U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Improper Medicare Fee-for-Service Payments Report

Fiscal Year 2004

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PROGRAM INTEGRITY MISSION

The primary objective of program integrity activities at the Centers for Medicare & Medicaid Services (CMS) is to insure that the Medicare Fee-for-Service program pays claims correctly. To meet this goal, Medicare contractors must pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.

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To obtain additional copies of this report, see www.cms.hhs.gov/cert

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EXECUTIVE SUMMARY

Background

CMS has established two programs to monitor the accuracy of 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 contractor and HPMP with each component representing about 50% of the error rate. 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).

The Improper Medicare FFS Payments Report for FY 2004 is the second produced by CMS. The first was produced in FY 2003.

Strong outcome-oriented performance measures are a good way to assess the degree to which a government program is accomplishing its mission and to identify improvement opportunities. The *Improper Medicare Fee-for-Service Payments Report* for FY 2004, describes the performance measurement process for the Medicare FFS Program.

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates from FY 1996 to FY 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 paid). To better measure the performance of the Carriers/DMERCs/FIs and to gain insight regarding the causes of errors, CMS decided to calculate a number of additional rates. The additional rates include a provider compliance error rate (which measures how well providers prepared claims for submission) and contractor-specific paid claims error rates (which measure how accurately each specific Carrier/DMERC/FI/QIO made claims payment decisions).

CMS calculated the Medicare FFS error rate and improper payment estimate using a methodology the OIG approved. This methodology includes:

- Randomly selecting a sample of approximately 160,803 claims submitted in calendar year 2003[1]
- Requesting medical records from providers that submitted the claims in the sample
- Reviewing the claims and medical records to see if the claims complied with Medicare coverage, coding, and billing rules
- Assigning errors to claims paid or denied incorrectly[2]
- Classifying relevant providers as non-responders

[1] QIO data was based on discharges that occurred between 7/01/02 and 6/30/03.
[2] QIO data is based only on paid claims, not denied claims.

- Treating non-response claims as errors
- Having the Carriers/DMERCs/FIs send providers overpayment letters for claims that Carriers/DMERCs/FIs overpaid

Impact of Improper Payment Information Act (IPIA)

In order 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. The IPIA mandates that agencies use gross figures when reporting improper payment amounts and rates. In the past, the OIG and CMS reported Medicare FFS error rates and improper payment estimates using net figures. A gross improper payment amount is calculated by **adding** underpayments to overpayments. A net improper payment amount is calculated by **subtracting** underpayments from overpayments. In order to comply with the IPIA and facilitate comparison to prior year estimates, the *Improper Medicare FFS Payments Report* for FY 2004 states both the gross and net figures from FY 1996 to FY 2004. However, CMS expects to report primarily gross figures in the FY 2005 and future reports.

Summary of Findings

This report shows that 10.1% (9.3% net) of the dollars paid in gross did not comply with Medicare rules. The FY 2004 national paid claims error rate equates to $21.7 B gross ($19.9 B net) in improper payments.

The following chart depicts the gross and net error rates and improper payment amounts for the Medicare FFS program for FY 2004.

			Gross (Overpayments + Underpayments)		Net (Overpayments – Underpayments)	
	Overpayments	Underpayments	Improper Payments	Error Rate	Improper Payments	Error Rate
Carrier *	$6.7 B	$0.2 B	$6.9 B	11.4%	$6.5 B	10.7%
DMERC *	$1.0 B	$0.0 B[3]	$1.0 B	11.1%	$1.0 B	11.1%
FI *	$9.5 B	$0.2 B	$9.7 B	16.4%	$9.3 B	15.8%
QIOs *	$3.6 B	$0.5 B	$4.1 B	4.8%	$3.1 B	3.6%
All Medicare FFS *	$20.8 B	$0.9 B	$21.7 B	10.1%	$19.9 B	9.3%

* This data has been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

This report describes the error rates using multiple categories and formats in order to provide the most specific information available to target problem areas, including error rates by error types, contractor types, specific contractors, service types, and provider types.

Error Rates by Error Type. Although providers' failure to respond to requests for medical records was a significant problem in last year's report (over half of the unadjusted FY 2003 error

[3] Although there was one DMERC claim that was underpaid (worth $56.00), when projected to the universe this dollar figure dropped to $0.

rate was due to provider non-response), this number dropped to 29.7% in FY 2004. Instead, the most significant type of error in FY 2004 was insufficient documentation of services. Insufficient documentation of services accounted for 43.7% ($8.7 B) of the net errors.

Error Rates by Contractor Type. The contractor type with the highest gross error rate for highest improper payment amount is FIs (16.4% gross), which equates to $9.7 B gross improper payment.

Contractor-Specific Error Rates. The specific contractor with the highest gross error rate and highest gross improper payment amount is Mutual of Omaha, (26.8%) which equates to $3.2 B gross improper payments.

Error Rates by Service Type. The service type with the highest gross error rate is Spinal Orthoses (58.5%), which equates to $63.7 million net improper payments. Skilled Nursing Facility (SNF) is the service type with the highest net improper payments ($5.6 B), which equates to a net error rate of 25.5%.

Error Rates by Provider Type. The provider type with the highest net error rate is Orthotists (44.0%), which equates to $152.3 million net improper payments. The provider type with the highest net improper payments is SNF ($5.6 B), which equates to a net error rate of 25.5%.

NOTE: When comparing contractors, services, or provider types, the greater of both error rate and improper payments must be considered. For instance, while the error rate is higher for chiropractic services than for E&M services, there are more dollars associated with claims submitted for E&M than chiropractic services. Therefore, the cost of correcting each problem relative to the potential reduction for improper payments must be considered when deciding which problem to target first.

Corrective Actions

One of CMS' performance goals for FY 2004 was to reduce the percentage of improper payments made under the FFS program to 4.8% (net) or less. This equates to 5.6% gross. The net paid claims error rate for FY 2004 was 9.3% (net) and 10.1% (gross).

CMS is working with the Carriers/DMERCs/FIs/QIOs to implement aggressive efforts to lower the paid claims error rate by:

1) Developing a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data;

2) Increasing and refining one-on-one educational contacts with providers found to be billing in error; and

3) Developing projects with the QIOs addressing state-specific admissions necessity and coding concerns, as well as conducting surveillance and monitoring of inpatient payment error trends by error type.

CMS has also directed Carriers/DMERCs/FIs to develop local efforts to lower the error rate by developing plans that address the cause of the errors, the steps they are taking to fix the problems, and other recommendations that will ultimately lower the error rate.

New for FY 2005, CMS has initiated several processes to decrease the insufficient documentation problem. CMS recently extended the time providers have to respond to documentation requests from 55 days to 90 days. CMS anticipates that, by allowing providers to have extra time to prepare their medical record submissions, an increased numbers of providers will submit documentation and those submissions will be more complete. The extension of time to submit records will help solve two problems that lead to insufficient documentation:

1) If the billing provider is not the provider who maintains the medical record and the billing provider must contact a third party to locate the record, the new timeline will allow more time for the third party to submit the record; and

2) If the provider has multiple offices and records are not accessible from all offices and if the request goes to an office that does not have access to the requested records, then the time extension will provide extra time for the provider to forward the request to the correct office.

Additionally, CMS now requires the CERT contractor to give every provider a "second chance" to submit sufficient documentation. Therefore, when a component of a medical record is missing, the CERT contractor will contact the provider, indicate the information that is missing, and give the provider 15 days to respond. In the past, the CERT contractor did not give all providers a second opportunity to supplement the initial documentation.

CMS will encourage FIs to remind facilities, especially SNFs, of the importance of meeting all Medicare documentation requirements (e.g. signing plans of care).

To reduce the improper payments due to medically unnecessary services, CMS will encourage Carriers/DMERCs/FIs to target for education and claims review those medically unnecessary services that are contributing to the high national paid claims error rate (i.e., those services listed on tables 7C1, 7C2, and 7C3). QIOs who indentify hospitals with a billing problem will initiate aggressive educational campaigns.

To reduce the improper payments among specific contractors with high error rates and high improper payment amounts, CMS will perform a small area variation analysis. This analysis will produce maps of the United States, which display error rates and improper payment amounts geographically. When available, CMS will post all data to www.cms.hhs.gov/cert. This information will assist Carriers/DMERCs/FIs in targeting their review and educational efforts.

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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) 2003, more than 41 million beneficiaries were enrolled in the Medicare program, and the total Medicare expenditure (both Medicare Fee-for-Service (FFS) and managed care payments) was estimated at about $257 B[4].

CMS uses several types of contractors to ensure the accurate coding and coverage of 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 claims 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 the Medicare rules and implement the most effective methods for accurately answering coverage and coding questions. 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 in order to help Carriers/DMERCs/FIs/QIOs to better focus review and education efforts.

History of Error Rate Production

Prior to FY 2003, the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) estimated the Medicare FFS error rate. The OIG produced Medicare FFS error rates from FY 1996 - FY 2002. The OIG's sampling method was designed to estimate only 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 type of service, type of provider, type of contractor, or contractor-specific error rates. Following recommendations from the OIG, CMS refined the OIG methodology and

[4] *2003 CMS Statistics: U.S. Department of Health and Human Services*, CMS pub. no. 03445, June 2003

increased the sample size under the CERT program, and began producing the Medicare FFS error rate for FY 2003. The sample size for the FY 2004 Medicare FFS error rates was 160,803 claims.

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 and a services processed error rate. Descriptions of all three types of error rates are listed below.

Paid Claims Error Rate

This rate is based on dollars paid after the Carrier/DMERC/FI/QIO made its payment decision on the claim/admission. For the FY 1996 – FY 2002 reports, these rates included only paid claims and excluded all denied claims. For the *Medicare Fee-for-Service Payments Report FY 2004,* these rates included paid and denied claims for Carriers/DMERCs/FIs and paid claims only for QIOs[5]. The paid claims error rate is the percentage of dollars that Carriers/DMERCs/FIs/QIOs erroneously paid and is a good indicator of how claim errors in the Medicare FFS program affect the trust fund. CMS included both a gross paid claims error rate and a net paid claims error rate in this report. CMS calculated the net rate by subtracting underpayments from overpayments and the gross rate by adding underpayments to overpayments. This error rate is quantified in dollars.

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 included both a gross provider compliance error rate and a net provider compliance error rate in this report. CMS calculated the net rate by subtracting underpayments from overpayments and the gross rate by adding underpayments to overpayments. This error rate is quantified in dollars.

Services Processed Error Rate

This rate is based on services processed and measures whether the Carrier/DMERC made appropriate payment decisions on claims. This is a gross rate where the number of services overpaid is added to the number of services underpaid. The services processed error rate is a good indicator of how well the Carrier/DMERC is doing overall at finding and preventing claim errors. The number of services quantifies this error rate.

CMS calculated error rates in this report by reviewing claims that providers submitted during the time period shown in Table 1.

[5] CMS plans to include denied claims in the QIO sample for the FY 2005 report.

Table 1: Reporting Periods

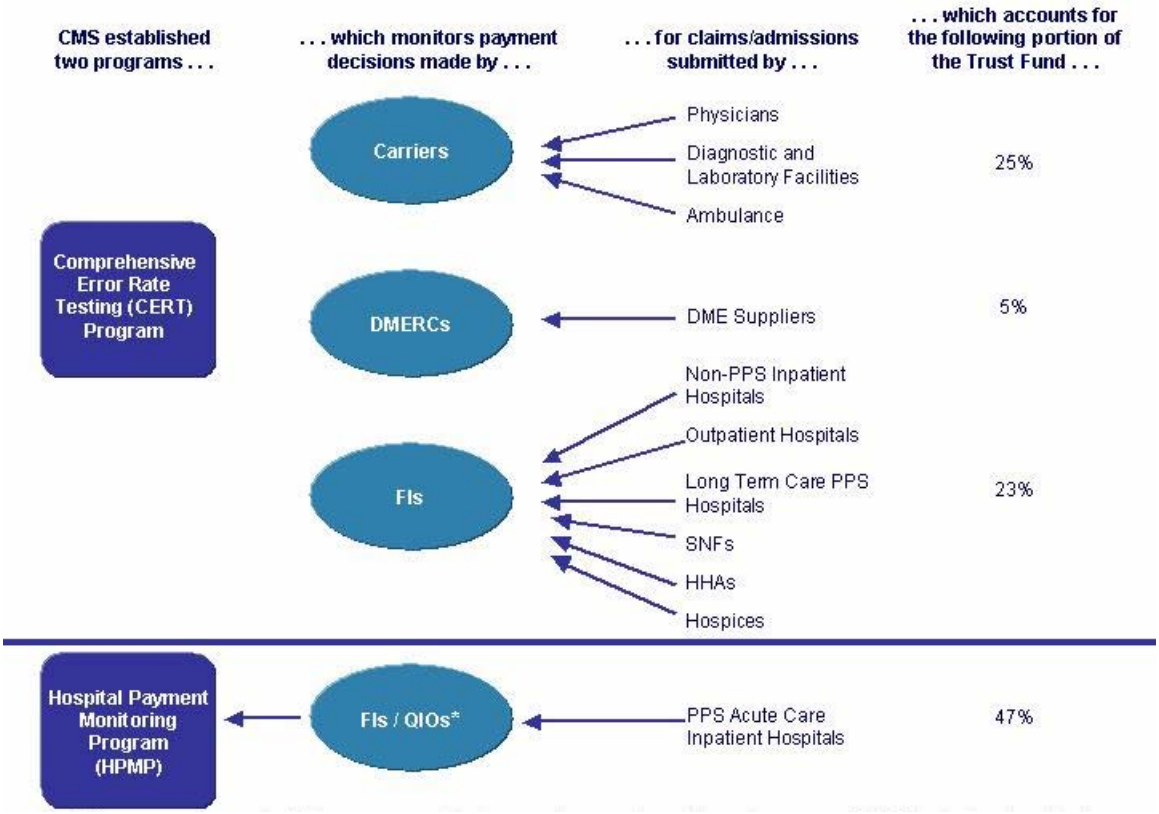
Carriers:	Claims submitted between January 1, 2003 – December 31, 2003
DMERCs:	Claims submitted between January 1, 2003 – December 31, 2003
FIs:	Claims submitted between January 1, 2003 – December 31, 2003
QIOs:	Discharges that occurred between July 1, 2003 – June 30, 2003

Although the reporting periods varied between the Carriers/DMERCs/FIs and QIOs, the error rates can be compared and combined for statistical purposes. CMS is currently working toward making the reporting periods for all four contractor types the same.

Two Measurement Programs: CERT and HPMP

CMS has established two programs to monitor the accuracy of Medicare FFS: The **Comprehensive Error Rate Testing (CERT)** program and the **Hospital Payment Monitoring Program (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) inpatient hospital admissions only. The CERT program monitors all other claims. Each program comprises approximately 50% of the Medicare FFS payments. Figure 1 depicts the types of claims/admissions involved in each monitoring program.

Figure 1: CMS' Process for Monitoring the Accuracy of Medicare FFS Payments



* FIs process payments; QIOs are responsible for ensuring accurate coding and coverage of PPS Acute Care Inpatient Hospitals and Long Term Care PPS Hospitals.

Both the CERT program and HPMP produce a paid claims error rate and the CERT program produces a number of additional rates. Table 2 summarizes the data presented in this report.

Table 2: Error Rates Available in this Report

Monitoring Program	Type of Error Rate(s) Produced	Paid Claims Error Rate	Provider Compliance Error Rate	Services Processed Error Rate	Refer to Page
CERT + HPMP	Medicare	✓	Not Produced	Not Produced	12
CERT	Carrier-Specific	✓	✓	✓	28
	DMERC-Specific	✓	✓	✓	30
	FI-Specific	✓	Available in 2005	Available in 2005	32
	Type of Service	✓	Not Produced	Not Produced	37
	Type of Provider	✓	✓	✓	44
HPMP	QIO-Specific	✓	Not Produced	Not Produced	31
	Type of Service	✓	Not Produced	Not Produced	N/A
	Type of Provider	✓	Not Produced	Not Produced	N/A

The national Medicare FFS paid claims error rate and the Carrier-specific, DMERC-specific, and FI-specific error rates will be updated on a quarterly basis, beginning January 2005; each update will incorporate the review results on claims from providers that submitted late documentation to the CERT contractor (i.e., after June 11, 2004) and the results of provider appeals submitted to Carriers/DMERCs/FIs. Although CMS will not amend this written report, the most up-to-date rates will be available at www.cms.hhs.gov/cert. Table 3 summarizes the update schedule.

Table 3: Update Schedule for National Medicare FFS Paid Claims Error Rate and Carrier/DMERC/FI Error Rates

Date Quarterly Update will be Posted	Including Late Documentation Received from Providers Through the Following Dates	Including Feedback and Appeals Information Received from Carriers/DMERCs/FIs Received Through the Following Dates
January 1, 2005	September 23, 2004	December 6, 2004
April 1, 2005	January 23, 2005	March 6, 2005
July 1, 2005	April 23, 2005	June 6, 2005
October 1, 2005	July 23, 2005	September 6, 2005

Sampling

For this report, the CERT contractor randomly sampled 122,355 claims from Carrier groups, DMERCs, and FI groups[6]. The CERT contractor randomly selected about 167 claims each month from each Carrier/DMERC/FI. This process was designed to pull a blind, electronic sample of claims each day from all of the claims submitted that day.

For the Improper Medicare FFS Payments Report for FY 2004, the CERT program randomly sampled 122,355 claims from Carriers/DMERCs/FIs.

If a Carrier/DMERC/FI performed complex medical review on a sampled claim (i.e., requested and received a medical record from the provider that submitted the claim), the CERT contractor requested the medical record associated with the claim from the Carrier/DMERC/FI. Otherwise, the CERT contractor requested the medical record from the provider. The CERT contractor sent the initial request for medical records via letter. If the provider failed to respond to the initial request after 19 days, the CERT contractor sent three subsequent letters and made up to three phone calls to the provider.

In cases where the CERT contractor received no documentation from the provider once 55-days[7] had passed since the initial request, the CERT contractor considered the case to be a non-response claim and counted it as an error. The CERT contractor considered any documentation received after the 55th day "late documentation." If the CERT contractor received late documentation prior to the documentation cut-off date for this report (June 11, 2004), 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 counted the case as an error. The quarterly update reports will reflect the results of reviewing those cases.

Review of Claims

Upon receipt of medical records, the CERT contractor's clinicians conducted a review of the claims and submitted documentation. They followed Medicare regulations, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective Carrier/DMERC/FI's Local Coverage Determinations (LCDs) and articles.

Appeal of Claims

In FY 2003, if a provider elected to appeal a CERT initiated denial (using the normal appeals process) and the CERT determination was overturned by the appeal entity, the CERT contractor did not remove the error from the error rate. However, in FY 2004, the CERT contractor implemented an appeals tracking system and began to back out all overturned CERT initiated denials from the error rate. Unfortunately, some contractors

[6] Throughout the reminder of this document, CMS will refer to Carrier groups and FI groups as Carriers and FIs. The contractors in each group are identified in Appendix B.

[7] For several hundred claims in this report, the CERT contractor failed to send four letters following the normal 55-day schedule. CMS does not anticipate this problem will occur in the future.

were unable to enter the appeals information into the new tracking system before the cut-off date for the report. Therefore, only some CERT determination reversals were backed out of the error rate. The four quarterly update reports will reflect changes to the error rate as contractors enter appeals information into the tracking system. In the future, CMS anticipates that all overturned appeals will be entered into the appeals tracking system in sufficient time for production of the error rates.

Hospital Payment Monitoring Program (HPMP)

Sampling

Each month, CMS contractors selected data from a clinical data warehouse that mirrored the National Claims History (NCH) database maintained by CMS, and provided the data to the Clinical Data Abstraction Centers (CDACs). The database contained an extract of all records CMS had paid. No denied claims were in the HPMP sample for FY 2004[8].

