(1.3%) - 5.5%
Echography - other	3.0%	516	$14,587,395	1.5%	0.1% - 5.9%
Other - Medicare fee schedule	9.9%	283	$13,271,222	3.2%	3.6% - 16.1%
Home visit	8.7%	162	$12,662,889	3.9%	1.1% - 16.3%
Specialist - other	6.6%	287	$12,517,981	2.2%	2.2% - 11.0%
Standard imaging - nuclear medicine	0.6%	1,048	$11,340,476	0.3%	0.1% - 1.2%
Major procedure, cardiovascular-Other	1.2%	300	$11,272,330	1.1%	(0.9%) - 3.3%
Advanced imaging - CAT: other	0.9%	1,034	$10,862,700	0.6%	(0.2%) - 2.0%
Lab tests - other (Medicare fee schedule)	0.7%	1,547	$10,681,684	0.3%	0.1% - 1.3%
Eye procedure - other	1.8%	176	$8,898,453	1.5%	(1.2%) - 4.8%
Anesthesia	0.7%	840	$8,879,874	0.4%	0.0% - 1.4%
Ambulatory procedures - skin	0.8%	1,450	$8,298,175	0.3%	0.2% - 1.3%
Imaging/procedure - other	2.4%	430	$7,970,606	1.5%	(0.5%) - 5.2%
Echography - heart	0.6%	1,580	$7,805,879	0.3%	0.1% - 1.1%
Standard imaging - other	2.5%	678	$7,461,899	0.8%	0.9% - 4.1%
Minor procedures - skin	0.7%	1,301	$6,509,199	0.2%	0.3% - 1.0%
Standard imaging - chest	1.8%	2,439	$6,500,234	0.5%	0.8% - 2.7%
Other tests - EKG monitoring	4.9%	140	$5,849,768	2.3%	0.3% - 9.5%
Echography - carotid arteries	1.9%	212	$5,503,581	1.8%	(1.6%) - 5.4%
Echography - abdomen/pelvis	2.5%	331	$5,183,353	1.2%	0.1% - 4.8%
Oncology - radiation therapy	0.5%	511	$5,074,179	0.3%	(0.1%) - 1.0%
Standard imaging - breast	1.2%	892	$4,837,717	0.6%	(0.0%) - 2.4%
Echography - eye	4.6%	144	$4,718,742	1.1%	2.4% - 6.8%
Dialysis services	4.1%	139	$4,333,149	2.9%	(1.6%) - 9.8%
Immunizations/Vaccinations	1.3%	2,154	$4,319,087	0.4%	0.5% - 2.1%
Oncology - other	1.1%	624	$3,654,360	0.5%	0.1% - 2.1%
Other tests - cardiovascular stress tests	1.2%	412	$3,602,494	0.6%	0.1% - 2.3%
Lab tests - blood counts	1.3%	2,340	$3,429,274	0.3%	0.7% - 1.9%
Lab tests - routine venipuncture (non Medicare fee schedule)	2.3%	4,487	$3,402,549	0.4%	1.6% - 3.0%
Advanced imaging - MRI: other	0.2%	369	$3,140,876	0.1%	(0.1%) - 0.4%
Lab tests - urinalysis	4.3%	1,406	$2,511,873	0.7%	3.0% - 5.6%
Lab tests - automated general profiles	0.6%	2,389	$1,923,285	0.2%	0.2% - 1.0%
Ambulatory procedures - musculoskeletal	0.4%	95	$1,532,495	0.3%	(0.2%) - 1.1%