For the Improper Medicare FFS Payments Report for FY 2004, the HPMP randomly sampled 38,448 discharges from PPS inpatient hospitals.

The sample was drawn from 52 states and jurisdictions (the Virgin Islands were excluded). For this report, the HPMP randomly sampled 38,448 discharges. The final action was that paid claims were selected four months after the month of discharge using a sequential sampling methodology.

Review of Claims

The CDACs performed record abstraction and initial screening review and completed screening review using existing information. The CDACs did not follow-up with providers; the follow-up was done by the QIOs.

The CDACs extracted specific data elements from each medical record received. Next, the CDACs screened the records for admission necessity and DRG coding. Additionally, the CDACs reviewed Maryland records for length of stay (Maryland is the only waivered non-PPS state).

Screening involved a detailed examination of each individual's medical record for a specific hospitalization, treatment, etc. The primary types of screening pertinent to payment error include medical necessity review (hospital admissions) and DRG validation. The CDAC nurse reviewers used specific modules of the InterQual criteria to screen for admission necessity. Qualified coding specialists performed DRG coding validation screening. The CDAC referred records that failed screening and records the CDAC did not receive in a timely manner to the responsible QIO for case review.

The HPMP relied on the QIOs to review medical records to determine if claims were paid in error.

[8] CMS plans to include denied claims in the QIO sample for the FY 2005 report.

Weighting and Determining the Final Results

The CERT contractor weighted the error rates such that each Carrier/DMERC/FI/QIO contribution to the error rate was in proportion to its size (as measured by percent of claims or discharges for which they were responsible). In addition to the error rate, the *Improper Medicare Fee-for-Service Payments Report* for FY 2004 report provides the confidence interval as an expression of how certain CMS is that the error rate estimate is correct.

The improper payments listed on pages 12 through 15 were calculated by removing the co-insurance and deductible amounts paid by the beneficiary. CMS adopted this practice in order to be consistent with the methodology used by the OIG from FY 1996 – FY 2002. Most improper payments listed were calculated without adjusting for coinsurance, deductibles, and reductions to recover previous overpayments. CMS did not adjust these charts because payment amounts at the provider type and service type levels were not available. This means that the improper payment amounts listed in some charts appear larger than they otherwise would. However, error rates are unaffected. CMS is considering changing this practice next year to report all improper payments after adjusting for coinsurance deductibles and reductions to recover previous overpayments, thereby making all data consistent with the OIG methodology.

Outcome of Sampled Claims

When the CERT contractor detected an overpayment, they notified the Carrier/DMERC/FI that made the overpayment. If a provider did not submit requested documentation, the CERT contractor considered any payments that the Carrier/DMERC/FI made for the claim as overpayments.

Providers can appeal denials following normal appeal processes including non-response denials (by submitting documentation supporting their claims). For the *Improper Medicare Fee-for-Service Payments Report* for FY 2003, the CERT contractor did not consider the outcome of appeal determinations. However, beginning with the claims in the *Improper Medicare Fee-for-Service Payments Report* for FY 2004, the CERT contractor considered the outcome of any appeal determinations that reversed the CERT contractor's decision when computing the error rates. For FY 2004, the CERT contractor backed out $1.4 B from the error rate in appeals reversals.

When the CERT contractor detected an underpayment (i.e., the provider billed a lower code than what was documented in the medical records and needed by the beneficiary, or the Carrier/DMERC/FI made an incorrect full or partial denial), they notified the Carrier/DMERC/FI. CMS will instruct the Carriers/DMERCs/FIs to make payments to providers in underpayment cases identified for the FY 2006 and later reports. For more

information about underpayments, see Appendix H. When the QIO detected an overpayment, they sent a notification (called "adjustments") to the FI who collected the overpayment from the provider. When the QIO detected an underpayment, they sent adjustments to the FIs who made payments to providers in underpayment cases.

GPRA Goals

Under the Government Performance and Results Act (GPRA), CMS aims to accomplish three error rate goals by 2008.

CMS aims to reduce the National Medicare FFS paid claims error rate to 4.7% gross by 2008.

1. Reduce the National Medicare FFS Paid Claims Error Rate

   - By 2004, reduce the percentage of improper payments under the Medicare FFS program to 5.6% gross (4.8% net).

     STATUS: <u>This goal was not met.</u> CMS was unable to achieve its 5.6% gross (4.8% net) goal. See the Reasons Section in the back of the report.

   - By 2005, reduce the percent of improper payments under Medicare FFS to 7.9% gross.

   - By 2006, reduce the percent of improper payments under Medicare FFS to 6.9% gross.

   - By 2007, reduce the percent of improper payments under Medicare FFS to 5.4% gross.

   - By 2008, reduce the percent of improper payments under Medicare FFS to 4.7% gross.

2. Reduce the Contractor-Specific Paid Claims Error Rate

   - By 2004, set baseline.

     STATUS: <u>This goal was met.</u> CMS has set the baseline. For FY 2004, 9.7% of Medicare claims were processed by contractors with a gross paid claim error rate (including non-response) less than or equal to the national error rate for FY 2004 (10.1% gross). See Tables 7, 8, and 9.

   - By 2005, 25% of Medicare claims will be processed by contractors with an error rate less than or equal to the national error rate for FY 2004 (10.1%)gross.

   - By 2006, 50% of Medicare claims will be processed by contractors with an error rate less than or equal to the national error rate for FY 2005.

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

- By 2008, every Medicare claim will be processed by contractors with an error rate less than or equal to the national error rate for FY 2007.

3. Decrease the Provider Compliance Error Rate

   STATUS: <u>This goal was met.</u> CMS has set the baseline for Carriers and DMERCs as the Carrier-Specific and DMERC-Specific provider compliance error rates (including non-response claims) that are listed in Tables 7 and 8.

   - In 2005, CMS will set the baseline for FIs.

   - In 2005, decrease the Provider Compliance Error Rate 20% over the 2004 level.

   - In 2006, decrease the Provider Compliance Error Rate 20% over the 2005 level (25.2% gross for providers who submitted claims to carriers; 19.7% gross for providers who submitted claims to DMERCs).

   - In 2007, decrease the Provider Compliance Error Rate 20% over the 2006 level.

   - In 2008, decrease the Provider Compliance Error Rate 20% over the 2007 level.

How CMS and the Carriers/DMERCs/FIs Will Use the Rates

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, claims processing, and provider billing practices. The tracking and reporting of error rates help CMS identify emerging trends and implement immediate corrective actions to manage Carrier/DMERC/FI performance accurately.

The Carriers/DMERCs/FIs will use the error rate findings to adjust their Error Rate Reduction Plans. The error rates will provide guidance to Carriers/DMERCs/FIs in order to target their claim review, provider education efforts, and intensification of data analysis.

FINDINGS

National Medicare FFS Paid Claims Error Rate

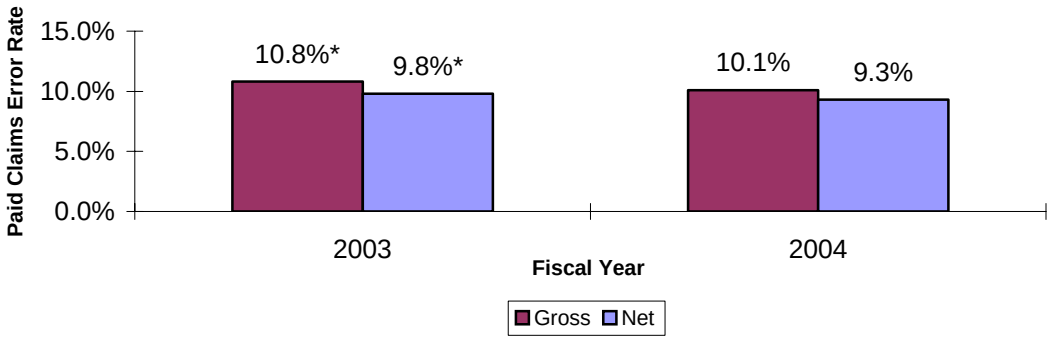
The national paid claims error rate in the Medicare FFS program for FY 2004 was 10.1% gross (9.3% net). This means that of the $213.5 B the Medicare FFS program paid during the timeframe studied, the program paid $21.7 B gross ($19.9 B net) incorrectly. The 95% confidence interval for the FY 2004 gross national paid claims error rate was 9.6% - 10.6% gross (8.8% - 9.8% net).

Table 4: Gross and Net Error Rates (FY 2003 – FY 2004)

Year	Total Payments Issued in Medicare FFS Program	Overpayments Made by Medicare FFS Program	Underpayments Made by Medicare FFS Program	Gross (Overpayments + Underpayments)		Net (Overpayments - Underpayments)	
				Improper Payment Amount	Error Rate	Improper Payment Amount	Error Rate
2003	$ 199.1 B	$ 20.5 B	$ 0.9 B	$ 21.5 B *	10.8%*	$19.6 B *	9.8%*
2004	$213.5 B	$20.8 B	$0.9 B	$21.7 B	10.1%	$19.9 B	9.3%

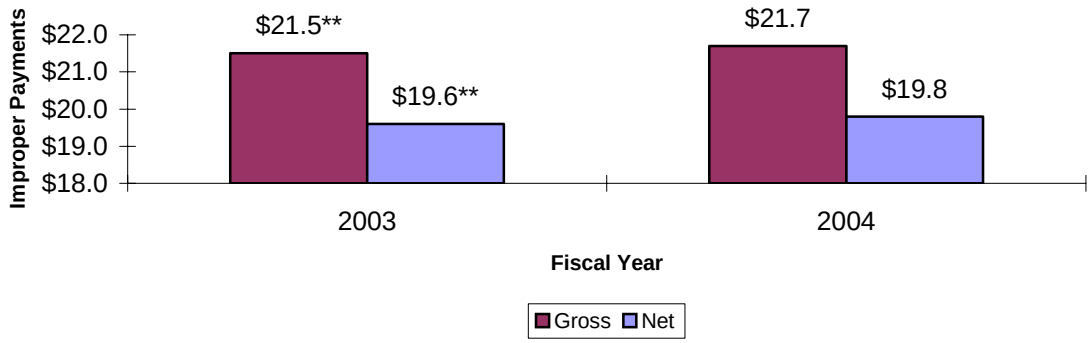
* These figures have not been adjusted to account for the high provider non-response experienced in 2003.

Figure 2a: Gross and Net National Medicare FFS Error Rates (FY 2003 – FY 2004)



* These figures have not been adjusted to account for the high provider non-response experienced in FY 2003. Had the adjustment been made, the national paid claims would have been 6.4% (gross) and 5.8% (net).

Figure 2b: Gross and Net Projected Improper Payments (FY 2003 – FY 2004)



* All data has been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.
** These figures have not been adjusted to account for the high provider non-response experienced in 2003. Had the adjustment been made, the improper payments would have been $12.7 B (gross) and $11.6 B (net).

Overpayments and Underpayments

When the OIG developed the methodology for measuring improper payments in the Medicare program in 1996, they **subtracted** underpayments from overpayments. The result is called a "net" improper payment. CMS reported net improper payments in the *Improper Medicare Fee-for-Service Payments Report* for FY 2003.

The Improper Payment Information Act (IPIA) requires federal agencies to calculate their annual improper payment estimates as a "gross" number (where underpayments are **added** to overpayments). To comply with the IPIA and facilitate comparison with prior years, CMS has included both net and gross numbers in the *Improper Medicare Fee-for-Service Payments Report* for FY 2004.

Table 5 summarizes the overpayments, underpayments, improper payments, and error rates by year and by contractor type.

Table 5a: Overpayments and Underpayments in Medicare FFS, FY 1996 – FY 2004*

Year	Total Payments Issued in Medicare FFS Program	Overpayments Made by Medicare FFS Program	Underpayments Made by Medicare FFS Program	Gross (Overpayments + Underpayments)		Net (Overpayments – Underpayments)	
				Improper Payments	Error Rate	Improper Payments	Error Rate
1996	$168.1 B	$23.5 B	$0.3 B	$23.8 B	14.2%	$23.2 B	13.8%
1997	$177.9 B	$20.6 B	$0.3 B	$20.9 B	11.8%	$20.3 B	11.4%
1998	$177.0 B	$13.8 B	$1.2 B	$14.9 B	8.4%	$12.6 B	7.1%
1999	$168.9 B	$14.0 B	$0.5 B	$14.5 B	8.6%	$13.5 B	8.0%
2000	$174.6 B	$14.1 B	$2.3 B	$16.4 B	9.4%	$11.9 B	6.8%
2001	$191.3 B	$14.4 B	$2.4 B	$16.8 B	8.8%	$12.1 B	6.3%
2002	$212.8 B	$15.2 B	$1.9 B	$17.1 B	8.0%	$13.3 B	6.3%
2003[9]	$ 199.1 B	$ 20.5 B	$ 0.9 B	$ 12.7 B**	6.4%**	$ 11.6 B**	5.8%**
2004	$213.5 B	$20.8 B	$0.9 B	$21.7 B	10.1%	$19.9 B	9.3%

* This data has been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

** These figures have been adjusted to account for the high provider non-response experienced in 2003. Had the adjustment not been made, the national paid claims would have been 9.8% (net) and 10.8% (gross) and the improper payments would have been $21.5 B (gross) and $19.6B (net).

[9] The 2003 data was based on unadjusted figures.

Table 5b: Underpayments and Overpayments by Contractor Type, FY 2004*

Type of Contractor	Overpayments	Underpayments	Gross (Overpayments + Underpayments)		Net (Overpayments – Underpayments)	
			Improper Payments	Error Rate	Improper Payments	Error Rate
Carriers	$6.7 B	$0.2 B	$6.9 B	11.4%	$6.5 B	10.7%
DMERCs	$1.0 B	$0.0[10]	$1.0 B	11.1%	$1.0 B	11.1%
FIs	$9.5 B	$0.2 B	$9.7 B	16.4%	$9.3 B	15.8%
QIOs	$3.6 B	$0.5 B	$4.1 B	4.8%	$3.1 B	3.6%
All Medicare FFS	$20.8 B	$0.9 B	$21.7 B	10.1%	$19.9 B	9.3%

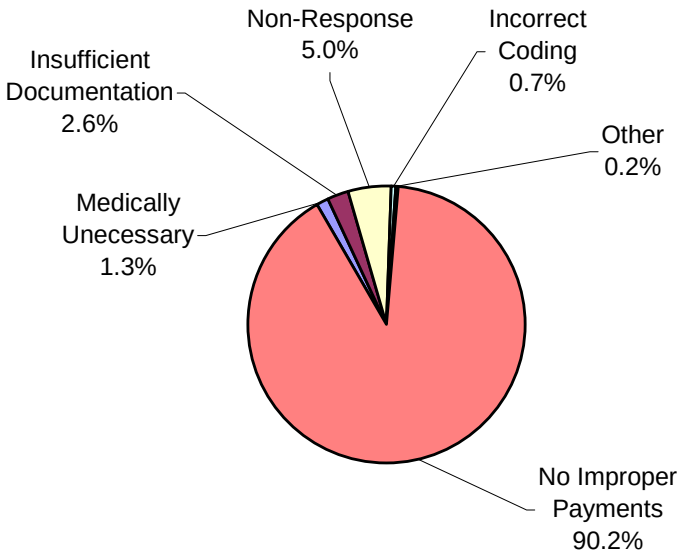
* This data has been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Paid Claims Error Rates by Error Type

Figures 3a and 3b summarize the percent of net paid claims errors by category for FY 2003 and FY 2004. Table 6 provides a summary of net paid claims error rates by error category from FY 1996 through FY 2004.

[10] Although there was one DMERC claim that was underpaid (worth $56.00), when projected to the universe this figure dropped to $0.0.

Figure 3a: FY 2003 Net Errors as a Percentage of Total Dollar Amount Sampled**



**These figures have not been adjusted to account for the high provider non-response experienced in FY 2003. Had the adjustment been made, 1.1% of the total dollars sampled would have been in error due to non-response.

Figure 3b: FY 2004 Net Errors as a Percentage of Total Dollar Amount Sampled

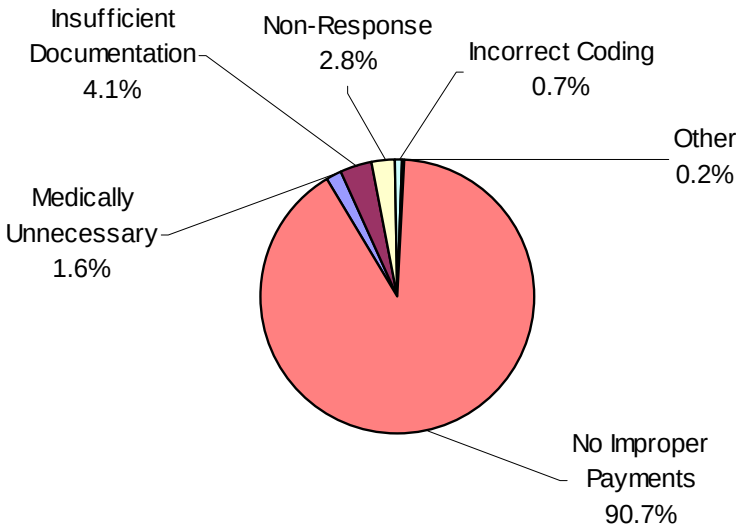


Table 6: Percentage of Net Errors by Category for Each Fiscal Year

Type of Error	1996	1997	1998	1999	2000	2001	2002	2003*	2004
Insufficient Documentation	32.8%	25.6%	11.2%	33.1%	19.2%	30.5%	20.1%	45.0%	43.7%
Non-Response	14.0%	18.7%	5.6%	7.3%	17.2%	12.4%	8.5%	18.5%	29.7%
Medically Unnecessary	36.8%	36.9%	55.6%	32.8%	43.0%	43.2%	57.1%	21.7%	17.2%
Incorrect Coding	8.5%	14.7%	18.0%	15.8%	14.7%	17.0%	14.3%	12.1%	7.7%
Other	7.9%	4.1%	9.6%	11.0%	5.9%	(3.1%)	0.0%	2.7%	1.6%
Total (%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* The FY 2003 data is based on adjusted figures.

Insufficient Documentation Errors

"Insufficient documentation" means that the provider did not include pertinent patient facts (i.e., the patient's overall condition, diagnosis, and extent of services performed) in the medical record documentation submitted.

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 7a lists the services with the highest insufficient documentation paid claims error rates for each contractor type in FY 2004. The table is sorted by paid claims error rate.

Table 7a1: Services with Insufficient Documentation Errors: Carriers

Service Billed to Carriers (HCPCS[11])	Insufficient Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Follow-up inpatient consult (99263)	36.3%	$20,246,608	24.8% - 47.7%
Follow-up inpatient consult (99262)	35.0%	$23,507,596	8.6% - 61.3%
Mechanical traction therapy (97012)	31.1%	$2,013,214	10.0% - 52.2%
X-ray exam, knee, 4 or more (73564)	30.2%	$7,113,661	5.4% - 55.0%
Massage therapy (97124)	25.5%	$5,909,624	8.0% - 43.0%
Electrical stimulation (97032)	24.7%	$8,005,924	12.0% - 37.4%
Hemodialysis, one evaluation (90935)	24.3%	$36,749,272	8.0% - 40.7%
Subsequent hospital care (99231)	24.3%	$170,923,298	18.9% - 29.6%
Radiation therapy dose plan (77300)	24.0%	$16,173,469	0.8% - 47.2%
Ct head/brain w/o&w dye (70470)	23.6%	$7,808,186	(7.7%) - 55.0%
Antigen therapy services (95165)	23.5%	$13,250,176	3.5% - 43.6%
Therapeutic activities (97530)	23.5%	$34,533,117	10.1% - 37.0%
Rest home visit, est pat (99332)	22.7%	$6,281,863	3.6% - 41.7%
Follow-up inpatient consult (99261)	22.0%	$3,571,213	3.4% - 40.7%
MD recertification HHA PT (G0179)	21.7%	$7,459,932	9.5% - 33.9%
Subsequent hospital care (99233)	21.2%	$234,803,355	14.8% - 27.6%
Critical care, first hour (99291)	20.9%	$134,657,112	8.6% - 33.1%
Rhythm ECG, tracing (93041)	20.7%	$530,124	18.7% - 22.8%
Vitamin b12 injection (J3420)	19.8%	$141,116	6.8% - 32.8%
Neuromuscular reeducation (97112)	18.8%	$13,835,636	9.3% - 28.3%
All Other Codes	4.4%	$3,343,199,409	3.9% - 4.8%
All Services Billed to Carriers	5.1%	$4,090,713,907	4.6% - 5.6%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

[11] CPT codes, descriptions and other data only are copyright 2004 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. CDT-4 codes and descriptions are © 2004 American Dental Association. All rights reserved.

Table 7a2: Services with Insufficient Documentation Errors: DMERCs

Service Billed to DMERCs (HCPCS)	Insufficient Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Mycophenolate mofetil oral (J7517)	10.6%	$11,580,179	(5.2%) - 26.4%
Drain ostomy pouch w/flange (A5063)	9.6%	$1,233,011	(0.9%) - 20.0%
Direct heat form shoe insert (A5509)	7.9%	$4,807,782	(1.7%) - 17.6%
Diab shoe for density insert (A5500)	6.0%	$3,161,085	(1.4%) - 13.3%
Ostomy sknbarr w flng <=4sq¾ (A4414)	5.3%	$824,304	(4.8%) - 15.3%
Disposable nebulizer sml vol (A7004)	4.6%	$77,383	(2.1%) - 11.4%
Blood glucose/reagent strips (A4253)	4.4%	$36,363,435	3.1% - 5.6%
Lens sphcyl bifocal 4.00d/.1 (V2203)	4.3%	$1,240,439	(0.8%) - 9.4%
Lens spher bifoc plano 4.00d (V2200)	3.7%	$298,193	(3.6%) - 10.9%
Blood glucose monitor home (E0607)	3.3%	$894,624	(0.8%) - 7.3%
Lancets per box (A4259)	3.2%	$2,754,945	1.8% - 4.6%
Powered pres-redu air mattrs (E0277)	3.2%	$7,752,206	(3.4%) - 9.8%
Enter feed supkit syr by day (B4034)	2.7%	$977,906	(2.6%) - 7.9%
Enteral feed supp pump per d (B4035)	2.6%	$5,505,171	(0.5%) - 5.7%
Ipratropium brom inh sol u d (J7644)	2.5%	$14,237,305	0.4% - 4.5%
Albuterol inh sol u d (J7619)	2.3%	$9,847,778	0.6% - 4.1%
Nebulizer with compression (E0570)	2.3%	$1,602,940	1.0% - 3.5%
Trapeze bar attached to bed (E0910)	2.1%	$91,752	(2.0%) - 6.1%
Enteral formulae category i (B4150)	2.0%	$4,073,454	0.0% - 4.0%
Commode chair stationry fxd (E0163)	2.0%	$1,081,246	(0.8%) - 4.8%
All Other Codes	1.0%	$71,769,730	0.6% - 1.3%
All Services Billed to DMERCs	1.7%	$180,174,869	1.6% - 1.9%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7a3: Services with Insufficient Documentation Errors: FIs

Service Billed to FIs (Type of Bill)	Insufficient Documentation Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
SNF-inpatient (including Part A) (21)	21.0%	$4,246,070,340	17.2% - 24.7%
SNF-inpatient or home health visits (Part B only) (22)	18.6%	$273,684,474	12.6% - 24.6%
Clinic-CORF (75)	11.1%	$19,358,361	1.0% - 21.2%
Hospital-swing beds (18)	9.4%	$56,603,247	0.7% - 18.1%
Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74)	8.8%	$62,826,830	3.5% - 14.1%
Special facility or ASC surgery-hospice (hospital based) (82)	6.5%	$40,815,983	0.1% - 12.9%
Clinic-hospital based or independent renal dialysis facility (72)	6.3%	$468,926,189	4.5% - 8.1%
Hospital-outpatient (HHA-A also) (13)	5.7%	$1,626,398,587	4.9% - 6.5%
HHA-outpatient (HHA-A also) (33)	4.0%	$153,232,068	2.0% - 6.0%
Special facility or ASC surgery-hospice (non-hospital based) (81)	3.8%	$176,070,198	2.4% - 5.3%
Hospital-inpatient (including Part A) (11)	3.7%	$209,872,266	(1.1%) - 8.5%
Hospital-other (Part B) (14)	3.6%	$88,039,869	2.9% - 4.4%
SNF-outpatient (HHA-A also) (23)	3.6%	$5,823,502	1.2% - 6.1%
HHA-inpatient or home health visits (Part B only) (32)	3.6%	$137,058,105	1.9% - 5.2%
Hospital-inpatient or home health visits (Part B only) (12)	3.6%	$13,615,967	0.2% - 6.9%
Special facility or ASC surgery-rural primary care hospital (85)	3.5%	$45,981,914	2.2% - 4.8%
Special facility or ASC surgery-ambulatory surgical center (83)	3.1%	$3,514,401	(0.1%) - 6.3%
Clinic-independent provider based FQHC (73)	2.5%	$7,633,133	1.0% - 4.0%
Clinic-rural health (71)	1.5%	$8,326,212	0.9% - 2.0%
All Services Billed to FIs	9.2%	$7,643,851,646	8.1% - 10.3%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

The following is an example of an insufficient documentation error:

An FI paid an outpatient hospital $96.00 for a clinic visit. The documentation did not include a doctor's order, a medical history, or notes to support the diagnosis listed on the claim form. As a result, the CERT contractor counted the entire payment as an error.

Non-Response Errors

"Non-Response" means that the provider did not submit any documentation to support the services provided.

Non-response errors fall into two categories:

- Those in which nothing was received from the provider in response to a CERT documentation request, and
- Those in which the provider responded to a CERT documentation request but did not provide a medical record to support payment of a claim, including:
  - The provider submitted a letter requesting payment for supplying the requested medical record,
  - The provider indicated that it is a Health Insurance Portability and Accountability Act (HIPAA) violation to supply the record,
  - The provider submitted a statement that the record was destroyed, or
  - The provider indicated in writing that they did not provide a service to the beneficiary on the date indicated on the claim.

Date of Service issues comprised 16% of the non-QIO non-response rate.

CMS attributed non-response to multiple factors, including provider lack of familiarity with the CERT contractor (as compared to the OIG), concerns about compliance with HIPAA, and cases where documentation did not exist. In some instances, all of the documentation may be located at a third party. If providers fail to contact the third party or the third party fails to submit the documentation, CMS counted the claim as a non-response error. Non-response errors were seen primarily for Carrier/DMERC/FI claims. There were few non-response errors among claims for which QIOs were responsible.

Table 7b lists the services with the highest non-response paid claims error rates for each contractor type for FY 2004. The table is sorted by paid claims error rate.

Table 7b1: Services with Non-Response Errors: Carriers

Service Billed to Carriers (HCPCS)	Non-Response Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Hot or cold packs therapy (97010)	65.2%	$496,702	2.3% -128.1%
Rhythm ECG, report (93042)	19.3%	$2,867,360	(8.3%) - 47.0%
Cytopath, c/v, thin layer (88142)	17.5%	$1,563,418	9.6% - 25.4%
Drainage of skin abscess (10060)	17.5%	$7,982,291	5.5% - 29.6%
Airway inhalation treatment (94640)	17.3%	$4,579,468	11.5% - 23.2%
Telephone analy, pacemaker (93736)	17.0%	$2,967,870	0.6% - 33.5%
Analyze pacemaker system (93731)	15.4%	$4,128,387	(3.4%) - 34.2%
Assay of lipoprotein (83718)	14.7%	$966,105	12.4% - 17.1%
Radiation therapy dose plan (77300)	13.2%	$8,913,664	(3.4%) - 29.9%
Home visit, est patient (99349)	12.9%	$5,369,374	7.1% - 18.8%
Nursing fac care, subseq (99313)	12.5%	$23,386,950	2.2% - 22.8%
Radiation treatment aid(s) (77334)	12.4%	$14,278,243	(4.5%) - 29.4%
Decalcify tissue (88311)	12.4%	$1,077,814	4.5% - 20.2%
Electrocardiogram report (93010)	12.1%	$19,660,953	9.5% - 14.7%
Cytopathology, fluids (88104)	11.7%	$2,490,657	(11.1%) - 34.6%
Us exam, pelvic, complete (76856)	11.6%	$4,196,185	(5.7%) - 28.8%
Subsequent hospital care (99233)	11.5%	$127,589,978	7.0% - 16.1%
Radiation tx management, x5 (77427)	11.4%	$23,622,242	(1.8%) - 24.6%
Reagent strip/blood glucose (82948)	11.3%	$198,589	8.4% - 14.2%
Renal function panel (80069)	11.3%	$743,039	(1.7%) - 24.2%
All Other Codes	3.2%	$2,465,802,936	2.8% - 3.5%
All Services Billed to Carriers	3.4%	$2,722,882,225	3.1% - 3.8%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7b2: Services with Non-Response Errors: DMERCs

Service Billed to DMERCs (HCPCS)	Non-Response Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Enter feed supkit syr by day (B4034)	15.3%	$5,544,100	(1.0%) - 31.6%
Bedside drainage bag (A4357)	13.1%	$803,062	(3.1%) - 29.3%
Disposable nebulizer sml vol (A7004)	9.2%	$154,513	(0.1%) - 18.6%
Mycophenolate mofetil oral (J7517)	9.2%	$10,043,498	(4.3%) - 22.6%
Patient lift hydraulic (E0630)	6.7%	$1,943,552	(2.2%) - 15.6%
Pos airway press headgear (A7035)	6.5%	$460,631	(6.0%) - 19.0%
Lens sphcyl bifocal 4.00d/.1 (V2203)	6.3%	$1,820,054	(1.3%) - 13.9%
Battery for glucose monitor (A4254)	6.1%	$166,399	(5.6%) - 17.9%
All Other Codes	5.9%	$531,073,409	2.7% - 9.1%
Press pad alternating w pump (E0180)	5.5%	$165,624	(2.2%) - 13.1%
Aerosol mask used w nebulize (A7015)	4.8%	$23,771	(4.6%) - 14.2%
Nebulizer administration set (A7003)	4.8%	$375,342	1.2% - 8.5%
Cath w/drainage 2-way latex (A4314)	4.2%	$175,115	(4.0%) - 12.5%
Albuterol inh sol u d (J7619)	4.2%	$17,587,968	1.8% - 6.5%
High strength ltwt whlchr (K0004)	4.1%	$3,516,519	(3.7%) - 12.0%
Standard wheelchair (K0001)	3.9%	$3,525,427	(0.8%) - 8.5%
Enteral formulae category i (B4150)	3.6%	$7,305,248	(0.4%) - 7.7%
Lens spher bifoc plano 4.00d (V2200)	3.5%	$287,496	(3.3%) - 10.4%
Heated humidifier used w pap (K0531)	3.3%	$380,719	(3.3%) - 9.9%
Enteral feed supp pump per d (B4035)	3.1%	$6,667,114	0.1% - 6.1%
Nasal application device (A7034)	3.1%	$814,573	(2.9%) - 9.1%
All Services Billed to DMERCs	5.7%	$592,834,136	5.6% - 5.9%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7b3: Services with Non-Response Errors: FIs

Service Billed to FIs (Type of Bill)	Non-Response Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Hospital-inpatient or home health visits (Part B only) (12)	20.2%	$77,279,206	7.0% - 33.4%
Clinic-CMHC (76)	14.4%	$16,773,295	(9.0%) - 37.8%
Hospital-outpatient (HHA-A also) (13)	8.2%	$2,329,438,382	6.0% - 10.3%
Hospital-inpatient (including Part A) (11)	7.4%	$417,414,222	0.7% - 14.1%
Special facility or ASC surgery-hospice (hospital based) (82)	7.0%	$44,137,476	(3.1%) - 17.1%
Hospital-other (Part B) (14)	6.9%	$166,908,677	5.9% - 7.9%
Clinic-independent provider based FQHC (73)	6.5%	$19,370,480	4.1% - 8.8%
HHA-inpatient or home health visits (Part B only) (32)	6.0%	$228,755,148	3.6% - 8.3%
Special facility or ASC surgery-rural primary care hospital (85)	4.4%	$58,623,433	2.6% - 6.3%
HHA-outpatient (HHA-A also) (33)	4.3%	$166,243,866	2.6% - 6.0%
Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74)	4.2%	$30,191,773	2.5% - 6.0%
SNF-inpatient or home health visits (Part B only) (22)	3.9%	$57,228,331	1.4% - 6.4%
Clinic-rural health (71)	3.4%	$19,527,831	2.4% - 4.4%
SNF-outpatient (HHA-A also) (23)	3.2%	$5,064,916	0.2% - 6.1%
Clinic-hospital based or independent renal dialysis facility (72)	3.1%	$231,884,155	1.8% - 4.5%
SNF-inpatient (including Part A) (21)	2.5%	$514,508,733	0.8% - 4.3%
Hospital-swing beds (18)	2.5%	$14,943,202	(2.0%) - 6.9%
Special facility or ASC surgery-hospice (non-hospital based) (81)	1.8%	$82,083,791	0.6% - 2.9%
Clinic-CORF (75)	1.5%	$2,595,260	(0.4%) - (3.4%)
Special facility or ASC surgery-ambulatory surgical center (83)	0.8%	$856,929	(0.3%) - 1.8%
All other Codes	0.0%	$0	0.0% - 0.0%
All Services Billed to FIs	5.4%	$4,483,829,105	4.4% - 6.4%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

The following is an example of non-response:

A carrier paid $91.89 for an office visit and services. After repeated attempts from the CERT contractor to obtain the supporting medical records from the provider, the provider indicated that they could not locate the records. As a result, the CERT contractor counted the entire payment as an error.

More data regarding non-response errors is located in Appendix E.

Medically Unnecessary Services Errors

"Medically Unnecessary Services" includes situations where the CERT claim review staff identified enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary. In FY 2004, medically unnecessary services were also found in claims for which QIOs were responsible. Of the claims for which Carriers/DMERCs/FIs were responsible, the CERT contractor found that less than 1% of the allowed charges contained errors due to medical necessity.

Table 7c lists the services with the highest paid claims error rates due to medically unnecessary services for each contractor type in FY 2004. The table is sorted by paid claims error rate.

Table 7c1: Services with Medically Unnecessary Errors: Carriers

Service Billed to Carriers (HCPCS)	Medically Unnecessary Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Td vaccine > 7, im (90718)	31.3%	$425,922	(12.0%) - 74.6%
Echo guide for biopsy (76942)	25.8%	$19,764,551	(12.3%) - 63.9%
Chiropractic manipulation (98942)	6.8%	$6,423,507	(1.6%) - 15.2%
Thromboplastin time, partial (85730)	6.8%	$402,389	(2.5%) - 16.1%
Comprehensive hearing test (92557)	6.3%	$2,551,444	(3.1%) - 15.8%
Chiropractic manipulation (98941)	4.5%	$14,915,654	1.0% - 7.9%
Elec stim other than wound (G0283)	4.5%	$1,298,133	(0.7%) - 9.6%
Neuromuscular reeducation (97112)	4.4%	$3,251,062	(0.4%) - 9.3%
Basic support routine suppls (A0382)	4.3%	$190,259	(4.0%) - 12.6%
BLS (A0428)	4.3%	$30,282,522	0.6% - 7.9%
Manual therapy (97140)	3.8%	$7,966,828	1.2% - 6.4%
Obtaining screen pap smear (Q0091)	3.3%	$1,090,877	(1.9%) - 8.4%
Electrical stimulation (97032)	3.2%	$1,036,154	(0.7%) - 7.1%
Debride skin, partial (11040)	3.1%	$1,305,733	(3.0%) - 9.3%
Therapeutic exercises (97110)	3.0%	$18,153,360	1.3% - 4.7%
CA screen;pelvic/breast exam (G0101)	2.7%	$769,926	(2.5%) - 7.9%
Trim nail(s) (11719)	2.7%	$402,041	(2.2%) - 7.5%
Methylprednisolone 80 MG inj (J1040)	2.3%	$212,429	(2.2%) - 6.8%
Echo transthoracic (93350)	2.1%	$1,125,284	1.7% - 2.5%
Pt evaluation (97001)	2.1%	$1,484,171	(1.7%) - 5.9%
All Other Codes	0.1%	$91,440,346	0.1% - 0.2%
All Services Billed to Carriers	0.3%	$204,492,593	0.2% - 0.3%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7c2: Services with Medically Unnecessary Errors: DMERCs

Service Billed to DMERCs (HCPCS)	Medically Unnecessary Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Ostomy skin barrier w flange <=4sq¾ (A4414)	16.7%	$2,615,738	(3.0%) - 36.4%
Mycophenolate mofetil oral (J7517)	14.2%	$15,469,460	(1.9%) - 30.2%
Drain ostomy pouch w/flange (A5063)	11.1%	$1,429,549	(1.2%) - 23.4%
Lancets per box (A4259)	11.0%	$9,325,777	6.9% - 15.0%
Blood glucose/reagent strips (A4253)	10.9%	$91,074,641	8.3% - 13.5%
Lancet device each (A4258)	9.8%	$1,441,783	3.3% - 16.3%
Battery for glucose monitor (A4254)	7.8%	$210,788	(0.5%) - 16.0%
Nebulizer administration set (A7003)	7.0%	$549,257	3.2% - 10.8%
Iv pole (E0776)	6.4%	$603,891	(2.2%) - 14.9%
Cont airway pressure device (E0601)	6.3%	$7,347,841	2.8% - 9.9%
Enteral feed supp pump per d (B4035)	6.0%	$12,756,073	0.1% - 11.8%
Stationary liquid 02 (E0439)	5.4%	$6,835,659	(1.0%) - 11.8%
Nasal application device (A7034)	4.9%	$1,311,306	(1.4%) - 11.3%
Aerosol mask used w nebulize (A7015)	4.8%	$23,645	(4.6%) - 14.2%
Albuterol inh sol u d (J7619)	4.7%	$19,813,652	2.5% - 6.8%
Blood glucose monitor home (E0607)	4.6%	$1,270,836	0.2% - 9.0%
Enteral formulae category i (B4150)	4.6%	$9,142,807	0.1% - 9.1%
Portable liquid 02 (E0434)	4.5%	$1,529,459	(0.1%) - 9.0%
Powered pres-redu air mattrs (E0277)	4.2%	$10,194,168	(0.5%) - 8.9%
Ipratropium brom inh sol u d (J7644)	4.2%	$24,057,691	2.2% - 6.2%
All Other Codes	1.8%	$129,097,927	0.7% - 2.8%
All Services Billed to DMERCs	3.3%	$346,101,947	3.0% - 3.7%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7c3: Services with Medically Unnecessary Errors: FIs

Service Billed to FIs (Type of Bill)	Medically Unnecessary Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Clinic-CMHC (76)	3.3%	$3,834,840	2.5% - 4.1%
Special facility or ASC surgery-hospice (non-hospital based) (81)	2.0%	$91,665,177	0.4% - 3.6%
SNF-outpatient (HHA-A also) (23)	1.7%	$2,762,783	(0.8%) - 4.3%
SNF-inpatient (including Part A) (21)	1.1%	$230,212,945	0.5% - 1.8%
Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74)	0.6%	$4,386,043	0.1% - 1.1%
HHA-outpatient (HHA-A also) (33)	0.6%	$22,211,168	(0.3%) - 1.5%
HHA-inpatient or home health visits (Part B only) (32)	0.4%	$15,432,112	(0.1%) - 0.9%
Hospital-outpatient (HHA-A also) (13)	0.2%	$57,527,005	(0.1%) - 0.5%
Special facility or ASC surgery-rural primary care hospital (85)	0.2%	$2,637,653	(0.1%) - 0.5%
Hospital-other (Part B) (14)	0.1%	$2,591,272	0.0% - 0.2%
SNF-inpatient or home health visits (Part B only) (22)	0.1%	$1,251,625	0.0% - 0.2%
Clinic-hospital based or independent renal dialysis facility (72)	0.0%	$788,301	(0.0%) - 0.0%
All Services Billed to FIs	0.5%	$435,300,925	0.3% - 0.7%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

The following is an example of a medically unnecessary service:

An FI paid a Skilled Nursing Facility (SNF) $49.22 for 30 minutes of therapeutic procedures; however, the certification by the physician for the services did not cover the dates for which the services were billed. As a result, the reviewer determined that the services were not medically necessary and, consequently, counted the claim as an error.