Lab tests - glucose	5.5%	505	$1,193,067	2.1%	1.3% - 9.8%
Lab tests - bacterial cultures	1.6%	547	$1,120,243	0.6%	0.4% - 2.7%
Endoscopy - cystoscopy	0.4%	125	$1,091,326	0.4%	(0.4%) - 1.1%
Endoscopy - other	0.8%	73	$1,084,224	0.8%	(0.7%) - 2.3%
Endoscopy - colonoscopy	0.1%	290	$1,004,396	0.1%	(0.1%) - 0.3%
Other - non-Medicare fee schedule	2.0%	427	$768,778	1.1%	(0.1%) - 4.1%
Medical/surgical supplies	18.8%	70	$750,384	12.8%	(6.4%) - 43.9%
Advanced imaging - CAT: head	0.2%	407	$713,139	0.2%	(0.2%) - 0.7%
Standard imaging - contrast gastrointestinal	0.7%	108	$655,901	0.5%	(0.4%) - 1.8%
Endoscopy - upper gastrointestinal	0.1%	195	$609,497	0.1%	(0.1%) - 0.4%
Enteral and parenteral	0.3%	98	$207,851	0.3%	(0.3%) - 1.0%
Endoscopy - laryngoscopy	0.0%	36	N/A	N/A	N/A
Eye procedure - cataract removal/lens insertion	0.0%	251	N/A	N/A	N/A
Imaging/procedure - heart including cardiac catheter	0.0%	327	N/A	N/A	N/A
Major procedure, cardiovascular-Coronary angioplasty (PTCA)	0.0%	38	N/A	N/A	N/A
Major procedure, orthopedic - other	0.0%	112	N/A	N/A	N/A
Orthotic devices	0.0%	61	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**4.8%**	**99,723**	**$3,486,240,139**	**0.3%**	**4.3% - 5.3%**

Table 13b: Paid Claims Error Rates by Service Type: DMERCs

Service Types Billed to DMERCs (SADMERC Policy Group)	**Paid Claims Error Rate**				
	Error Rate	Number of Line Items (Sample)	Projected Improper Payment Amount	Standard Error	95% Confidence Interval
All Policy Groups with Less than 30 Claims	20.4%	467	$246,504,738	6.0%	8.8% - 32.1%
Nebulizers & Related Drugs	14.5%	2,971	$144,761,592	3.8%	7.1% - 21.8%
Negative Pressure Wound Therapy	49.5%	61	$122,006,369	12.6%	24.8% - 74.2%
Glucose Monitor	10.0%	3,328	$112,876,731	0.8%	8.3% - 11.7%
Enteral Nutrition	16.8%	521	$103,052,495	5.2%	6.6% - 27.1%
Support Surfaces	22.0%	99	$27,132,843	8.3%	5.7% - 38.3%
CPAP	6.5%	948	$25,058,897	1.3%	3.9% - 9.1%
Lower Limb Orthoses	10.0%	195	$21,341,400	6.2%	(2.2%) - 22.1%
Oxygen Supplies/Equipment	1.0%	2,926	$20,912,645	0.2%	0.5% - 1.5%
Ostomy Supplies	13.9%	366	$19,890,015	5.8%	2.5% - 25.2%
Wheelchairs Options/Accessories	7.0%	474	$13,220,081	3.8%	(0.5%) -

					14.5%
Immunosuppressive Drugs	2.5%	371	$12,304,690	1.2%	0.1% - 4.9%
Surgical Dressings	11.8%	187	$9,321,921	6.5%	(1.0%) - 24.6%
Wheelchairs Manual	4.2%	741	$9,095,227	0.9%	2.5% - 5.9%
Urological Supplies	12.1%	263	$6,599,720	5.5%	1.3% - 22.9%
TENS	27.2%	40	$4,969,009	14.7%	(1.7%) - 56.0%
Respiratory Assist Device	4.9%	74	$4,215,671	2.9%	(0.9%) - 10.6%
Lenses	6.2%	374	$3,984,533	2.8%	0.7% - 11.7%
Walkers	4.2%	192	$3,464,173	1.8%	0.7% - 7.8%
Hospital Beds/Accessories	1.3%	497	$3,418,637	0.6%	0.1% - 2.4%
Diabetic Shoes	2.1%	212	$3,118,879	1.6%	(1.0%) - 5.2%
Suction Pump	18.5%	62	$2,499,927	11.7%	(4.4%) - 41.4%
Patient Lift	2.6%	61	$733,089	1.8%	(1.0%) - 6.2%
Repairs/DME	8.6%	33	$706,000	5.8%	(2.9%) - 20.0%
Upper Limb Orthoses	1.7%	70	$572,340	1.1%	(0.4%) - 3.9%
Wheelchairs Seating	3.4%	40	$518,315	3.5%	(3.5%) - 10.4%
Commodes/Bed Pans/Urinals	1.5%	116	$494,348	1.5%	(1.4%) - 4.3%
Infusion Pumps & Related Drugs	0.1%	206	$161,929	0.1%	(0.1%) - 0.2%
Spinal Orthoses	0.2%	40	$148,434	0.3%	(0.3%) - 0.7%
Canes/Crutches	1.2%	41	$77,165	1.2%	(1.1%) - 3.4%
Orthopedic Footwear	0.0%	38	N/A	N/A	N/A
Routinely Denied Items	N/A	85	N/A	N/A	N/A
All Type of Services (Incl. Codes Not Listed)	**10.0%**	**16,099**	**$923,161,814**	**1.1%**	**7.8% - 12.2%**