Coding Errors

Providers use a standard coding system 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 "upcoded" 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).

A study of the claims in the sample for the *Improper Medicare Fee-for-Service Payments Report* for FY 2003 showed that carrier claims had 523 lines of service undercoded. This means that providers undercoded .67% of claims submitted to carriers. Eighty-three percent of undercoding by underpayment amount is attributed to undercoding of 32 E&M services.

There was significantly less undercoding among claims submitted to DMERCs and FIs than among claims submitted to carriers. There were only 3 DMERC and 34 FI lines of service undercoded respectively. This means that suppliers undercoded .02% of the claims submitted to DMERCs and facilities undercoded .05% of the claims submitted to FIs. The extent of undercoding among claims providers submitted to DMERCs and FIs is not significant or systemic. Therefore, undercoding in DMERCs and FIs most likely represents random billing errors.

A common error involved upcoding or downcoding 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 7d lists the services with the highest undercoding paid claims error rates for each contractor type in FY 2004. The table is sorted by paid claims error rate.

Table 7d1: Services with Undercoding Errors: Carriers

Service Billed to Carriers (HCPCS)	Undercoding Errors		
	Paid Claims Error Rate (Underpayments)	Projected Improper Payments* (Underpayments)	95% Confidence Interval
Home visit, est patient (99348)	(43.2%)	$(22,545,191.00)	(95.9%) - 9.4%
Office consultation (99241)	(16.9%)	$ (4,761,166.00)	(32.2%) - (1.6%)
Office/outpatient visit, est (99212)	(6.5%)	$ (60,009,114.00)	(7.6%) - (5.4%)
Nursing fac care, subseq (99311)	(6.3%)	$ (12,845,956.00)	(8.8%) - (3.8%)
Office/outpatient visit, est (99211)	(5.9%)	$ (13,375,855.00)	(8.3%) - (3.4%)
Office/outpatient visit, new (99201)	(5.1%)	$ (893,655.00)	(8.3%) - (1.8%)
Emergency dept visit (99282)	(5.0%)	$ (1,761,466.00)	(11.8%) - 1.9%
Initial inpatient consult (99251)	(4.6%)	$ (1,046,820.00)	(9.9%) - 0.6%
Tissue exam by pathologist (88304)	(4.1%)	$ (880,144.00)	(12.4%) - 4.1%
Emergency dept visit (99283)	(3.3%)	$ (9,654,531.00)	(5.0%) - (1.7%)
Follow-up inpatient consult (99261)	(3.1%)	$ (506,332.00)	(4.3%) - (2.0%)
IV infusion, additional hour (90781)	(2.9%)	$ (1,216,300.00)	(8.6%) - 2.8%
Sodium hyaluronate injection (J7317)	(2.7%)	$ (1,823,349.00)	(3.1%) - (2.3%)
Subsequent hospital care (99231)	(2.6%)	$ (18,359,647.00)	(4.2%) - (1.0%)
Ct thorax w/o dye (71250)	(1.9%)	$ (1,776,530.00)	(2.3%) - (1.5%)
Follow-up inpatient consult (99263)	(1.8%)	$ (1,008,547.00)	(5.1%) - 1.5%
Us exam, pelvic, complete (76856)	(1.8%)	$ (649,465.00)	(5.3%) - 1.8%
Ground mileage (A0425)	(1.8%)	$ (7,937,114.00)	(4.4%) - 0.8%
Unlisted Procedures (99999)	(1.8%)	$ (692,535.00)	(5.2%) - 1.7%
X-ray exam of neck spine (72040)	(1.6%)	$ (105,887.00)	(4.8%) - 1.6%
All Other Codes	(0.2%)	$ (120,425,876.00)	(0.2%) - (0.1%)
All Services Billed to Carriers	(0.4%)	$ (282,275,478.00)	(0.4%) - (0.3%)

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7d2: Services with Undercoding Errors: DMERCs

Service Billed to DMERCs (HCPCS)	Undercoding Errors		
	Paid Claims Error Rate (Underpayments)	Projected Improper Payments* (Underpayments)	95% Confidence Interval
Enteral formulae category I (B4150)	(0.4%)	($729,069)	(1.1%) - 0.3%
All Services Billed to DMERCs	0.0%	($729,069)	(0.0%) - (0.0%)

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7d3: Services with Undercoding Errors: FIs

Service Billed to FIs (Type of Bill)	Undercoding Errors		
	Paid Claims Error Rate (Underpayments)	Projected Improper Payments* (Underpayments)	95% Confidence Interval
HHA-outpatient (HHA-A also) (33)	(0.3%)	($13,337,522)	(0.7%) - 0.0%
Special facility or ASC surgery-rural primary care hospital (85)	(0.2%)	($3,048,029)	(0.7%) - 0.2%
SNF-inpatient or home health visits (Part B only) (22)	(0.2%)	($2,920,736)	(0.4%) - 0.0%
Hospital-outpatient (HHA-A also) (13)	(0.2%)	($46,427,352)	(0.3%) - (0.1%)
Hospital-inpatient or home health visits (Part B only) (12)	(0.1%)	($532,655)	(0.2%) - (0.1%)
Clinic-CORF (75)	0.0%	($45,821)	(0.1%) - 0.0%
HHA-inpatient or home health visits (Part B only) (32)	0.0%	($971,957)	(0.1%) - 0.0%
Clinic-hospital based or independent renal dialysis facility (72)	0.0%	($1,738,104)	(0.0%) - (0.0%)
SNF-inpatient (including Part A) (21)	0.0%	($1,837,737)	(0.0%) - 0.0%
Hospital-other (Part B) (14)	0.0%	($131,562)	(0.0%) - 0.0%
Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74)	0.0%	($6,682)	(0.0%) - 0.0%
All Services Billed to FIs	-0.1%	($70,998,157)	(0.1%) - (0.0%)

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

For more data pertaining to undercoding errors, see Appendix H.

The following is an example of a coding error:

A carrier paid a physician $135.42 for the evaluation and management (E&M) of an established patient. This procedure requires at least two of three key components: a detailed history, a detailed examination, and/or medical decision-making of moderate complexity. The medical reviewer determined that the services did not meet the minimum criteria for the key components since a licensed nurse rendered the services rather than a physician. Instead, the medical record met the criteria for a lower level service. The CERT reviewer determined that the service should have been billed at a lower E&M code and counted as $43.83 paid in error.

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 G for more information about these codes.

Other Errors

"Other errors" include instances when providers' claims did not meet benefit category requirements or other billing requirements. Errors for services that did not meet the benefit category requirements were more common among claims submitted to DMERCs than among claims submitted to carriers and FIs. The absence of a valid physician's order made some Durable Medical Equipment (DME) items non-covered because an order or Certificate of Medical Necessity (CMN) was required to meet the benefit category requirements for the DME item.

Table 7e lists the services with the highest "other errors" paid claims error rate for each contractor for FY 2004. The table is sorted by paid claims error rate.

Table 7e1: Services with Other Errors: Carriers

Service Billed to Carriers (HCPCS)	Other Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Comprehensive hearing test (92557)	6.1%	$2,479,212	(3.4%) - 15.6%
Td vaccine > 7, im (90718)	5.9%	$79,738	(5.6%) - 17.4%
Echo guide for biopsy (76942)	3.6%	$2,772,437	(3.6%) - 10.9%
Immunization admin (90471)	3.3%	$55,004	2.0% - 4.7%
Debride skin, partial (11040)	2.5%	$1,024,437	(2.3%) - 7.3%
X-ray exam of foot (73630)	2.0%	$404,272	(1.9%) - 5.8%
Remove impacted ear wax (69210)	1.6%	$828,273	(1.0%) - 4.3%
Psy dx interview (90801)	1.5%	$2,582,404	(1.5%) - 4.6%
Hepatitis b surface ag, eia (87340)	1.4%	$268,200	(1.4%) - 4.3%
Transport portable x-ray (R0070)	1.4%	$1,638,390	(1.4%) - 4.2%
Assay of parathormone (83970)	1.3%	$1,191,443	(1.2%) - 3.8%
Set up port xray equipment (Q0092)	1.2%	$228,422	(1.1%) - 3.4%
Medication management (90862)	1.0%	$1,656,324	(0.4%) - 2.5%
IV infusion therapy, 1 hour (90780)	0.8%	$981,987	(0.8%) - 2.4%
Chemotherapy, sc/im (96400)	0.8%	$204,150	(0.2%) - 1.8%
Normal saline solution infus (J7040)	0.8%	$43,217	(0.9%) - 2.4%
Assay of iron (83540)	0.6%	$186,946	(0.6%) - 1.9%
Office/outpatient visit, est (99211)	0.4%	$937,988	(0.1%) - 0.9%
Assay of psa, total (84153)	0.4%	$306,048	(0.4%) - 1.2%
Follow-up inpatient consult (99262)	0.4%	$262,183	(0.4%) - 1.2%
All Other Codes	0.0%	$11,067,140	0.0% - 0.0%
All Services Billed to Carriers	0.0%	$29,198,214	0.0% - 0.1%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7e2: Services with Other Errors: DMERCs

Service Billed to DMERCs (HCPCS)	Other Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
Blood glucose monitor home (E0607)	3.1%	$844,891	(2.9%) - 9.1%
Lancet device each (A4258)	1.5%	$227,091	(1.5%) - 4.6%
Calibrator solution/chips (A4256)	0.8%	$144,018	(0.8%) - 2.5%
Lancets per box (A4259)	0.6%	$481,747	(0.3%) - 1.4%
Nebulizer with compression (E0570)	0.3%	$186,250	(0.3%) - 0.8%
Blood glucose/reagent strips (A4253)	0.2%	$1,293,525	(0.1%) - 0.4%
All Services Billed to DMERCs	0.0%	$3,177,522	0.0% - 0.0%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 7e3: Services with Other Errors: FIs

Services Billed to FIs (Type of Bill)	Other Errors		
	Paid Claims Error Rate	Projected Improper Payments*	95% Confidence Interval
HHA-inpatient or home health visits (Part B only) (32)	0.3%	$9,705,976	(0.2%) - 0.7%
Special facility or ASC surgery-rural primary care hospital (85)	0.2%	$2,777,561	(0.0%) - 0.4%
SNF-inpatient or home health visits (Part B only) (22)	0.2%	$2,974,018	(0.2%) - 0.6%
SNF-inpatient (including Part A) (21)	0.1%	$21,876,654	(0.1%) - 0.3%
Hospital-outpatient (HHA-A also) (13)	0.1%	$25,999,561	0.0% - 0.2%
Clinic-rural health (71)	0.1%	$340,537	(0.1%) - 0.2%
Hospital-other (Part B) (14)	0.0%	$674,999	(0.0%) - 0.1%
Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97) (74)	0.0%	$189,719	(0.0%) - 0.1%
All Other Codes	0.0%	($1,178,913)	(0.1%) - 0.0%
All Services Billed to FIs	0.1%	$63,360,110	0.0% - 0.1%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

The following is an example of an "other error":

A carrier paid $76.64 for routine foot care. Routine foot care is statutorily excluded. Therefore, the CERT contractor counted the full payment as an error.

Paid Claims Error Rates by Type of Contractor

As illustrated in Figure 4, the estimated paid claims error rate for claims submitted between January 1, 2003 and December 31, 2003,[12] was 11.4% gross (10.7% net) for Carriers, 11.1% gross (11.1% net) for DMERCs, 16.4% gross (15.8% net) for FIs, 4.8% gross (3.6% net) for QIOs. The estimated improper payments made during the time period[13] were $6.9 B gross ($6.1 B net) for Carriers, $1.0 B gross ($1.0 B net) for DMERCs, and $9.7 B gross ($9.3 B net) for FIs, and $4.1 B gross ($3.0 B net) for QIOs.

[12] QIO error rates were based on discharges between 7/01/02 and 6/30/03.

[13] QIO error rates were based on claims submitted.

Figure 4a: Gross and Net Paid Claims Error Rates by Contractor Type: FY 2004

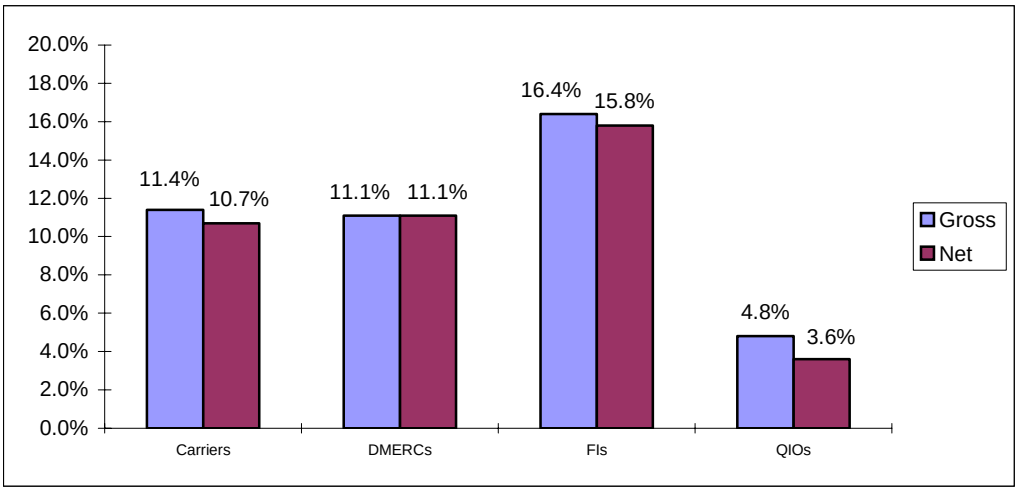
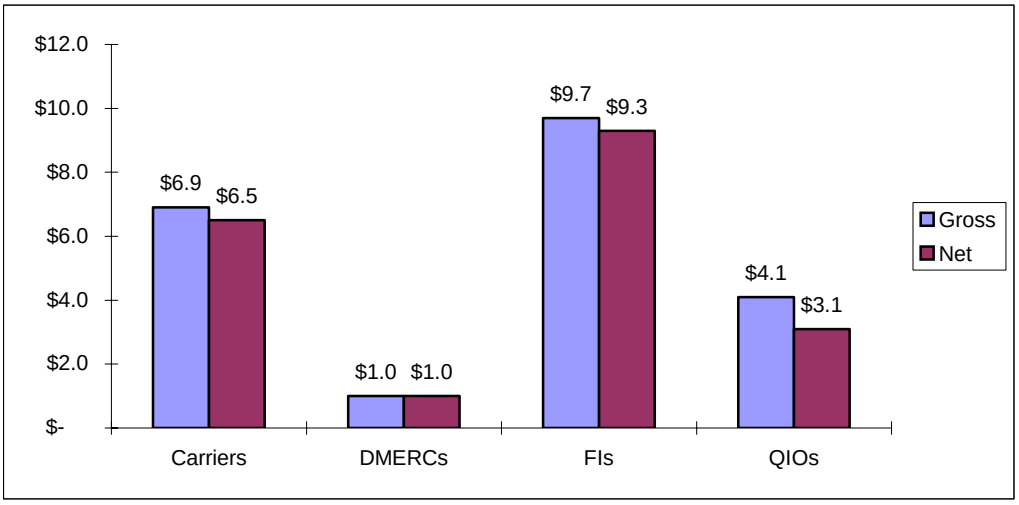


Figure 4b: Gross and Net Projected Improper Payments by Contractor Type: FY 2004*



* This data except QIO has not been adjusted to include beneficiary copayments, deductibles, and reductions to recover previous overpayments

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Carrier-Specific Error Rates

Table 8 contains carrier-specific error rates and improper payment amounts. The table is sorted by projected improper payments.

Table 8a: Gross Error Rates: Carriers

Carrier Clusters	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Ecluding Non-Response Claims
WPS WI/IL/MI/MN	11.6%	$943,740,273	1.6%	8.5% - 14.7%	7.7%	25.1%	22.3%	13.3%	8.6%
Empire NY/NJ	11.6%	$842,025,251	1.5%	8.6% - 14.6%	8.9%	26.4%	24.6%	12.7%	9.2%
First Coast Service Options FL	10.7%	$788,994,971	1.1%	8.5% - 12.9%	7.6%	22.4%	20.2%	12.1%	9.5%
NHIC CA	11.3%	$769,628,535	1.2%	9.0% - 13.6%	8.4%	29.6%	28.0%	14.3%	11.3%
TrailBlazer TX	14.8%	$765,354,037	1.5%	11.9% - 17.7%	10.3%	31.5%	28.6%	15.1%	10.6%
CIGNA ID/TN/NC	12.0%	$575,692,745	1.8%	8.5% - 15.5%	8.8%	20.4%	17.7%	12.5%	10.3%
Noridian AZ/HI/NV/AK/OR/WA	11.0%	$550,162,398	1.6%	7.9% - 14.2%	9.2%	25.6%	24.4%	12.1%	9.1%
Cahaba GBA AL/GA/MS	12.4%	$480,390,057	1.6%	9.2% - 15.6%	9.1%	24.6%	22.1%	13.1%	10.2%
Palmetto GBA OH/WV	11.0%	$462,499,979	1.2%	8.6% - 13.4%	8.5%	23.2%	21.4%	11.4%	9.1%
TrailBlazer MD/DC/DE/VA	10.2%	$425,546,737	1.1%	8.0% - 12.4%	6.6%	27.0%	24.6%	11.2%	7.5%
HGSA PA	10.6%	$381,138,420	1.3%	8.0% - 13.1%	9.1%	25.5%	24.4%	11.7%	9.9%
NHIC MA/ME/NH/VT	10.3%	$342,023,866	1.0%	8.4% - 12.2%	6.7%	23.4%	20.8%	12.0%	8.8%
BCBS AR NM/OK/LA	13.1%	$300,986,739	1.2%	10.7% - 15.5%	8.8%	25.8%	22.5%	14.2%	9.3%
AdminaStar IN/KY	10.8%	$291,924,810	1.5%	7.8% - 13.8%	7.2%	17.6%	14.5%	10.2%	7.7%
BCBS AR AR/MO	11.2%	$257,512,278	1.4%	8.4% - 14.1%	8.4%	24.2%	22.2%	12.2%	8.8%
Noridian CO/ND/SD/WY/IA	10.1%	$188,573,393	1.4%	7.3% - 12.8%	6.9%	30.0%	28.0%	9.1%	6.8%
Palmetto SC	13.7%	$163,205,313	1.9%	10.0% - 17.5%	10.5%	22.6%	20.1%	14.3%	11.6%
Triple S, Inc. PR/VI	18.7%	$128,690,658	1.6%	15.5% - 21.8%	14.8%	26.4%	23.2%	21.2%	18.3%
HealthNow NY	9.2%	$124,466,605	1.3%	6.6% - 11.8%	6.5%	20.3%	18.2%	11.2%	8.5%
BCBS KS KS/NE/Kansas City	7.5%	$119,346,327	1.0%	5.5% - 9.5%	5.1%	13.7%	11.6%	10.9%	8.7%
First Coast Service Options CT	8.2%	$90,049,819	0.9%	6.5% - 9.9%	6.6%	27.2%	26.0%	9.8%	7.9%
GHI NY	16.0%	$59,462,633	1.6%	12.9% - 19.1%	12.0%	29.3%	26.4%	17.2%	13.2%
BCBS RI	13.9%	$32,303,597	1.5%	10.9% - 16.9%	8.0%	28.1%	24.1%	14.3%	10.0%
BCBS UT	10.6%	$30,713,236	1.3%	8.2% - 13.1%	7.6%	27.8%	25.8%	23.9%	21.9%
BCBS MT	6.2%	$11,844,210	0.9%	4.4% - 7.9%	5.6%	21.3%	21.0%	8.7%	7.6%
All Carrier Clusters	11.4%	$9,126,276,887	0.4%	10.7% - 12.1%	8.3%	25.2%	23.0%	12.7%	9.5%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Most carriers (64%) made fewer projected net improper payments in FY 2004 than in FY 2003. For example, in FY 2003, Empire NY/NJ made $1.4 B in projected net improper payments. In FY 2004, Empire NY/NJ made $0.8 B in projected net improper payments.

Nine carriers (CIGNA ID/TN/NC, Palmetto OH/WV, NHIC MA/ME/NH/VT, BCBS AR AR/MO, AdminaStar IN/KY, Palmetto SC, Noridian CO/ND/SD/WY/ID, First Coast Service Options CT, and BCBS RI) made more projected improper payments in FY 2004 than in 2003.

Paid/Allowed Claims Error Rate: This is the percentage of dollars that carriers erroneously paid and is a good indicator of how accurately each carrier paid claims.

Provider Compliance Error Rate: This rate is based on how claims looked when they first arrived at the carrier – before the carrier applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the carrier is educating the provider community since it measures how well providers prepared claims for submission.

Services Processed Error Rate: This rate is based on the number of services processed and measures whether the carrier made appropriate payment decisions on claims.

Table 8b Net Error Rates: Carriers

Carrier Clusters	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
WPS WI/IL/MI/MN	11.1%	$902,013,249	1.6%	8.0% - 14.2%	7.1%	24.6%	21.8%
Empire NY/NJ	10.8%	$784,955,565	1.6%	7.7% - 13.9%	8.1%	25.8%	23.9%
NHIC CA	10.8%	$738,445,918	1.1%	8.6% - 13.1%	7.9%	29.3%	27.7%
TrailBlazer TX	14.1%	$728,838,389	1.5%	11.2% - 17.0%	9.6%	31.0%	28.1%
First Coast Service Options FL	9.7%	$714,648,461	1.1%	7.5% - 11.9%	6.6%	21.6%	19.3%
Noridian AZ/HI/NV/AK/OR/WA	10.7%	$532,975,956	1.6%	7.5% - 13.9%	8.9%	25.3%	24.1%
CIGNA ID/TN/NC	10.9%	$526,484,660	1.8%	7.4% - 14.5%	7.8%	19.5%	16.8%
Palmetto GBA OH/WV	10.6%	$448,059,825	1.2%	8.2% - 13.1%	8.2%	22.9%	21.1%
Cahaba GBA AL/GA/MS	11.1%	$429,356,026	1.6%	7.9% - 14.3%	7.7%	23.5%	21.0%
TrailBlazer MD/DC/DE/VA	9.2%	$382,544,443	1.1%	7.0% - 11.4%	5.5%	26.1%	23.7%
HGSA PA	9.7%	$349,812,850	1.3%	7.1% - 12.3%	8.2%	24.7%	23.7%
NHIC MA/ME/NH/VT	9.6%	$319,026,915	1.0%	7.7% - 11.5%	6.0%	22.8%	20.2%
BCBS AR NM/OK/LA	12.7%	$291,221,542	1.2%	10.3% - 15.0%	8.4%	25.5%	22.1%
AdminaStar IN/KY	10.0%	$270,833,138	1.5%	7.0% - 13.0%	6.4%	16.9%	13.7%
BCBS AR AR/MO	10.6%	$243,035,358	1.4%	7.8% - 13.4%	7.8%	23.7%	21.6%
Noridian CO/ND/SD/WY/IA	9.5%	$177,259,816	1.4%	6.7% - 12.2%	6.3%	29.5%	27.5%
Palmetto SC	13.1%	$155,793,095	1.9%	9.4% - 16.9%	9.9%	22.1%	19.5%
Triple S, Inc. PR/VI	17.9%	$123,371,220	1.6%	14.7% - 21.1%	14.0%	25.5%	22.3%
HealthNow NY	8.2%	$111,357,901	1.3%	5.6% - 10.8%	5.5%	19.5%	17.3%
BCBS KS KS/NE/Kansas City	6.9%	$109,106,596	1.0%	4.8% - 8.9%	4.4%	13.0%	10.9%
First Coast Service Options CT	7.6%	$84,062,290	0.9%	5.9% - 9.3%	6.0%	26.8%	25.5%
GHI NY	14.3%	$53,250,906	1.6%	11.2% - 17.4%	10.2%	27.9%	24.9%
BCBS RI	13.5%	$31,381,956	1.5%	10.5% - 16.5%	7.6%	27.8%	23.7%
BCBS UT	10.2%	$29,346,734	1.2%	7.7% - 12.6%	7.1%	27.4%	25.4%
BCBS MT	5.3%	$10,251,897	0.9%	3.6% - 7.0%	4.8%	20.7%	20.3%
All Carrier Clusters	10.7%	$8,547,434,706	0.4%	10.0% - 11.4%	7.6%	24.6%	22.3%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Paid/Allowed Claims Error Rate: This is the percentage of dollars that carriers erroneously paid and is a good indicator of how accurately each carrier paid claims.

Provider Compliance Error Rate: This rate is based on how claims looked when they first arrived at the carrier – before the carrier applied any edits or conducted any reviews. The

provider compliance error rate is a good indicator of how well the carrier is educating the provider community since it measures how well providers prepared claims for submission.

There is no services processed error rate column in this chart since the services processed error rate is only caclulated as a gross error rate.

DMERC-Specific Error Rates

Table 9 contains DMERC-specific error rates and improper payment amounts. Please note net and gross figures are the same because there were no DMERC underpayments[14].

Table 9: Gross and Net Error Rates: DMERCs

	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
DMERCs	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Palmetto GBA - Region C	14.0%	$689,920,500	2.9%	8.3% - 19.6%	4.6%	23.2%	15.7%	14.4%	11.3%
CIGNA-Region D	11.6%	$208,815,642	2.1%	7.5% - 15.6%	9.0%	21.4%	19.3%	14.6%	12.9%
AdminaStar Federal-Region B	6.6%	$147,915,927	0.9%	4.8% - 8.4%	5.4%	13.9%	12.9%	8.3%	7.0%
TriCenturion-Region A	7.3%	$99,637,653	0.9%	5.6% - 9.0%	5.5%	13.7%	12.0%	10.3%	7.9%
All DMERCs	11.1%	$1,146,289,722	1.5%	8.2% - 14.0%	5.7%	19.7%	15.2%	12.4%	10.1%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Although two DMERCs made fewer improper payments in FY 2004 than in FY 2003, the other two DMERCs (CIGNA and AdminaStar) made more improper payments in FY 2004 than in FY 2003.

Paid/Allowed Claims Error Rate: This is the percentage of dollars that DMERCs erroneously paid and is a good indicator of how accurately each DMERC paid claims.

Provider Compliance Error Rate: This rate is based on how claims looked when they first arrived at the DMERC– before the DMERC applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the DMERC is educating the provider community since it measures how well providers prepared claims for submission.

Services Processed Error Rate: This rate is based on the number of services processed and measures whether the DMERC made appropriate payment decisions on claims.

[14] Although there was one DMERC claim that was underpaid (worth $56.00), when projected to the universe this figure dropped to $0.

FI-Specific Error Rates

Table 10 contains FI-specific error rates and improper payment amounts.

Table 10a: Gross Error Rates: FIs

FI Clusters	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Mutual of Omaha	26.8%	$3,166,378,673	3.2%	20.5% - 33.2%	19.2%	N/A	N/A	N/A	N/A
UGS CA/HI/AS/GU/NMI	20.5%	$1,230,461,543	2.1%	16.4% - 24.6%	13.9%	N/A	N/A	N/A	N/A
AdminaStar IN/IL/KY/OH	12.5%	$1,199,842,132	2.7%	7.2% - 17.8%	8.2%	N/A	N/A	N/A	N/A
Empire NY/CT/DE	17.5%	$1,016,038,739	2.9%	11.8% - 23.2%	12.3%	N/A	N/A	N/A	N/A
UGS MI/WI	13.6%	$671,270,365	2.5%	8.8% - 18.4%	9.6%	N/A	N/A	N/A	N/A
TRAILBLAZER TX/CO/NM	14.3%	$651,135,803	2.0%	10.4% - 18.1%	9.1%	N/A	N/A	N/A	N/A
Palmetto GBA SC	10.5%	$648,160,352	1.1%	8.3% - 12.7%	6.2%	N/A	N/A	N/A	N/A
Riverbend TN/NJ	17.0%	$613,143,644	2.9%	11.4% - 22.6%	10.2%	N/A	N/A	N/A	N/A
First Coast Service Options FL	23.1%	$570,144,460	2.9%	17.4% - 28.7%	17.0%	N/A	N/A	N/A	N/A
CareFirst MD/DC	25.7%	$553,748,148	4.8%	16.2% - 35.2%	18.9%	N/A	N/A	N/A	N/A
Palmetto GBA NC	16.7%	$533,144,761	3.0%	10.9% - 22.5%	13.1%	N/A	N/A	N/A	N/A
Veritus PA	15.4%	$319,761,538	2.7%	10.1% - 20.6%	13.7%	N/A	N/A	N/A	N/A
Anthem MA/ME	10.5%	$301,427,813	2.2%	6.2% - 14.9%	7.0%	N/A	N/A	N/A	N/A
Trispan MS/LA/MO	16.2%	$272,196,256	2.6%	11.1% - 21.3%	13.6%	N/A	N/A	N/A	N/A
Cahaba GBA IA	6.2%	$263,303,734	1.1%	4.1% - 8.2%	4.6%	N/A	N/A	N/A	N/A
UGS VA/WV	16.7%	$241,275,828	2.8%	11.1% - 22.2%	13.5%	N/A	N/A	N/A	N/A
Noridian MN/ND	16.9%	$220,723,714	3.3%	10.3% - 23.4%	9.9%	N/A	N/A	N/A	N/A
BCBS RI	23.0%	$179,812,951	3.2%	16.8% - 29.2%	19.7%	N/A	N/A	N/A	N/A
BCBS GA	7.1%	$148,600,497	1.5%	4.1% - 10.1%	4.5%	N/A	N/A	N/A	N/A
Premera WA/AK	14.1%	$142,624,151	3.0%	8.2% - 20.0%	13.1%	N/A	N/A	N/A	N/A
BCBS AR	26.1%	$125,705,034	5.5%	15.3% - 36.8%	12.0%	N/A	N/A	N/A	N/A
Cahaba GBA AL	15.7%	$110,471,946	2.2%	11.3% - 20.0%	8.7%	N/A	N/A	N/A	N/A
Medicare Northwest OR/ID/UT	14.7%	$104,067,546	2.6%	9.5% - 19.8%	10.5%	N/A	N/A	N/A	N/A
BCBS OK	8.8%	$97,700,812	2.2%	4.6% - 13.1%	7.9%	N/A	N/A	N/A	N/A
Anthem NH/VT	9.0%	$57,818,712	1.7%	5.7% - 12.3%	4.6%	N/A	N/A	N/A	N/A
BCBS KS	10.2%	$52,407,237	2.2%	5.8% - 14.6%	7.7%	N/A	N/A	N/A	N/A
BCBS NE	12.8%	$38,430,526	2.7%	7.5% - 18.1%	6.1%	N/A	N/A	N/A	N/A
BCBS AZ	7.5%	$24,360,234	1.4%	4.7% - 10.3%	5.8%	N/A	N/A	N/A	N/A
COSVI PR/VI	12.0%	$19,075,732	2.1%	7.9% - 16.1%	5.0%	N/A	N/A	N/A	N/A
BCBS MT	7.1%	$16,288,020	1.7%	3.8% - 10.3%	6.2%	N/A	N/A	N/A	N/A
BCBS WY	15.1%	$12,543,120	2.8%	9.6% - 20.6%	13.7%	N/A	N/A	N/A	N/A
All FI Clusters	16.4%	$13,602,064,018	0.7%	15.0% - 17.8%	11.4%	N/A	N/A	N/A	N/A

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Paid/Allowed Claims Error Rate: This is the percentage of dollars that FIs erroneously paid and is a good indicator of how accurately each FI paid claims.

Provider Compliance Error Rate: These rates will be available in the FY 2005 report.

Services Processed Error Rate: These rates will be available in the FY 2005 report.

Table 10b: Net Error Rates: FIs

FI Clusters	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate	
	Including Non-Response Claims	Projected Improper Payment Amount Including Non-Response*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Mutual of Omaha	26.8%	$3,161,718,603	3.2%	20.4% - 33.1%	19.2%	N/A	N/A
UGS CA/HI/AS/GU/NMI	20.4%	$1,224,634,538	2.1%	16.3% - 24.5%	13.8%	N/A	N/A
AdminaStar IN/IL/KY/OH	12.2%	$1,172,489,739	2.7%	6.8% - 17.5%	7.9%	N/A	N/A
Empire NY/CT/DE	17.2%	$999,541,314	2.9%	11.5% - 22.9%	12.1%	N/A	N/A
UGS MI/WI	13.5%	$668,592,686	2.5%	8.7% - 18.4%	9.5%	N/A	N/A
TRAILBLAZER TX/CO/NM	14.1%	$642,506,469	2.0%	10.2% - 17.9%	8.9%	N/A	N/A
Palmetto GBA SC	10.3%	$638,080,566	1.1%	8.1% - 12.6%	6.0%	N/A	N/A
First Coast Service Options FL	23.0%	$568,679,054	2.9%	17.3% - 28.7%	16.9%	N/A	N/A
CareFirst MD/DC	25.3%	$546,367,039	4.9%	15.8% - 34.8%	18.5%	N/A	N/A
Palmetto GBA NC	16.7%	$532,741,242	3.0%	10.9% - 22.5%	13.1%	N/A	N/A
Riverbend TN/NJ	9.7%	$351,337,074	3.0%	3.9% - 15.5%	9.4%	N/A	N/A
Veritus PA	14.7%	$305,632,405	2.7%	9.4% - 19.9%	13.0%	N/A	N/A
Anthem MA/ME	10.4%	$296,640,588	2.2%	6.0% - 14.7%	6.8%	N/A	N/A
Trispan MS/LA/MO	15.8%	$264,693,236	2.6%	10.75% - 20.9%	13.1%	N/A	N/A
UGS VA/WV	16.6%	$240,673,512	2.8%	11.1% - 22.2%	13.5%	N/A	N/A
Cahaba GBA IA	5.6%	$239,317,062	1.1%	3.5% - 7.7%	4.1%	N/A	N/A
Noridian MN/ND	16.2%	$212,211,798	3.3%	9.7% - 22.7%	9.2%	N/A	N/A
BCBS RI	19.3%	$150,888,605	3.2%	13.0% - 25.6%	15.9%	N/A	N/A
BCBS GA	6.9%	$145,283,562	1.5%	3.9% - 10.0%	4.4%	N/A	N/A
BCBS AR	26.1%	$125,656,436	5.5%	15.39% - 36.8%	12.0%	N/A	N/A
Cahaba GBA AL	15.5%	$109,279,442	2.2%	11.1% - 19.9%	8.5%	N/A	N/A
Medicare Northwest OR/ID/UT	14.6%	$103,824,467	2.6%	9.4% - 19.8%	10.5%	N/A	N/A
BCBS OK	8.6%	$95,396,035	2.2%	4.4% - 12.9%	7.7%	N/A	N/A
Premera WA/AK	7.3%	$73,362,688	3.1%	1.3% - 13.3%	6.0%	N/A	N/A
Anthem NH/VT	9.0%	$57,763,000	1.7%	5.7% - 12.3%	4.6%	N/A	N/A
BCBS KS	10.0%	$51,258,470	2.2%	5.6% - 14.3%	7.6%	N/A	N/A
BCBS NE	12.8%	$38,282,494	2.7%	7.5% - 18.0%	6.1%	N/A	N/A
BCBS AZ	7.3%	$23,730,180	1.4%	4.5% - 10.1%	5.6%	N/A	N/A
COSVI PR/VI	11.9%	$18,899,869	2.1%	7.8% - 16.0%	4.9%	N/A	N/A
BCBS MT	6.8%	$15,619,297	1.7%	3.5% - 10.1%	6.0%	N/A	N/A
BCBS WY	14.7%	$12,201,445	2.8%	9.2% - 20.2%	13.3%	N/A	N/A
All FI Clusters	15.7%	$13,087,302,914	0.7%	14.3% - 17.2%	11.0%	N/A	N/A

Paid/Allowed Claims Error Rate: This is the percentage of dollars that FIs erroneously paid and is a good indicator of how accurately each FI paid claims.

Provider Compliance Error Rate: These rates will be available in the FY 2005 report.

Services Processed Error Rate: These rates will be available in the FY 2005 report.

There is no services processed error rate column in this chart since the services processed error rate is only caclulated as a gross error rate.