Table 13c: Paid Claims Error Rates by Service Type: FIs

Service Types Billed to FIs (Type of Bill)	**Paid Claims Error Rate**				
	Error Rate	Number of Claims (Sample)	Projected Improper Payments	Standard Error	95% Confidence Interval
OPPS, Laboratory (an FI), Ambulatory (Billing an FI)	2.2%	39,110	$384,307,290	0.2%	1.7% - 2.6%
SNF	1.5%	2,479	$235,158,148	0.3%	1.0% - 2.0%
HHA	0.8%	1,818	$78,401,077	0.2%	0.3% - 1.2%
Other FI Service Types	2.1%	6,260	$76,851,903	0.5%	1.0% - 3.1%
Hospice	1.0%	860	$61,048,433	0.5%	0.1% - 1.9%
ESRD	0.7%	1,141	$37,181,187	0.2%	0.4% - 1.1%
Non-PPS Hospital In-patient	0.8%	2,426	$28,093,371	0.3%	0.3% - 1.4%
FQHC	1.1%	544	$3,802,461	0.5%	0.1% - 2.1%
RHCs	0.5%	3,084	$2,292,100	0.2%	0.2% - 0.9%
Free Standing Ambulatory Surgery	0.0%	70	$7,169	0.0%	0.0% - 0.0%
All Type of Services (Incl.	**1.4%**	**57,792**	**$907,143,140**	**0.1%**	**1.2% - 1.7%**

Codes Not Listed)					

Table 13d: Paid Claims Error Rates by Service Type: QIOs[14]

PPS Acute Care Hospital Service Types Billed to QIOs(DRGs)	Paid Claims Error Rate				
	Error Rate	Number of Claims (Sample)	Projected Improper Payments	Standard Error	95% Confidence Interval
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	13.7%	1,018	$185,695,437	1.7%	10.5% - 17.0%
CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	9.1%	168	$162,106,762	3.8%	1.6% - 16.6%
CHEST PAIN	23.4%	671	$147,773,061	2.6%	18.4% - 28.5%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	12.2%	737	$119,233,591	1.8%	8.7% - 15.7%
RENAL FAILURE	6.8%	690	$111,246,301	1.2%	4.4% - 9.2%
MEDICAL BACK PROBLEMS	31.0%	277	$101,444,641	5.2%	20.9% - 41.2%
HEART FAILURE & SHOCK	2.8%	1,936	$96,535,491	0.6%	1.7% - 3.9%
SEPTICEMIA AGE >17	3.4%	907	$96,288,711	0.8%	1.9% - 4.9%
RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.6%	430	$74,939,893	1.1%	0.5% - 4.8%
OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	10.6%	174	$71,559,670	4.3%	2.1% - 19.1%
PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	9.4%	142	$71,549,748	3.9%	1.8% - 17.1%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	7.4%	685	$69,801,825	1.7%	4.1% - 10.8%
OTHER KIDNEY & URINARY TRACT PROCEDURES	16.7%	110	$69,026,012	6.6%	3.7% - 29.7%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	10.9%	192	$68,284,707	3.9%	3.4% - 18.4%
SYNCOPE & COLLAPSE W CC	13.5%	368	$67,973,240	2.6%	8.3% - 18.7%
OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	8.7%	318	$67,439,792	1.9%	5.0% - 12.4%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	4.0%	452	$66,519,117	1.2%	1.7% - 6.3%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	15.1%	253	$63,157,660	3.6%	7.9% - 22.2%
CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	5.9%	365	$60,341,057	3.0%	(0.0%) - 11.8%
EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	5.1%	153	$59,028,186	3.3%	(1.3%) - 11.5%
G.I. HEMORRHAGE W CC	4.4%	835	$58,622,435	1.1%	2.2% - 6.5%
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	21.5%	264	$53,146,997	4.2%	13.3% - 29.7%