QIO-Specific Error Rates

Table 11a: Gross Error Rates: QIOs

States	Paid/Allowed Claims Error Rates					Provider Compliance Error Rates		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
California	7.4%	$553,090,198	1.7%	4.0% - 10.8%	N/A	N/A	N/A	N/A	N/A
Texas	6.8%	$381,706,664	0.9%	5.0% - 8.6%	N/A	N/A	N/A	N/A	N/A
Florida	6.4%	$367,190,426	0.9%	4.6% - 8.2%	N/A	N/A	N/A	N/A	N/A
Pennsylvania	4.9%	$211,932,447	0.6%	3.6% - 6.1%	N/A	N/A	N/A	N/A	N/A
New York	3.2%	$211,085,564	0.5%	2.2% - 4.3%	N/A	N/A	N/A	N/A	N/A
Massachusetts	8.7%	$186,926,036	0.9%	6.9% -10.5%	N/A	N/A	N/A	N/A	N/A
Illinois	4.6%	$177,467,523	0.7%	3.2% - 5.9%	N/A	N/A	N/A	N/A	N/A
Michigan	4.8%	$167,528,022	0.7%	3.5% - 6.1%	N/A	N/A	N/A	N/A	N/A
Kentucky	9.3%	$137,858,598	1.1%	7.2% -11.5%	N/A	N/A	N/A	N/A	N/A
New Jersey	3.4%	$122,435,373	0.6%	2.3% - 4.5%	N/A	N/A	N/A	N/A	N/A
Ohio	3.2%	$112,075,691	0.6%	2.0% - 4.4%	N/A	N/A	N/A	N/A	N/A
South Carolina	6.7%	$93,227,477	1.1%	4.6% - 8.7%	N/A	N/A	N/A	N/A	N/A
Louisiana	6.5%	$91,331,155	0.9%	4.7% - 8.4%	N/A	N/A	N/A	N/A	N/A
North Carolina	3.0%	$81,305,135	0.5%	2.0% - 4.0%	N/A	N/A	N/A	N/A	N/A
Virginia	4.0%	$76,666,058	0.7%	2.5% - 5.4%	N/A	N/A	N/A	N/A	N/A
Indiana	4.1%	$73,798,649	0.7%	2.8% - 5.4%	N/A	N/A	N/A	N/A	N/A
Tennessee	3.1%	$66,217,535	0.6%	2.0% - 4.3%	N/A	N/A	N/A	N/A	N/A
Maryland	3.0%	$66,058,560	0.6%	1.8% - 4.3%	N/A	N/A	N/A	N/A	N/A
Alabama	4.1%	$65,241,423	0.6%	3.0% - 5.2%	N/A	N/A	N/A	N/A	N/A
Georgia	3.0%	$62,015,611	0.5%	2.0% - 4.0%	N/A	N/A	N/A	N/A	N/A
Arizona	5.3%	$56,650,194	0.8%	3.9% - 6.8%	N/A	N/A	N/A	N/A	N/A
Connecticut	4.0%	$50,858,533	0.7%	2.6% - 5.4%	N/A	N/A	N/A	N/A	N/A
Arkansas	5.9%	$50,549,884	0.6%	4.6% - 7.2%	N/A	N/A	N/A	N/A	N/A
Mississippi	4.9%	$44,842,669	1.0%	3.0% - 6.8%	N/A	N/A	N/A	N/A	N/A
Oklahoma	4.4%	$42,676,032	0.7%	3.1% - 5.8%	N/A	N/A	N/A	N/A	N/A
Minnesota	3.0%	$42,035,131	0.5%	2.0% - 4.0%	N/A	N/A	N/A	N/A	N/A
West Virginia	5.1%	$37,033,484	0.8%	3.5% - 6.8%	N/A	N/A	N/A	N/A	N/A
Missouri	1.8%	$35,272,982	0.4%	1.1% - 2.6%	N/A	N/A	N/A	N/A	N/A
Washington	2.7%	$33,857,301	0.5%	1.7% - 3.7%	N/A	N/A	N/A	N/A	N/A
Kansas	4.3%	$32,560,580	0.9%	2.6% - 6.1%	N/A	N/A	N/A	N/A	N/A
Iowa	3.9%	$32,099,880	0.6%	2.7% - 5.2%	N/A	N/A	N/A	N/A	N/A
Wisconsin	2.0%	$31,254,626	0.4%	1.3% - 2.8%	N/A	N/A	N/A	N/A	N/A
Colorado	4.1%	$29,804,203	0.7%	2.8% - 5.5%	N/A	N/A	N/A	N/A	N/A
Oregon	4.1%	$28,927,103	0.6%	2.9% - 5.3%	N/A	N/A	N/A	N/A	N/A
Puerto Rico	6.9%	$26,064,900	1.0%	5.0% - 8.7%	N/A	N/A	N/A	N/A	N/A
New Mexico	8.0%	$25,948,023	0.8%	6.3% - 9.6%	N/A	N/A	N/A	N/A	N/A
Nevada	5.8%	$23,046,478	0.7%	4.3% - 7.2%	N/A	N/A	N/A	N/A	N/A
Utah	5.1%	$20,015,374	0.8%	3.6% - 6.6%	N/A	N/A	N/A	N/A	N/A
Maine	4.7%	$19,844,122	0.7%	3.4% - 6.1%	N/A	N/A	N/A	N/A	N/A
Rhode Island	5.2%	$14,191,948	0.8%	3.7% - 6.7%	N/A	N/A	N/A	N/A	N/A
Delaware	4.6%	$12,495,166	0.7%	3.2% - 6.0%	N/A	N/A	N/A	N/A	N/A
New Hampshire	3.7%	$12,175,321	0.6%	2.5% - 4.9%	N/A	N/A	N/A	N/A	N/A
South Dakota	4.5%	$10,520,928	0.7%	3.2% - 5.8%	N/A	N/A	N/A	N/A	N/A
District of Columbia	2.1%	$8,054,654	0.4%	1.4% - 2.8%	N/A	N/A	N/A	N/A	N/A
Idaho	3.3%	$7,689,352	0.5%	2.2% - 4.3%	N/A	N/A	N/A	N/A	N/A
Nebraska	1.4%	$7,275,925	0.4%	0.7% - 2.2%	N/A	N/A	N/A	N/A	N/A
Vermont	3.6%	$5,813,336	0.6%	2.5% - 4.7%	N/A	N/A	N/A	N/A	N/A
North Dakota	2.4%	$5,096,251	0.4%	1.6% - 3.2%	N/A	N/A	N/A	N/A	N/A
Alaska	4.1%	$4,150,208	0.6%	2.8% - 5.3%	N/A	N/A	N/A	N/A	N/A

States	Paid/Allowed Claims Error Rates					Provider Compliance Error Rates		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Montana	1.6%	$3,792,688	0.5%	0.7% - 2.4%	N/A	N/A	N/A	N/A	N/A
Hawaii	1.5%	$3,095,080	0.3%	0.8% - 2.1%	N/A	N/A	N/A	N/A	N/A
Wyoming	1.6%	$1,518,792	0.4%	0.8% - 2.4%	N/A	N/A	N/A	N/A	N/A
Nationwide	4.8%	$4,064,369,293	0.2%	4.4% - 5.2%	N/A	N/A	N/A	N/A	N/A

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Paid/Allowed Claims Error Rate: This is the percentage of dollars that QIOs erroneously allowed to be paid.

Table 11b: Net Error Rates: QIOs

States	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate	
	Including Non-Response Claims	Projected Improper Payment Amount Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
California	4.6%	$345,818,061	1.7%	1.2% - 8.0%	N/A	N/A	N/A
Florida	5.1%	$290,535,982	0.9%	3.2% - 6.9%	N/A	N/A	N/A
Texas	4.2%	$234,091,761	1.0%	2.3% - 6.0%	N/A	N/A	N/A
Massachusetts	8.6%	$183,673,991	0.9%	6.8% -10.4%	N/A	N/A	N/A
Illinois	4.4%	$170,035,027	0.7%	3.0% - 5.7%	N/A	N/A	N/A
New York	2.6%	$169,590,660	0.6%	1.5% - 3.7%	N/A	N/A	N/A
Kentucky	9.3%	$137,858,598	1.1%	7.2% -11.5%	N/A	N/A	N/A
Michigan	3.9%	$135,235,007	0.7%	2.5% - 5.2%	N/A	N/A	N/A
Ohio	3.2%	$111,026,699	0.6%	2.0% - 4.4%	N/A	N/A	N/A
Pennsylvania	2.5%	$107,271,067	0.7%	1.2% - 3.8%	N/A	N/A	N/A
New Jersey	2.9%	$104,266,575	0.6%	1.8% - 4.0%	N/A	N/A	N/A
Louisiana	5.8%	$80,521,615	0.9%	3.9% - 7.6%	N/A	N/A	N/A
South Carolina	5.4%	$76,058,336	1.1%	3.3% - 7.5%	N/A	N/A	N/A
Indiana	4.1%	$73,170,814	0.7%	2.7% - 5.4%	N/A	N/A	N/A
Virginia	3.5%	$67,669,309	0.7%	2.1% - 5.0%	N/A	N/A	N/A
Maryland	3.0%	$62,015,611	0.5%	2.0% - 4.0%	N/A	N/A	N/A
North Carolina	2.1%	$57,124,693	0.5%	1.1% - 3.1%	N/A	N/A	N/A
Alabama	3.2%	$51,324,209	0.6%	2.1% - 4.4%	N/A	N/A	N/A
Georgia	2.1%	$46,520,538	0.7%	0.9% - 3.4%	N/A	N/A	N/A
Connecticut	3.2%	$41,448,637	0.7%	1.8% - 4.7%	N/A	N/A	N/A
Arkansas	4.5%	$38,301,517	0.7%	3.2% - 5.8%	N/A	N/A	N/A
Tennessee	1.7%	$35,589,733	0.6%	0.6% - 2.8%	N/A	N/A	N/A
Oklahoma	3.5%	$33,766,182	0.7%	2.2% - 4.9%	N/A	N/A	N/A
West Virginia	4.4%	$32,077,866	0.8%	2.8% - 6.1%	N/A	N/A	N/A
Iowa	3.6%	$29,239,066	0.6%	2.3% - 4.9%	N/A	N/A	N/A
Washington	2.1%	$26,327,311	0.5%	1.1% - 3.1%	N/A	N/A	N/A
Arizona	2.4%	$25,953,324	0.8%	0.9% - 4.0%	N/A	N/A	N/A
Kansas	2.8%	$21,346,720	0.9%	1.1% - 4.6%	N/A	N/A	N/A
Missouri	1.1%	$21,292,383	0.4%	0.4% - 1.8%	N/A	N/A	N/A
New Mexico	6.1%	$19,800,114	0.9%	4.4% - 7.7%	N/A	N/A	N/A
Maine	4.6%	$19,218,885	0.7%	3.2% - 5.9%	N/A	N/A	N/A
Nevada	4.6%	$18,530,547	0.8%	3.1% - 6.1%	N/A	N/A	N/A
Puerto Rico	4.8%	$18,069,608	1.0%	2.8% - 6.7%	N/A	N/A	N/A
Oregon	2.5%	$17,246,626	0.6%	1.2% - 3.7%	N/A	N/A	N/A
Wisconsin	1.0%	$15,755,190	0.4%	0.3% - 1.8%	N/A	N/A	N/A
Utah	3.8%	$14,802,053	0.8%	2.3% - 5.3%	N/A	N/A	N/A
Minnesota	1.0%	$14,128,604	0.5%	0.0% - 2.1%	N/A	N/A	N/A
Delaware	4.2%	$11,415,592	0.7%	2.8% - 5.6%	N/A	N/A	N/A
Rhode Island	4.2%	$11,336,001	0.8%	2.6% - 5.7%	N/A	N/A	N/A
New Hampshire	3.4%	$11,159,593	0.6%	2.2% - 4.6%	N/A	N/A	N/A
Mississippi	1.2%	$10,617,505	1.0%	(0.7%) - 3.1%	N/A	N/A	N/A
Colorado	1.3%	$9,141,169	0.7%	(0.1%) - 2.7%	N/A	N/A	N/A
South Dakota	3.8%	$8,845,918	0.7%	2.5% - 5.1%	N/A	N/A	N/A
Nebraska	1.4%	$7,004,919	0.4%	0.6% - 2.1%	N/A	N/A	N/A
Idaho	2.6%	$6,167,158	0.6%	1.5% - 3.7%	N/A	N/A	N/A
Vermont	3.3%	$5,435,123	0.6%	2.2% - 4.4%	N/A	N/A	N/A
District of Columbia	1.3%	$5,112,968	0.4%	0.6% - 2.0%	N/A	N/A	N/A
North Dakota	2.0%	$4,324,930	0.4%	1.2% - 2.8%	N/A	N/A	N/A
Alaska	3.5%	$3,534,476	0.7%	2.2% - 4.7%	N/A	N/A	N/A
Montana	0.7%	$1,588,198	0.5%	(0.2%) - 1.5%	N/A	N/A	N/A
Wyoming	1.1%	$1,098,497	0.4%	0.4% - 1.9%	N/A	N/A	N/A
Hawaii	0.5%	$1,015,054	0.3%	(0.2%) - 1.1%	N/A	N/A	N/A
Nationwide	3.6%	$3,044,500,020	0.2%	3.2% - 4.0%	N/A	N/A	N/A

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Most of the QIOs (60%) allowed FIs to make more improper payments in 2004 than in 2003. For example, in FY 2003, the QIO for California allowed $253 million in projected net improper payments. In FY 2004, this QIO allowed $346 million in projected net improper payments.

There is no services processed error rate column in this chart since the services processed error rate is only caclulated as a gross error rate.

Paid/Allowed Claims Error Rate: This is the percentage of dollars that QIOs erroneously allowed to be paid.

There is no services processed error rate column in this chart since the services processed error rate is only caclulated as a gross error rate.

Paid Claims Error Rates by Service Type

Table 12 displays the paid claims error rate by service type for FY 2004 by contractor type. The table is sorted by projected improper payments from highest to lowest.

Table 12a: Paid Claims Error Rates by Service Type: Carriers

	Paid/Allowed Claims Error Rate					
Service Types Billed to Carriers (BETOS)	Including Non-Response Claims	Number of Line Items (Sample)	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims
Hospital visit – subsequent	30.6%	5,160	$1,516,074,181	1.4%	27.8% - 33.4%	24.3%
Consultations	21.7%	2,039	$792,286,523	1.2%	19.4% - 24.0%	18.4%
Office visits – established	7.2%	14,242	$775,452,753	0.3%	6.5% - 7.8%	4.9%
Hospital visit – initial	32.5%	778	$473,432,419	1.9%	28.7% - 36.4%	26.8%
Minor procedures - other (Medicare fee schedule)	17.8%	4,668	$422,326,883	2.2%	13.5% - 22.1%	15.8%
Other drugs	6.9%	1,870	$284,388,962	1.5%	4.0% - 9.8%	5.3%
Chemotherapy	6.9%	376	$251,643,897	3.3%	0.4% - 13.4%	5.7%
Hospital visit - critical care	34.2%	211	$228,905,956	7.0%	20.5% - 47.9%	28.6%
Office visits – new	18.5%	1,010	$224,017,352	1.6%	15.3% - 21.6%	14.9%
Nursing home visit	18.3%	1,510	$217,032,108	1.5%	15.4% - 21.3%	11.5%
Oncology - radiation therapy	17.5%	555	$182,968,721	4.6%	8.5% - 26.5%	12.3%
Emergency room visit	11.5%	1,257	$182,684,654	1.3%	9.0% - 14.1%	5.3%
Anesthesia	11.0%	750	$150,714,456	1.6%	7.9% - 14.2%	7.2%
Lab tests - other (non-Medicare fee schedule)	7.2%	9,608	$134,902,632	0.7%	5.8% - 8.6%	3.9%
Specialist – pathology	11.3%	1,013	$127,193,301	1.7%	8.1% - 14.6%	5.9%
Major procedure, cardiovascular-Other	9.9%	363	$126,828,714	4.4%	1.3% - 18.4%	9.2%
Other tests – other	11.6%	1,398	$123,531,120	2.8%	6.1% - 17.0%	6.9%
Ambulance	3.7%	1,879	$122,764,054	0.9%	1.9% - 5.5%	2.7%
Dialysis services (Non MFS)	19.6%	149	$107,531,209	3.8%	12.1% - 27.1%	13.4%
Ambulatory procedures - other	14.4%	451	$91,094,707	4.7%	5.1% - 23.7%	9.6%
Major procedure, cardiovascular-CABG	12.7%	39	$88,864,582	11.8%	(10.4%) - 35.8%	12.7%
All Codes Less Than 30 Lines	4.1%	311	$84,164,047	2.6%	(0.9%) - 9.1%	2.1%
Eye procedure - cataract removal/lens insertion	4.0%	222	$83,143,599	1.6%	0.9% - 7.1%	1.9%
Specialist – psychiatry	8.2%	1,441	$82,757,097	2.5%	3.3% - 13.0%	6.4%
Dialysis services	26.0%	255	$79,609,898	6.3%	13.7% - 38.3%	16.8%
BETOS code not specified	28.1%	195	$77,864,671	18.2%	(7.6%) - 63.7%	26.9%
Chiropractic	12.2%	1,391	$74,801,542	1.7%	8.8% - 15.6%	10.7%
Standard imaging – musculoskeletal	9.7%	2,038	$74,128,507	1.5%	6.9% - 12.6%	5.3%
Standard imaging - nuclear medicine	4.1%	892	$73,746,822	1.8%	0.7% - 7.6%	1.7%
Other tests – electrocardiograms	15.9%	2,263	$72,101,962	1.3%	13.4% - 18.3%	10.2%
Advanced imaging - CAT: other	5.8%	896	$72,068,161	1.7%	2.4% - 9.2%	3.8%
Minor procedures – musculoskeletal	9.7%	635	$71,955,762	2.3%	5.2% - 14.2%	5.1%
Specialist – ophthalmology	3.3%	2,307	$68,434,559	0.8%	1.8% - 4.8%	1.3%
Eye procedure – other	8.3%	169	$67,382,440	4.2%	0.1% - 16.5%	3.0%
Major procedure – Other	6.6%	207	$66,643,660	3.3%	0.2% - 13.0%	6.0%
Major procedure, cardiovascular-Coronary angioplasty	21.6%	31	$60,563,949	10.2%	1.6% - 41.5%	0.0%
Echography – heart	4.0%	1,440	$54,715,453	0.9%	2.3% - 5.7%	1.7%
Minor procedures – skin	3.6%	1,211	$46,635,928	0.8%	2.0% - 5.2%	1.9%
Standard imaging – chest	10.6%	2,428	$45,195,044	1.0%	8.6% - 12.6%	5.1%
Specialist – other	21.3%	253	$42,324,986	4.2%	13.2% - 29.5%	18.0%
Advanced imaging - MRI: brain	7.6%	139	$42,175,101	3.6%	0.7% - 14.6%	5.5%

Service Types Billed to Carriers (BETOS)	Paid/Allowed Claims Error Rate					
	Including Non-Response Claims	Number of Line Items (Sample)	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims
Advanced imaging - MRI: other	4.4%	212	$38,858,650	1.9%	0.7% - 8.2%	2.7%
Advanced imaging - CAT: head	15.1%	293	$35,053,280	4.7%	5.8% - 24.4%	6.2%
Echography – other	8.6%	335	$30,915,878	3.1%	2.5% - 14.7%	6.4%
Echography - abdomen/pelvis	12.5%	314	$27,344,565	3.4%	5.8% - 19.1%	8.2%
Standard imaging – other	8.7%	714	$27,258,158	2.8%	3.2% - 14.2%	3.1%
Other tests - cardiovascular stress tests	8.3%	395	$26,799,392	2.1%	4.3% - 12.4%	3.8%
Major procedure, orthopedic – other	3.2%	79	$24,624,069	2.3%	(1.3%) - 7.7%	0.0%
Other - Medicare fee schedule	18.6%	187	$24,218,916	4.7%	9.4% - 27.9%	12.0%
Other tests - EKG monitoring	12.4%	122	$24,174,249	4.7%	3.1% - 21.7%	9.2%
Ambulatory procedures – skin	1.6%	1,368	$24,101,867	0.5%	0.7% - 2.6%	0.7%
Standard imaging – breast	6.0%	564	$24,087,494	1.5%	3.0% - 9.0%	2.2%
Imaging/procedure – other	4.2%	407	$23,868,792	1.6%	1.0% - 7.4%	2.7%
Standard imaging - contrast gastrointestinal	19.5%	131	$23,329,178	7.4%	5.1% - 34.0%	11.2%
Oncology – other	7.7%	356	$22,993,798	2.2%	3.4% - 12.0%	6.8%
Echography - carotid arteries	7.2%	228	$21,789,021	3.4%	0.6% - 13.8%	1.0%
Lab tests - blood counts	6.9%	2,099	$21,222,325	0.7%	5.4% - 8.3%	3.8%
Endoscopy – cystoscopy	5.1%	131	$20,941,058	3.0%	(0.8%) - 10.9%	3.6%
Endoscopy - upper gastrointestinal	3.6%	222	$19,648,860	1.8%	0.1% - 7.1%	1.7%
Endoscopy – colonoscopy	1.5%	311	$17,057,474	0.6%	0.3% - 2.6%	0.4%
Lab tests - automated general profiles	4.5%	2,084	$15,572,214	0.6%	3.3% - 5.8%	2.7%
Ambulatory procedures - musculoskeletal	2.8%	85	$15,334,873	2.9%	(2.9%) - 8.6%	0.0%
Imaging/procedure - heart including cardiac catheter	8.3%	336	$14,851,144	2.9%	2.5% - 14.1%	5.8%
Lab tests - routine venipuncture (non Medicare fee	7.0%	4,003	$12,302,733	0.5%	5.9% - 8.0%	3.9%
Endoscopy – laryngoscopy	13.5%	42	$9,342,303	6.5%	0.7% - 26.3%	6.1%
Echography – eye	6.9%	147	$8,951,425	3.6%	(0.1%) - 13.9%	4.3%
Lab tests – urinalysis	10.8%	1,306	$8,408,048	1.2%	8.4% - 13.2%	8.4%
Lab tests - bacterial cultures	9.4%	377	$5,918,854	2.5%	4.5% - 14.3%	7.3%
Lab tests - other (Medicare fee schedule)	2.5%	290	$5,778,490	1.3%	(0.0%) - 5.0%	1.4%
Immunizations/Vaccinations	2.2%	1,980	$4,925,265	0.6%	1.0% - 3.5%	1.0%
Minor procedures - other (non-Medicare fee schedule	12.3%	32	$2,613,903	7.8%	(3.0%) - 27.6%	0.0%
Medical/surgical supplies	42.3%	90	$2,103,738	15.4%	12.2% - 72.4%	37.1%
Other - non-Medicare fee schedule	3.3%	374	$1,456,206	1.3%	0.7% - 5.9%	2.3%
Eye procedure – treatment	0.4%	35	$1,106,091	0.1%	0.3% - 0.5%	0.4%
Lab tests – glucose	3.8%	449	$862,007	1.3%	1.4% - 6.3%	2.6%
Endoscopy – arthroscopy	0.0%	33	$85,038	0.0%	(0.0%) - 0.1%	0.0%
Endoscopy – other	0.0%	47	$0	0.0%	0.0% - 0.0%	0.0%
Home visit	(3.3%)	145	($5,517,023)	12.1%	(27.1%) - 20.5%	(9.6%)
All Types of Service Billed to Carriers (Incl. Codes Not Listed)	10.7%	88,373	$8,547,434,706	0.4%	10.0% - 11.4%	7.6%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 12b: Paid Claims Error Rates by Service Type: DMERCs