[14] Some error rates on this table may exceed 100%. For further information see "Weighting and Determining the Final Results."

INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	3.0%	863	$52,191,153	0.7%	1.7% - 4.3%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	3.2%	1,200	$51,908,876	0.8%	1.7% - 4.7%
DIABETES AGE >35	16.0%	274	$48,435,864	3.6%	8.8% - 23.1%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.8%	1,575	$45,925,244	0.4%	1.0% - 2.7%
STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	7.2%	111	$45,489,383	4.4%	(1.4%) - 15.7%
OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	9.4%	122	$44,847,099	4.2%	1.1% - 17.6%
MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8%	470	$44,193,388	0.7%	0.3% - 3.3%
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.3%	1,204	$43,523,162	0.5%	0.3% - 2.3%
SIGNS & SYMPTOMS W CC	32.1%	114	$43,292,429	8.1%	16.2% - 48.0%
O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	2.9%	183	$41,487,120	1.2%	0.6% - 5.2%
OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	6.1%	95	$40,405,903	2.3%	1.7% - 10.6%
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	4.5%	699	$40,272,497	1.1%	2.3% - 6.6%
DEGENERATIVE NERVOUS SYSTEM DISORDERS	16.4%	155	$40,197,772	3.7%	9.1% - 23.7%
CELLULITIS AGE >17 W CC	7.1%	389	$39,500,204	2.0%	3.2% - 11.0%
PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	14.8%	52	$39,470,237	6.7%	1.6% - 28.0%
OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	8.4%	100	$38,022,352	3.8%	0.9% - 15.9%
RESPIRATORY NEOPLASMS	8.4%	196	$37,076,508	3.0%	2.4% - 14.4%
OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	14.1%	177	$36,069,154	5.0%	4.3% - 24.0%
NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	13.2%	84	$35,542,678	5.0%	3.4% - 22.9%
ATHEROSCLEROSIS W CC	12.1%	298	$34,450,311	2.9%	6.4% - 17.8%
DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	14.3%	97	$33,997,041	11.8%	(8.7%) - 37.4%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	4.9%	309	$32,660,753	1.5%	2.0% - 7.8%
OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	8.4%	69	$32,099,362	4.4%	(0.2%) - 17.0%
TRANSIENT ISCHEMIA	8.3%	325	$30,427,594	1.9%	4.6% - 12.0%
PULMONARY EDEMA & RESPIRATORY FAILURE	4.0%	336	$29,604,968	1.5%	1.1% - 6.9%
RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	2.1%	523	$28,222,972	0.6%	0.8% - 3.3%
MAJOR CARDIOVASCULAR PROCEDURES W CC	2.0%	204	$27,448,187	1.7%	(1.3%) - 5.4%
G.I. OBSTRUCTION W CC	6.3%	299	$26,585,100	2.1%	2.1% - 10.5%
PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	10.0%	152	$26,425,193	3.2%	3.8% - 16.2%

EXTRACRANIAL PROCEDURES W CC	5.9%	153	$25,539,991	3.7%	(1.4%) - 13.1%
POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	7.6%	107	$23,028,508	3.3%	1.0% - 14.2%
INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	35.5%	31	$22,767,316	24.1%	(11.6%) - 82.7%
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	13.9%	235	$22,237,891	3.5%	6.9% - 20.8%
OTHER DISORDERS OF NERVOUS SYSTEM W CC	14.6%	97	$21,806,181	4.3%	6.2% - 23.1%
SEIZURE & HEADACHE AGE >17 W CC	6.8%	187	$21,369,878	2.1%	2.8% - 10.8%
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	18.9%	65	$21,345,717	9.6%	0.1% - 37.8%
DISORDERS OF PANCREAS EXCEPT MALIGNANCY	4.4%	240	$21,225,237	1.8%	0.8% - 8.0%
BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	10.2%	57	$20,823,690	6.1%	(1.8%) - 22.2%
CIRRHOSIS & ALCOHOLIC HEPATITIS	9.2%	97	$20,652,229	4.9%	(0.3%) - 18.8%
RED BLOOD CELL DISORDERS AGE >17	4.5%	356	$19,920,530	1.6%	1.4% - 7.6%
DYSEQUILIBRIUM	22.1%	124	$19,918,947	6.6%	9.2% - 34.9%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	1.3%	308	$19,611,809	0.5%	0.2% - 2.3%
PERIPHERAL VASCULAR DISORDERS W CC	4.4%	264	$19,513,790	1.1%	2.2% - 6.6%
COAGULATION DISORDERS	13.5%	53	$19,119,181	5.8%	2.2% - 24.9%
HYPERTENSION	13.4%	132	$17,651,887	3.9%	5.7% - 21.1%
OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	7.8%	78	$17,458,158	3.2%	1.6% - 14.0%
ORGANIC DISTURBANCES & MENTAL RETARDATION	22.2%	61	$17,339,221	11.4%	(0.2%) - 44.6%
PSYCHOSES	6.5%	235	$17,261,348	5.1%	(3.5%) - 16.6%
CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	9.6%	85	$16,969,197	3.9%	1.8% - 17.3%
FRACTURES OF HIP & PELVIS	10.7%	141	$16,873,941	4.2%	2.4% - 19.0%
LYMPHOMA & NON-ACUTE LEUKEMIA W CC	4.6%	94	$16,693,687	1.6%	1.5% - 7.6%
NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	20.3%	125	$16,321,496	4.5%	11.4% - 29.2%
SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	28.8%	67	$16,305,708	8.3%	12.6% - 45.0%
SKIN ULCERS	13.6%	64	$16,133,193	6.9%	0.0% - 27.2%
CONNECTIVE TISSUE DISORDERS W CC	14.9%	39	$15,714,000	10.1%	(4.9%) - 34.8%
ANGINA PECTORIS	23.8%	90	$14,626,499	8.1%	7.9% - 39.7%
SYNCOPE & COLLAPSE W/O CC	13.1%	126	$14,605,561	3.2%	6.8% - 19.3%
BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	23.1%	55	$14,503,106	7.4%	8.6% - 37.6%
KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	15.3%	113	$14,343,484	4.5%	6.5% - 24.2%

OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	32.6%	32	$13,866,833	12.2%	8.8% - 56.4%
LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	12.9%	73	$13,808,674	8.1%	(3.0%) - 28.8%
SEIZURE & HEADACHE AGE >17 W/O CC	20.6%	66	$13,548,939	8.2%	4.5% - 36.7%
BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	5.9%	130	$13,464,573	2.2%	1.7% - 10.2%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	13.4%	124	$13,168,787	5.9%	1.7% - 25.0%
SPINAL FUSION EXCEPT CERVICAL W CC	2.0%	134	$13,073,883	1.1%	(0.1%) - 4.1%
DISORDERS OF THE BILIARY TRACT W CC	6.0%	111	$12,793,391	3.1%	(0.1%) - 12.2%
SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	4.6%	78	$12,770,827	3.3%	(1.7%) - 11.0%
SPINAL FUSION EXCEPT CERVICAL W/O CC	3.2%	94	$12,416,305	3.1%	(2.9%) - 9.4%
OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	11.6%	81	$12,213,009	4.3%	3.2% - 20.0%
G.I. HEMORRHAGE W/O CC	19.0%	103	$12,082,604	7.4%	4.4% - 33.5%
LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	14.3%	66	$12,031,260	5.9%	2.8% - 25.8%
FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	14.2%	96	$11,930,965	4.8%	4.7% - 23.7%
WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	4.8%	45	$11,845,009	3.8%	(2.7%) - 12.2%
TRANSURETHRAL PROCEDURES W CC	10.3%	68	$11,806,484	6.5%	(2.5%) - 23.1%
DIGESTIVE MALIGNANCY W CC	4.5%	113	$11,728,733	1.5%	1.6% - 7.3%
OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.9%	133	$11,704,342	1.0%	(0.0%) - 3.7%
URINARY STONES W CC, &/OR ESW LITHOTRIPSY	10.1%	72	$11,601,108	5.9%	(1.4%) - 21.7%
ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	9.5%	133	$11,441,376	3.1%	3.4% - 15.6%
LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	5.2%	88	$11,421,232	3.8%	(2.2%) - 12.7%
TRANSURETHRAL PROSTATECTOMY W CC	8.1%	109	$11,064,244	4.0%	0.3% - 15.9%
TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	17.4%	54	$11,003,524	6.4%	5.0% - 29.9%
CRANIAL & PERIPHERAL NERVE DISORDERS W CC	7.4%	93	$10,975,155	2.4%	2.6% - 12.1%
COMPLICATIONS OF TREATMENT W CC	7.7%	85	$10,703,853	3.2%	1.5% - 14.0%
NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	20.6%	34	$10,627,643	13.0%	(4.9%) - 46.1%
CERVICAL SPINAL FUSION W CC	3.7%	49	$10,353,660	3.0%	(2.2%) - 9.7%