Service Types Billed to DMERCS (SADMERC Policy Group)	Paid/Allowed Claims Error Rate					
	Including Non-Response Claims	Number of Line Items (Sample)	Projected Improper Payment Amount Including Non-Response*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims
Glucose Monitor	18.0%	2,333	$176,499,988	1.5%	15.0% - 20.9%	15.9%
Wheelchairs	8.7%	1,237	$127,361,963	5.5%	(2.2%) - 19.5%	2.9%
Nebulizers & Related Drugs	9.9%	2,628	$115,979,224	1.4%	7.2% - 12.5%	7.1%
Lower Limb Prostheses	21.6%	119	$110,309,801	18.9%	(15.4%) - 58.7%	0.0%
Oxygen Supplies/Equipment	4.3%	2,540	$96,714,879	0.6%	3.1% - 5.6%	3.0%
Immunosuppressive Drugs	27.1%	114	$72,547,064	8.1%	11.1% - 43.0%	21.3%
Lower Limb Orthoses	25.2%	177	$72,145,209	9.0%	7.5% - 42.9%	6.4%
Spinal Orthoses	58.5%	44	$63,672,968	13.9%	31.3% - 85.8%	0.2%
Enteral Nutrition	9.5%	519	$58,620,896	2.5%	4.7% - 14.3%	6.4%
All Codes Less Than 30 Lines	8.7%	176	$45,289,182	7.3%	(5.6%) - 23.0%	0.0%
Ostomy Supplies	26.2%	433	$36,144,493	7.7%	11.1% - 41.3%	16.4%
Support Surfaces	10.2%	123	$26,923,155	5.1%	0.2% - 20.1%	7.7%
Surgical Dressings	32.6%	141	$22,714,683	19.0%	(4.6%) - 69.8%	3.4%
Upper Limb Orthoses	41.5%	63	$21,716,384	16.2%	9.8% - 73.3%	15.9%
Parenteral Nutrition	5.9%	67	$18,704,352	5.1%	(4.0%) - 15.8%	4.5%
Urological Supplies	18.1%	259	$16,956,429	13.1%	(7.6%) - 43.8%	2.2%
CPAP	8.8%	400	$15,715,167	1.9%	5.2% - 12.5%	6.9%
Hospital Beds/Accessories	4.1%	437	$13,070,179	1.2%	1.7% - 6.4%	2.0%
Diabetic Shoes	8.1%	133	$10,336,059	4.1%	0.1% - 16.1%	7.0%
Lenses	6.4%	476	$6,678,522	2.0%	2.4% - 10.3%	3.7%
SADMERC Policy Group not specified	15.6%	51	$5,281,842	9.5%	(3.0%) - 34.3%	13.8%
Commodes/Bed Pans/Urinals	8.0%	117	$4,606,799	3.2%	1.7% - 14.3%	6.8%
Walkers	4.3%	165	$3,776,994	2.0%	0.5% - 8.2%	3.8%
Patient Lift	9.9%	52	$2,876,069	5.1%	(0.0%) - 19.8%	3.4%
Canes/Crutches	1.6%	55	$189,284	1.1%	(0.6%) - 3.9%	0.0%
Routinely Denied Items	0.0%	95	$0	0.0%	0.0% - 0.0%	0.0%
Infusion Pumps & Related Drugs	0.0%	85	$0	0.0%	0.0% - 0.0%	0.0%
Breast Prostheses	0.0%	59	$0	0.0%	0.0% - 0.0%	0.0%
Respiratory Assist Device	0.0%	58	$0	0.0%	0.0% - 0.0%	0.0%
Dialysis Supplies & Equipment	0.0%	41	$0	0.0%	0.0% - 0.0%	0.0%
Suction Pump	0.0%	36	$0	0.0%	0.0% - 0.0%	0.0%
Misc. Drugs	0.0%	35	$0	0.0%	0.0% - 0.0%	0.0%
Orthopedic Footwear	0.0%	34	$0	0.0%	0.0% - 0.0%	0.0%
Misc. DMEPOS	0.0%	32	$0	0.0%	0.0% - 0.0%	0.0%
All Types of Service Billed to DMERCs (Incl. Codes Not Listed)	11.1%	13,334	$1,144,831,584	1.5%	8.2% - 13.9%	5.7%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 12c: Paid Claims Error Rate by Service Type: FIs

Service Types Billed to FIs (Type of Bill)	Paid/Allowed Claims Error Rate					
	Including Non-Response Claims	Number of Line Items (Sample)	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims
SNF	25.5%	2,560	$5,571,698,214	1.9%	21.7% - 29.2%	23.50%
OPPS, Laboratory (Billing an FI), Ambulatory Bill	14.1%	43,752	$4,240,419,682	1.1%	12.0% - 16.2%	6.60%
Non-PPS Hospital In-patient	13.1%	2,419	$973,050,296	3.1%	6.9% - 19.3%	6.00%
ESRD	10.7%	1,227	$795,595,011	1.2%	8.3% - 13.0%	7.8%
HHA	9.8%	1,590	$752,900,587	1.1%	7.7% - 11.9%	5.0%
Hospice	8.4%	743	$436,350,347	1.3%	5.8% - 11.0%	6.1%
Other FI Service Types	10.3%	4,475	$257,467,854	1.3%	7.7% - 12.9%	6.3%
RHCs	5.0%	2,943	$28,445,982	0.6%	3.8% - 6.1%	1.6%
FQHC	9.0%	503	$27,003,612	1.4%	6.3% - 11.7%	2.7%
Free Standing Ambulatory Surgery	3.8%	79	$4,371,330	1.7%	0.4% - 7.2%	3.1%
All Service Types Billed to FIs (Incl. Codes Not Listed)	15.7%	60,291	$13,087,302,914	0.7%	14.3% - 17.2%	11.0%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 13 shows the service type with the highest error rate and improper payment amount for each contractor type.

Table 13: Paid/Allowed Claims Error Rate by Service Type

Contractor Type	Error Rate by Service Type	
	Service Type With the Highest Paid Claims Error Rate Including Non-Response Claims*	Service Type With the Highest Dollars Paid in Error*
Carriers	Medical/Surgical Supplies 42.3% ($2.1 M)	Hospital visit - Subsequent 30.6% ($1.5 B)
DMERCs	Spinal Orthoses 58.5% ($63.7 M)	Glucose Monitors 18.0% ($176.5 M)
FIs	SNF 25.5% ($5.6 B)	SNF 25.5% ($5.6 B)

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Paid Claims Error Rate by Error Type

Table 14 displays the paid claims error rates for each type of service by type of error.

Table 14a: Error Rates for Each Type of Service by Type of Error: Carriers

Service Type Billed to Carriers	Type of Error					
	Paid Claims Error Rate Including Non-Response Claims	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
Medical/surgical supplies	42.3%	8.3%	34.0%	0.0%	0.0%	0.0%
Hospital visit - critical care	34.2%	7.8%	20.1%	0.0%	6.2%	0.0%
Hospital visit - initial	32.5%	8.3%	12.5%	0.1%	11.7%	0.0%
Hospital visit - subsequent	30.6%	8.5%	19.2%	0.1%	2.8%	0.0%
BETOS code not specified	28.1%	1.5%	26.5%	0.2%	(0.1%)	0.0%
Dialysis services	26.0%	11.1%	14.9%	0.0%	0.0%	0.0%
Consultations	21.7%	4.1%	6.3%	0.0%	11.3%	0.0%
Major procedure, cardiovascular-Coronary angioplasty (PTCA)	21.6%	15.8%	5.8%	0.0%	0.0%	0.0%
Specialist - other	21.3%	4.1%	11.9%	0.9%	2.9%	1.6%
Dialysis services (Non MFS)	19.6%	7.1%	11.5%	0.0%	1.0%	0.0%
Standard imaging - contrast gastrointestinal	19.5%	9.3%	9.2%	0.0%	0.0%	1.1%
Other - Medicare fee schedule	18.7%	7.5%	11.6%	0.0%	(0.4%)	0.0%
Office visits - new	18.5%	4.2%	2.8%	0.1%	11.4%	0.0%
Nursing home visit	18.3%	7.8%	7.0%	0.1%	3.4%	0.1%
Minor procedures - other (Medicare fee schedule)	17.8%	2.5%	10.6%	1.5%	3.2%	0.1%
Oncology - radiation therapy	17.5%	6.1%	11.4%	0.0%	0.1%	0.0%
Other tests - electrocardiograms	15.9%	6.4%	9.4%	0.0%	0.1%	0.0%
Advanced imaging - CAT: head	15.1%	9.5%	5.4%	0.0%	0.3%	0.0%
Ambulatory procedures - other	14.4%	5.3%	5.3%	3.3%	0.0%	0.4%
Endoscopy - laryngoscopy	13.5%	7.9%	5.6%	0.0%	0.0%	0.0%
Major procedure, cardiovascular-CABG	12.7%	0.0%	11.6%	0.0%	1.2%	0.0%
Echography - abdomen/pelvis	12.5%	4.6%	6.1%	0.0%	1.7%	0.0%
Other tests - EKG monitoring	12.4%	3.6%	7.6%	0.0%	2.1%	(0.9%)
Minor procedures - other (non-Medicare fee schedule)	12.3%	10.1%	2.3%	0.0%	0.0%	0.0%
Chiropractic	12.2%	1.8%	6.2%	3.8%	0.5%	0.0%
Other tests - other	11.6%	5.0%	5.5%	0.4%	0.5%	0.2%
Emergency room visit	11.5%	6.5%	1.8%	0.0%	3.2%	0.0%
Specialist - pathology	11.4%	5.8%	5.0%	0.0%	0.5%	0.0%
Anesthesia	11.0%	4.2%	6.7%	0.0%	0.2%	0.0%
Lab tests - urinalysis	10.8%	2.7%	7.8%	0.2%	0.2%	0.0%
Standard imaging - chest	10.6%	5.8%	4.2%	0.3%	0.2%	0.1%
Major procedure, cardiovascular-Other	9.9%	0.7%	9.2%	0.0%	0.0%	0.0%
Standard imaging - musculoskeletal	9.7%	4.7%	4.8%	0.0%	0.1%	0.1%
Minor procedures - musculoskeletal	9.7%	4.9%	4.6%	0.0%	0.2%	0.0%
Lab tests - bacterial cultures	9.4%	2.3%	6.8%	0.3%	0.0%	0.0%
Standard imaging - other	8.7%	5.8%	2.0%	0.3%	0.1%	0.6%
Echography - other	8.6%	2.3%	3.5%	2.0%	0.8%	0.0%
Other tests - cardiovascular stress tests	8.3%	4.7%	3.3%	0.4%	0.0%	0.0%
Imaging/procedure - heart including	8.3%	2.7%	5.6%	0.0%	0.0%	0.0%

Service Type Billed to Carriers	Type of Error					
	Paid Claims Error Rate Including Non-Response Claims	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
cardiac catheter						
Eye procedure - other	8.3%	5.5%	2.8%	0.0%	0.0%	0.0%
Specialist - psychiatry	8.2%	1.9%	5.6%	0.0%	0.3%	0.4%
Oncology - other	7.7%	1.0%	5.8%	0.0%	0.9%	0.1%
Advanced imaging - MRI: brain	7.6%	2.2%	5.4%	0.0%	0.0%	0.0%
Echography - carotid arteries	7.2%	6.3%	1.2%	0.0%	0.0%	(0.2%)
Lab tests - other (non-Medicare fee schedule)	7.2%	3.4%	2.6%	1.0%	0.1%	0.1%
Office visits - established	7.2%	2.4%	2.4%	0.1%	2.3%	0.1%
Lab tests - routine venipuncture (non Medicare fee schedule)	7.0%	3.2%	3.3%	0.4%	0.0%	0.1%
Echography - eye	6.9%	2.7%	4.2%	0.0%	0.0%	0.0%
Chemotherapy	6.9%	1.2%	2.6%	0.0%	3.1%	0.0%
Other drugs	6.9%	1.7%	4.9%	0.3%	0.0%	0.0%
Lab tests - blood counts	6.9%	3.2%	3.3%	0.2%	0.2%	0.0%
Major procedure - Other	6.6%	0.9%	5.7%	0.0%	0.0%	0.0%
Standard imaging - breast	6.0%	3.9%	2.1%	0.0%	0.0%	0.0%
Advanced imaging - CAT: other	5.8%	2.1%	3.3%	0.0%	0.4%	0.0%
Endoscopy - cystoscopy	5.1%	1.6%	3.5%	0.0%	0.0%	0.0%
Lab tests - automated general profiles	4.5%	1.9%	2.5%	0.0%	0.1%	0.0%
Advanced imaging - MRI: other	4.4%	1.7%	1.5%	0.1%	1.3%	(0.1%)
Imaging/procedure - other	4.2%	1.6%	2.2%	0.0%	0.4%	0.0%
Standard imaging - nuclear medicine	4.1%	2.5%	1.7%	0.0%	0.0%	0.0%
Eye procedure - cataract removal/lens insertion	4.0%	2.1%	1.6%	0.3%	0.0%	0.0%
Echography - heart	4.0%	2.3%	1.7%	0.0%	0.0%	0.0%
Lab tests - glucose	3.9%	1.3%	2.2%	0.3%	0.1%	0.0%
Ambulance	3.7%	1.0%	1.0%	1.3%	0.3%	0.0%
Minor procedures - skin	3.6%	1.7%	1.3%	0.3%	0.1%	0.3%
Endoscopy - upper gastrointestinal	3.6%	1.9%	1.5%	0.0%	0.0%	0.3%
Other - non-Medicare fee schedule	3.3%	1.1%	1.2%	1.0%	0.0%	0.0%
Specialist - ophthalmology	3.3%	2.1%	0.9%	0.0%	0.3%	0.0%
Major procedure, orthopedic - other	3.2%	3.2%	0.0%	0.0%	0.0%	0.0%
Ambulatory procedures - musculoskeletal	2.8%	2.8%	0.0%	0.0%	0.0%	0.0%
Lab tests - other (Medicare fee schedule)	2.5%	1.1%	1.3%	0.0%	0.0%	0.0%
Immunizations/Vaccinations	2.2%	1.2%	0.7%	0.2%	0.1%	0.1%
Ambulatory procedures - skin	1.6%	0.9%	0.4%	0.1%	0.2%	0.0%
Endoscopy - colonoscopy	1.5%	1.2%	0.1%	0.0%	0.3%	0.0%
Eye procedure - treatment	0.4%	0.0%	0.0%	0.0%	0.4%	0.0%
Endoscopy - arthroscopy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Endoscopy - other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Home visit	(3.3%)	5.8%	3.7%	0.0%	(12.7%)	0.0%

Table 14b: Error Rates for Each Type of Service by Type of Error: DMERCS

Service Type Billed to DMERCs	Type of Error					
	Paid Claims Error Rate Including Non-Response Claims	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
Spinal Orthoses	58.5%	58.4%	0.1%	0.0%	0.0%	0.0%
Upper Limb Orthoses	41.5%	30.5%	0.0%	0.5%	10.6%	0.0%
Surgical Dressings	32.6%	30.2%	1.6%	0.7%	0.1%	0.0%
Immunosuppressive Drugs	27.1%	7.4%	9.4%	9.2%	1.1%	0.0%
Ostomy Supplies	26.2%	11.7%	8.3%	6.2%	0.0%	0.0%
Lower Limb Orthoses	25.2%	20.1%	1.1%	3.0%	1.1%	0.0%
Lower Limb Prostheses	21.6%	21.6%	0.0%	0.0%	0.0%	0.0%
Urological Supplies	18.1%	16.2%	0.0%	1.8%	0.1%	0.0%
Glucose Monitor	18.0%	2.5%	4.1%	10.6%	0.5%	0.3%
SADMERC Policy Group not specified	15.6%	2.1%	8.5%	0.0%	5.0%	0.0%
Support Surfaces	10.2%	2.6%	3.6%	3.9%	0.0%	0.0%
Patient Lift	9.9%	6.7%	0.0%	3.2%	0.0%	0.0%
Nebulizers & Related Drugs	9.9%	3.0%	2.3%	4.2%	0.4%	0.0%
Enteral Nutrition	9.5%	3.3%	2.4%	4.0%	(0.1%)	0.0%
CPAP	8.8%	2.0%	1.0%	5.8%	0.0%	0.0%
Wheelchairs	8.7%	6.0%	0.2%	2.5%	0.0%	0.0%
Diabetic Shoes	8.1%	1.2%	7.0%	0.0%	0.0%	0.0%
Commodes/Bed Pans/Urinals	8.0%	1.3%	1.9%	4.8%	0.0%	0.0%
Lenses	6.4%	2.8%	2.2%	0.8%	0.6%	0.0%
Parenteral Nutrition	5.9%	1.5%	0.0%	4.4%	0.0%	0.0%
Oxygen Supplies/Equipment	4.4%	1.4%	1.1%	1.9%	0.0%	0.0%
Walkers	4.3%	0.6%	0.2%	3.3%	0.3%	0.0%
Hospital Beds/Accessories	4.1%	2.1%	0.8%	1.2%	0.0%	0.0%
Canes/Crutches	1.6%	1.6%	0.0%	0.0%	0.0%	0.0%

Table 14c: Error Rates for Each Type of Service by Type of Error: FIs

Service Type Billed to FIs	Type of Error					
	Paid Claims Error Rate Including Non-Response Claims	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
SNF	25.5%	2.6%	20.7%	1.1%	1.0%	0.1%
OPPS, Laboratory (Billing an FI), Ambulatory (Billing an FI)	14.1%	8.2%	5.4%	0.2%	0.3%	0.1%
Non-PPS Hospital In-patient	13.1%	7.6%	5.1%	0.0%	0.5%	0.0%
ESRD	10.7%	3.1%	6.3%	0.0%	1.3%	0.0%
Other FI Service Types	10.3%	4.3%	5.1%	0.4%	0.3%	0.1%
HHA	9.8%	5.1%	3.8%	0.5%	0.3%	0.1%
FQHC	9.0%	6.5%	2.5%	0.0%	0.0%	0.0%
Hospice	8.4%	2.4%	4.2%	1.8%	0.0%	0.0%
RHCs	5.0%	3.4%	1.5%	0.0%	0.0%	0.1%
Free Standing Ambulatory Surgery	3.8%	0.8%	3.1%	0.0%	0.0%	0.0%

Error Rates by Provider Type

Table 15 presents the error rates by provider type. CMS did not display provider types for which there were less than 30 lines of service in the sample. The table includes the top provider types based on improper payments for providers that bill each type of contractor.