COMPLICATED PEPTIC ULCER	17.1%	36	$9,830,052	10.6%	(3.6%) - 37.8%
CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.0%	419	$9,825,878	0.4%	0.3% - 1.7%
LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	2.0%	189	$9,761,472	1.0%	0.1% - 3.9%
RESPIRATORY SIGNS & SYMPTOMS W CC	16.3%	67	$9,742,380	7.1%	2.4% - 30.3%
PULMONARY EMBOLISM	2.7%	177	$9,734,983	2.2%	(1.6%) - 7.0%
PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI	5.3%	69	$9,728,042	2.5%	0.4% - 10.1%
BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	5.3%	169	$9,523,459	2.5%	0.5% - 10.1%
FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	51.1%	32	$9,428,938	24.0%	4.0% - 98.1%
G.I. OBSTRUCTION W/O CC	17.4%	79	$9,385,126	13.6%	(9.3%) - 44.1%
BRONCHITIS & ASTHMA AGE >17 W CC	5.4%	164	$8,816,904	2.1%	1.3% - 9.5%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	1.4%	181	$8,756,880	0.7%	(0.0%) - 2.8%
NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	5.2%	41	$8,754,208	2.5%	0.2% - 10.1%
HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	7.0%	69	$8,565,875	6.3%	(5.4%) - 19.3%
CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	4.0%	167	$8,345,941	1.9%	0.3% - 7.6%
MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	0.7%	439	$8,341,630	0.6%	(0.6%) - 2.0%
TENDONITIS, MYOSITIS & BURSITIS	10.1%	61	$8,327,107	4.6%	1.1% - 19.1%
PERIPHERAL VASCULAR DISORDERS W/O CC	13.1%	84	$8,263,763	7.6%	(1.8%) - 28.1%
PLEURAL EFFUSION W CC	5.2%	68	$8,132,729	3.0%	(0.7%) - 11.0%
PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	5.7%	46	$8,110,020	3.5%	(1.2%) - 12.5%
CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	24.5%	33	$8,033,744	11.4%	2.1% - 46.8%
BRONCHITIS & ASTHMA AGE >17 W/O CC	13.4%	76	$8,004,531	5.3%	3.1% - 23.7%
OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	26.4%	34	$7,949,000	11.8%	3.3% - 49.4%
OTITIS MEDIA & URI AGE >17 W CC	18.2%	45	$7,702,267	6.6%	5.2% - 31.1%
KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.5%	84	$7,114,044	2.5%	(2.3%) - 7.3%

MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	12.5%	37	$6,764,453	12.1%	(11.3%) - 36.3%
ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	17.5%	46	$6,760,221	7.9%	1.9% - 33.0%
THYROID PROCEDURES	11.9%	40	$6,590,166	9.3%	(6.3%) - 30.2%
CIRCULATORY DISORDERS W AMI, EXPIRED	2.3%	95	$6,500,516	1.3%	(0.3%) - 4.9%
HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	0.5%	463	$6,434,637	0.3%	(0.1%) - 1.1%
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	7.5%	91	$6,228,564	4.7%	(1.7%) - 16.6%
OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5%	68	$6,118,419	1.1%	0.4% - 4.7%
MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	2.5%	92	$6,020,820	2.4%	(2.3%) - 7.3%
MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	4.2%	89	$5,950,021	3.5%	(2.7%) - 11.2%
TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	3.6%	71	$5,891,182	1.7%	0.2% - 7.0%
OTHER CARDIOTHORACIC PROCEDURES	2.4%	31	$5,849,455	2.4%	(2.2%) - 7.1%
CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.3%	30	$5,649,990	1.3%	(1.2%) - 3.8%
OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	10.3%	37	$5,566,712	5.2%	0.2% - 20.4%
MAJOR MALE PELVIC PROCEDURES W/O CC	10.9%	41	$5,479,115	7.7%	(4.2%) - 26.0%
HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	12.7%	42	$5,467,709	5.4%	2.2% - 23.2%
EXTRACRANIAL PROCEDURES W/O CC	2.8%	133	$5,384,620	2.0%	(1.2%) - 6.8%
CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	0.6%	63	$5,258,562	0.6%	(0.5%) - 1.6%
HIV W MAJOR RELATED CONDITION	4.5%	32	$5,237,801	2.9%	(1.2%) - 10.1%
MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	3.3%	93	$5,178,625	1.9%	(0.5%) - 7.1%
TRANSURETHRAL PROSTATECTOMY W/O CC	10.5%	76	$4,988,561	4.1%	2.4% - 18.6%
ENDOCRINE DISORDERS W CC	3.5%	80	$4,911,629	1.7%	0.1% - 6.9%
INFLAMMATORY BOWEL DISEASE	5.9%	52	$4,853,555	3.4%	(0.7%) - 12.6%
PNEUMOTHORAX W CC	7.1%	49	$4,775,479	5.5%	(3.7%) - 17.8%
CORONARY BYPASS W CARDIAC CATH	1.5%	45	$4,679,453	1.4%	(1.4%) - 4.3%
INTERSTITIAL LUNG DISEASE W CC	3.9%	51	$4,649,748	2.8%	(1.7%) - 9.4%
CELLULITIS AGE >17 W/O CC	6.1%	107	$4,613,352	2.7%	0.8% - 11.4%

BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.2%	63	$4,384,918	1.2%	(1.1%) - 3.5%
VIRAL ILLNESS AGE >17	9.9%	40	$4,303,033	6.7%	(3.2%) - 23.0%
CRANIOTOMY AGE >17 W CC	0.7%	96	$4,234,114	0.5%	(0.3%) - 1.8%
FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	6.0%	88	$4,199,972	3.0%	0.1% - 11.9%
OTHER VASCULAR PROCEDURES W/O CC	2.2%	91	$4,097,365	1.2%	(0.2%) - 4.6%
NONTRAUMATIC STUPOR & COMA	6.3%	47	$3,809,360	2.2%	2.0% - 10.5%
ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	11.3%	43	$3,701,261	7.1%	(2.5%) - 25.2%
RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	3.4%	71	$3,521,331	1.5%	0.5% - 6.3%
EPISTAXIS	11.3%	30	$3,338,799	7.9%	(4.2%) - 26.7%
ANAL & STOMAL PROCEDURES W CC	4.8%	34	$3,077,588	2.6%	(0.3%) - 10.0%
RECTAL RESECTION W CC	2.7%	34	$3,059,525	2.6%	(2.5%) - 7.8%
AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	5.1%	53	$3,005,826	2.0%	1.2% - 9.0%
CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	0.3%	108	$2,915,583	0.3%	(0.2%) - 0.8%
TOTAL MASTECTOMY FOR MALIGNANCY W CC	3.6%	55	$2,512,509	3.6%	(3.4%) - 10.6%
CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	0.4%	85	$2,488,668	0.3%	(0.2%) - 1.0%
UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.6%	32	$2,412,234	1.8%	(0.9%) - 6.2%
OTHER VASCULAR PROCEDURES W CC	0.6%	80	$2,044,135	0.5%	(0.4%) - 1.6%
CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.1%	54	$2,029,470	0.8%	(0.5%) - 2.6%
NERVOUS SYSTEM NEOPLASMS W CC	1.4%	78	$1,880,019	0.8%	(0.1%) - 2.9%
CERVICAL SPINAL FUSION W/O CC	1.2%	67	$1,671,974	0.9%	(0.5%) - 2.9%
PERITONEAL ADHESIOLYSIS W CC	0.5%	73	$1,645,651	0.3%	(0.1%) - 1.1%
POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	9.6%	31	$1,625,711	5.2%	(0.7%) - 19.9%
MAJOR MALE PELVIC PROCEDURES W CC	1.8%	45	$1,545,673	1.1%	(0.4%) - 4.0%
MAJOR CHEST PROCEDURES	0.2%	162	$1,475,019	0.1%	(0.1%) - 0.4%
HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	0.9%	91	$1,455,236	0.9%	(0.8%) - 2.6%
PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	0.3%	80	$1,207,110	0.2%	(0.0%) - 0.7%
TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	4.1%	41	$1,132,875	3.6%	(2.9%) - 11.1%
POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.5%	134	$870,628	0.3%	(0.1%) - 1.0%

PANCREAS, LIVER & SHUNT PROCEDURES W CC	0.4%	34	$785,714	0.4%	(0.4%) - 1.1%
AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	0.1%	113	$782,121	0.1%	(0.1%) - 0.4%
FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.1%	57	$764,211	0.4%	0.3% - 1.9%
CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	0.1%	95	$564,615	0.1%	(0.1%) - 0.3%
KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	0.2%	43	$437,813	0.1%	(0.1%) - 0.5%
AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	0.3%	36	$331,680	0.1%	(0.0%) - 0.5%
VAGINA, CERVIX & VULVA PROCEDURES	0.4%	54	$289,759	0.3%	(0.2%) - 1.1%
PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	0.1%	74	$186,967	0.1%	(0.0%) - 0.2%
TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.3%	31	$71,600	0.2%	(0.1%) - 0.7%
CORONARY BYPASS W/O CARDIAC CATH	0.0%	38	$0	0.0%	0.0% - 0.0%
TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK DIAG W/O MAJ O.R.	0.0%	51	$0	0.0%	0.0% - 0.0%
TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK DIAG W MAJ O.R.	0.0%	76	$0	0.0%	0.0% - 0.0%
CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	0.0%	71	$0	0.0%	0.0% - 0.0%
REVISION OF HIP OR KNEE REPLACEMENT	0.0%	129	$0	0.0%	0.0% - 0.0%
O.R. PROCEDURES FOR OBESITY	0.0%	36	$0	0.0%	0.0% - 0.0%
UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	0.0%	30	$0	0.0%	0.0% - 0.0%
KIDNEY TRANSPLANT	0.0%	32	$0	0.0%	0.0% - 0.0%
All HPMP	**5.0%**	**N/A**	**$5,070,118,961**	**0.2%**	**4.7% - 5.3%**

CONTACT INFORMATION

Program Integrity Mission

To preserve and protect the integrity of the CMS programs by proactively developing strategies to identify, deter, and prevent fraud, waste, and abuse through effective partnerships with public and private entities.

Division of Analysis and Evaluation Mission

To guide Program Integrity by providing information to decision-makers through data analyses, improper payment and error rate measurements of CMS programs, and the promotion of efficient practices in a manner commensurate with the Group's goals.

CMS Contacts

See www.cms.hhs.gov/cert to obtain additional copies of this report.

CMS CERT Contacts: Jill Nicolaisen (CERT@cms.hhs.gov)
CMS HPMP Contact: Anita Bhatia (anita.bhatia@cms.hhs.gov)
CMS Public Affairs Contact: Jeff Nelligan (jeff.nelligan@cms.hhs.gov)