Table 15a: Error Rates by Provider Type: Carrier/DMERC/FI

	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
Providers Billing Carriers/ DMERCS/FIs	Including Non-Response Claims	Projected Improper Payment Amount Including Non-Response *	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
All	13.2%	$22,815,929,463	0.4%	12.4% - 13.9%	9.1%	24.0%	21.6%	12.7%	9.6%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 15b: Error Rates by Provider Type: Carriers

Provider Types Billing to Carriers	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payment Amount Including Non-Response *	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Internal Medicine	16.2%	$1,533,793,031	1.0%	14.3% - 18.0%	11.8%	26.3%	22.9%	16.7%	13.1%
Cardiology	13.9%	$989,904,353	1.4%	11.1% - 16.7%	10.7%	24.0%	21.5%	16.8%	12.4%
Family Practice	12.7%	$535,715,637	1.3%	10.2% - 15.2%	9.0%	25.1%	22.6%	13.9%	11.0%
Hematology/ Oncology	10.9%	$400,879,673	2.5%	5.9% - 15.8%	8.5%	22.3%	20.5%	11.7%	8.4%
Nephrology	23.2%	$350,658,282	2.9%	17.5% - 28.8%	16.3%	31.6%	26.1%	23.5%	17.8%
Urology	10.3%	$299,814,156	3.7%	3.0% - 17.6%	8.8%	21.6%	20.4%	12.0%	10.7%
Pulmonary Disease	20.2%	$292,125,432	2.8%	14.7% - 25.6%	11.4%	28.9%	22.0%	20.2%	14.3%
Orthopedic Surgery	7.4%	$253,812,844	1.6%	4.2% - 10.6%	4.6%	21.8%	19.6%	16.6%	14.0%
Diagnostic Radiology	5.4%	$242,974,127	0.7%	4.1% - 6.8%	2.3%	17.7%	15.2%	8.3%	3.5%
Ophthalmology	4.4%	$214,479,218	0.8%	2.8% - 6.0%	2.6%	16.5%	15.1%	5.8%	4.3%
Emergency Medicine	12.9%	$208,834,622	1.9%	9.2% - 16.5%	6.6%	23.4%	18.6%	15.5%	10.1%
Radiation Oncology	18.2%	$180,085,208	4.7%	9.0% - 27.4%	12.7%	30.6%	26.8%	18.2%	11.5%
Neurology	14.8%	$175,298,933	3.1%	8.6% - 20.9%	9.1%	33.9%	30.6%	19.0%	15.5%
Physical Therapist in Private Practice	17.5%	$171,444,221	2.4%	12.8% - 22.2%	16.3%	31.3%	30.5%	19.2%	17.9%
Gastroenterology	9.9%	$165,972,843	1.4%	7.2% - 12.5%	8.5%	29.3%	28.6%	18.5%	17.0%
Clinical Laboratory (Billing Independently)	6.5%	$161,669,377	0.7%	5.1% - 7.8%	3.5%	23.5%	21.5%	5.6%	3.0%
General Practice	15.6%	$156,293,486	2.9%	9.9% - 21.3%	9.8%	28.7%	24.4%	18.3%	14.3%
General Surgery	7.9%	$152,084,241	1.5%	5.0% - 10.8%	6.1%	26.8%	25.6%	16.6%	14.0%
Physical Medicine and Rehabilitation	24.2%	$151,962,717	3.1%	18.1% - 30.3%	19.5%	35.3%	31.9%	27.7%	24.2%
Psychiatry	15.7%	$137,932,447	2.4%	11.0% - 20.4%	10.2%	36.3%	32.9%	16.0%	11.0%
All Provider Types Billing to Carriers (including those not listed above)	10.7%	$8,547,434,706	0.4%	10.0% - 11.4%	7.6%	24.6%	22.3%	12.7%	9.5%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 15c: Error Rates by Provider Type: DMERCs

Provider Types Billing DMERCs	Paid/Allowed Claims Error Rates					Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
Pharmacy	11.0%	$425,886,738	1.0%	9.0% - 13.0%	8.7%	18.3%	16.2%	14.5%	12.5%
Medical supply company not included in 51, 52, or 53	8.2%	$327,293,349	2.2%	3.9% - 12.6%	3.8%	18.6%	15.1%	10.7%	8.1%
Individual orthotic personnel certified by an accredited organization	44.0%	$152,265,168	20.3%	4.2% - 83.8%	0.0%	44.7%	2.2%	22.3%	3.5%
Unknown Supplier/Provider	41.2%	$135,544,238	17.1%	7.6% - 74.8%	3.2%	47.0%	18.0%	27.0%	11.5%
Medical Supply Company with Respiratory Therapist	3.5%	$34,383,634	0.7%	2.1% - 4.9%	2.5%	13.9%	13.2%	6.5%	5.6%
Other Provider Types Billing to DMERC	23.9%	$14,784,751	4.9%	14.2% - 33.6%	17.0%	33.7%	28.5%	27.4%	23.5%
Medical supply company with prosthetic/ orthotic personnel	9.2%	$14,695,233	6.1%	(2.7%) - 21.1%	3.4%	14.9%	9.8%	16.0%	8.8%
Podiatry	22.2%	$12,533,737	10.5%	1.7% - 42.7%	20.1%	31.1%	29.4%	18.8%	17.0%
Nursing Facility, Other	18.1%	$11,088,861	12.1%	(5.5%) - 41.8%	18.1%	24.0%	24.0%	20.5%	20.5%
Individual prosthetic personnel certified by an accredited organization	3.1%	$5,137,288	2.6%	(2.0%) - 8.2%	3.1%	24.0%	24.0%	22.0%	22.0%
All Provider Types Billing Services to DMERCs (including Provider Types not listed above)	11.1%	$1,144,831,584	0.2%	10.6% - 11.5%	5.7%	19.7%	15.2%	12.4%	10.1%

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Table 15d: Error Rates by Provider Type: FIs

Provider Types Billing to FIs	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
SNF	25.5%	$5,571,698,214	1.9%	21.7% - 29.2%	23.5%	N/A	N/A	N/A	N/A
OPPS, Laboratory	14.1%	$4,240,419,682	1.1%	12.0% - 16.2%	6.6%	N/A	N/A	N/A	N/A

Provider Types Billing to FIs	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed Error Rate	
	Including Non-Response Claims	Projected Improper Payments Including Non-Response Claims*	Standard Error	95% Confidence Interval	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims	Including Non-Response Claims	Excluding Non-Response Claims
(Billing an FI), Ambulatory (Billing an FI)									
Non-PPS Hospital In-patient	13.1%	$973,050,296	3.1%	6.9% - 19.3%	6.0%	N/A	N/A	N/A	N/A
ESRD	10.7%	$795,595,011	1.2%	8.3% - 13.0%	7.8%	N/A	N/A	N/A	N/A
HHA	9.8%	$752,900,587	1.1%	7.7% - 11.9%	5.0%	N/A	N/A	N/A	N/A
Hospice	8.4%	$436,350,347	1.3%	5.8% - 11.0%	6.1%	N/A	N/A	N/A	N/A
Other FI Service Types	10.3%	$257,467,854	1.3%	7.7% - 12.9%	6.3%	N/A	N/A	N/A	N/A
RHCs	5.0%	$28,445,982	0.6%	3.8% - 6.1%	1.6%	N/A	N/A	N/A	N/A
FQHC	9.0%	$27,003,612	1.4%	6.3% - 11.7%	2.7%	N/A	N/A	N/A	N/A
Free Standing Ambulatory Surgery	3.8%	$4,371,330	1.7%	0.4% - 7.2%	3.1%	N/A	N/A	N/A	N/A
All Provider Types Billing to FIs (Including Provider Types not listed)	15.7%	$13,087,302,914	0.7%	14.3% - 17.2%	11.0%	N/A	N/A	N/A	N/A

* This data has not been adjusted to exclude beneficiary copayments, deductibles, and reductions to recover previous overpayments.

Error Rates by Type of Error by Cluster

Appendix C displays error rates for each type of provider by type of error. CMS did not display provider types for which there were less than 30 lines of service in the sample. Appendix D presents error rates by provider type and cluster.

Table 16 presents paid claims error rates by cluster and type of error. The table is sorted by paid claims error rate.

Table 16a: Error Rates for Each Cluster by Type of Error: Carrier/DMERC/FI

Services Billed to Carriers	Type of Error					
	Paid Claims Error Rate Including Non-Response	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
All	13.2%	4.5%	6.9%	0.6%	1.1%	0.1%

Table 16b: Error Rates for Each Cluster by Type of Error: Carriers

Carriers	Type of Error					
	Paid Claims Error Rate Including Non-Response	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
Triple S, Inc. PR/VI	17.9%	4.5%	7.9%	0.3%	5.0%	0.3%
GHI NY	14.3%	4.6%	6.0%	0.8%	3.3%	(0.3%)
TrailBlazer TX	14.1%	5.0%	6.3%	0.3%	2.5%	0.0%
BCBS RI	13.5%	6.4%	4.6%	0.1%	2.4%	0.1%
Palmetto SC	13.1%	3.6%	8.2%	0.3%	1.1%	0.0%
BCBS AR NM/OK/LA	12.7%	4.7%	6.3%	0.1%	1.6%	0.0%
WPS WI/IL/MI/MN	11.1%	4.3%	3.4%	0.2%	3.3%	0.0%
Cahaba GBA AL/GA/MS	11.1%	3.7%	5.9%	0.3%	1.2%	0.0%
CIGNA ID/TN/NC	11.0%	3.5%	5.8%	0.7%	1.0%	0.0%
NHIC CA	10.8%	3.2%	4.6%	0.4%	2.7%	0.0%
Empire NY/NJ	10.8%	3.0%	4.9%	0.2%	2.8%	0.0%
Noridian AZ/HI/NV/AK/OR/WA	10.7%	2.0%	7.1%	0.3%	1.2%	0.1%
Palmetto GBA OH/WV	10.7%	2.7%	6.3%	0.2%	1.4%	0.1%
BCBS AR AR/MO	10.6%	3.1%	6.2%	0.1%	1.3%	0.0%
BCBS UT	10.2%	3.4%	5.7%	0.3%	0.8%	0.0%
AdminaStar IN/KY	10.0%	3.9%	4.3%	0.0%	1.7%	0.0%
HGSA PA	9.7%	1.7%	6.5%	0.3%	1.2%	0.0%
First Coast Service Options FL	9.7%	3.4%	4.5%	0.1%	1.7%	0.0%
NHIC MA/ME/NH/VT	9.6%	3.8%	3.5%	0.1%	2.0%	0.2%
Noridian CO/ND/SD/WY/IA	9.5%	3.4%	4.8%	0.6%	0.7%	0.0%
TrailBlazer MD/DC/DE/VA	9.2%	3.9%	4.4%	0.2%	0.7%	0.0%
HealthNow NY	8.3%	2.9%	3.5%	0.5%	1.4%	0.0%
First Coast Service Options CT	7.6%	1.7%	3.8%	0.1%	1.9%	0.2%
BCBS KS KS/NE/Kansas City	6.9%	2.5%	3.4%	0.1%	0.7%	0.1%
BCBS MT	5.3%	0.6%	3.6%	0.3%	0.9%	0.0%
All Carrier Clusters	10.7%	3.4%	5.1%	0.3%	1.9%	0.0%

Table 16c: Error Rates for Each Cluster by Type of Error: DMERCs

DMERCs	Type of Error					
	Paid Claims Error Rate Including Non-Response	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
Palmetto-GBA-Region C	14.0%	9.9%	1.4%	2.6%	0.1%	0.1%
CIGNA-Region D	11.6%	2.8%	2.2%	5.9%	0.7%	0.0%
TriCenturion-Region A	7.3%	2.0%	2.7%	2.5%	0.1%	0.0%
AdminaStar Federal-Region B	6.6%	1.3%	1.7%	3.4%	0.2%	0.0%
ALL DMERC Clusters	11.1%	5.7%	1.7%	3.4%	0.2%	0.0%

Table 16d: Error Rates for Each Cluster by Type of Error: FIs

FIs	Type of Error					
	Paid Claims Error Rate Including Non-Response	Non-Response	Insufficient Documentation	Medically Unnecessary Services	Incorrect Coding	Other
Mutual of Omaha	26.8%	9.4%	16.7%	0.2%	0.5%	0.1%
BCBS AR	26.1%	16.0%	6.6%	1.6%	1.7%	0.1%
CareFirst MD/DC	25.3%	8.6%	12.6%	4.0%	0.2%	0.0%
First Coast Service Options FL	23.0%	7.4%	13.2%	2.3%	0.2%	0.0%
UGS CA/HI/AS/GU/NMI	20.4%	7.8%	10.1%	1.1%	1.0%	0.4%
BCBS RI	19.3%	4.1%	15.7%	0.6%	(1.1%)	0.0%
Empire NY/CT/DE	17.2%	5.9%	11.2%	0.0%	0.1%	0.0%
Palmetto GBA NC	16.7%	4.1%	9.7%	0.2%	2.7%	0.0%
UGS VA/WV	16.6%	3.8%	12.4%	0.2%	0.2%	0.1%
Noridian MN/ND	16.2%	7.9%	8.1%	0.5%	(0.2%)	0.1%
Trispan MS/LA/MO	15.8%	3.1%	11.8%	0.3%	0.7%	(0.1%)
Cahaba GBA AL	15.5%	7.8%	7.2%	0.4%	0.1%	0.0%
BCBS WY	14.7%	1.9%	9.7%	1.0%	1.5%	0.7%
Veritus PA	14.7%	2.0%	12.9%	0.1%	(0.2%)	0.0%
Medicare Northwest OR/ID/UT	14.6%	4.7%	8.4%	1.4%	0.1%	0.0%
TRAILBLAZER TX/CO/NM	14.1%	5.7%	7.6%	0.1%	0.7%	0.1%
UGS MI/WI	13.5%	4.8%	7.3%	1.1%	0.2%	0.1%
BCBS NE	12.8%	7.1%	5.6%	0.0%	0.1%	0.0%
AdminaStar IN/IL/KY/OH	12.2%	4.7%	6.0%	0.4%	1.1%	0.0%
COSVI PR/VI	11.9%	7.4%	3.8%	0.1%	0.6%	0.0%
Anthem NH/VT	10.4%	3.8%	5.9%	0.2%	0.6%	0.0%
Palmetto GBA SC	10.3%	4.6%	4.8%	0.8%	0.1%	0.0%
BCBS KS	10.0%	2.8%	6.7%	0.0%	0.4%	0.0%
Riverbend TN/NJ	9.7%	0.9%	6.6%	0.8%	1.5%	0.0%
Anthem NH/VT	9.0%	4.7%	4.1%	0.2%	0.1%	0.0%
BCBS OK	8.6%	1.0%	7.2%	0.1%	0.3%	0.0%
BCBS AZ	7.3%	1.9%	5.4%	0.0%	0.0%	0.0%
Premera WA/AK	7.3%	1.3%	7.9%	(3.3%)	0.3%	1.0%
BCBS GA	7.0%	2.7%	3.8%	0.0%	0.4%	0.1%
BCBS MT	6.8%	1.0%	4.6%	0.0%	1.2%	0.0%
Cahaba GBA IA	5.6%	1.6%	3.6%	0.2%	0.0%	0.2%
All FI Clusters	15.8%	5.4%	9.2%	0.5%	0.6%	0.1%

Non-Response Rate

Appendix E provides the non-response rate based on the ratio of medical records received to medical records requested. The *Improper Medicare Fee-for-Service Payments Report* for FY 2004, provides data for the nation by Carrier/DMERC/FI. The appendix provides three non-response rates for the following categories:

- All non-responses,
- Non-response rates that have a value of less than $100 in overpayments, and
- Non-response rates with a value of $100 or more in overpayments.

The non-response rates are different from the error due to non-response because the non-response rates are based on the number of records requested but not received, rather than the dollars in error due to non-response.

Dollars at Risk of Non-Response Report

Appendix F contains Dollars at Risk of Non-Response (DARN) rates for the nation and by provider type. CMS calculated the DARN rate by using the total dollar value of medical records for providers that received the final CERT follow up letter 10 days or more before the documentation cut off date for this report (i.e., June 11, 2004).

REASONS THE 2004 ERROR RATE IS HIGHER THAN THE 2004 GOAL AND CORRECTIVE ACTIONS

One of CMS' Medicare performance goals for FY 2004 was to reduce the percentage of improper payments made under the FFS program to 4.8% (net) or less. This equates to 5.6% gross. The paid claims error rate for FY 2004 was 9.3% net and 10.1% gross. The pages that follow provide a detailed discussion of the reasons why CMS believes it did not meet its goal, the corrective actions already taken, and new corrective actions planned for the upcoming year.

CMS has widely advertised the CERT contractor's activities and their effectiveness in detecting erroneous billing. CMS believes that the mere existence of the program as well as the initial results of CERT activities have encouraged providers to be more careful regarding how they bill Medicare and thus has increased the probability that a claim that appears error-free at first sight is truly error free. CMS remains vigilant in monitoring the error rate and developing corrective action plans designed to achieve our goals. Additionally, CMS is confident that implementation of our corrective actions will help us to reduce the error rate in the coming years.

Medically Unnecessary Services

Medically unnecessary services have increased from 1.3% of the total dollars sampled in 2003 to 1.6% in 2004. The majority of the improper payments due to medically unnecessary services were for claims for which the QIOs were responsible.

CMS has already undertaken a number of actions to correct this problem including:

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 state-specific hospital billing reports to help QIOs analyze administrative claims data.

Insufficient Documentation

The insufficient documentation problem grew considerably, increasing from 2.6% of the sampled payments in 2003 to 4.1% of the error rate in 2004. The majority of improper payments due to insufficient documentation were for claims submitted to Carriers/DMERCs/FIs.

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

- *Providers were 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 (e.g., the request was sent to the home office but the record was located in a field office) and the provider did not detain the record.*
- *Portions of the medical record were located at a third party (e.g., the request was sent to the billing physician but the record was located at the hospital), and the provider did not contact the third party.*
- *Providers failed to properly document the billed service in the medical record (e.g., the plan of care lacked the required physician signature).*
- *Provider misplaced portions of the medical record.*

CMS has already undertaken the following corrective actions aimed at resolving the insufficient documentation problem:

3. CMS recently extended the time that providers have to respond to documentation requests from 55 days to 90 days. CMS hopes that by allowing providers to have extra time to prepare their medical record submissions, increased number of providers will submit documentation and those submissions will be more complete. For example, if the billing provider is not the provider that maintains the medical record, and they must contact a third party to locate the record, then the new timeline will allow more time for the third party to submit the record.
4. The CERT program now solicits improved addresses from Carriers/DMERC/FIs and providers themselves.

In addition, CMS plans the following new corrective actions for 2005 to reduce the insufficient documentation problem:

5. In order for CMS to mitigate the risks associated with having a single CERT contractor and to further specialize the functions of CERT processes by contractor expertise, CMS hired a second CERT contractor for FY 2005, hereafter referred to as the CERT Documentation Contractor. The original CERT contractor -- hereafter referred to as the CERT Review Contractor -- will continue to randomly sample and review claims while the CERT Documentation Contractor will request and receive all of the needed medical records. The CERT Documentation Contractor will image all medical records they receive using a state-of-the-art document management system.
6. The CERT contractor has planned a number of improvements to the processes of requesting and receiving medical records. For example, the CERT Documentation Contractor plans to use fax servers to capture images of incoming

faxes. In addition, they will manually image all hardcopy medical records they receive. The secure maintenance of imaged records will facilitate the provider appeal process because records will be more easily accessible to the Carriers/DMERCs/FIs or other contractors responsible for processing the appeal.

7. CMS will modify the medical record request letters to clarify the components of the record needed for CERT review and to modify the medical record request letters to encourage the billing provider to forward the request to the appropriate location.

8. CMS will encourage Carriers/DMERCs/FIs to educate providers about the importance of submitting thorough and complete documentation, including signing all plans of care, etc.

Non-Response

Although CMS significantly improved the non-response problem from 2003 to 2004, 2.8% of the total dollars sampled resulted in a non-response error. This is still too high. CMS conducted a Non-Responder Special Study to determine why providers did not respond and to estimate the degree to which non-response claims represent "true" errors. The non-response problem continues to be a bigger problem in the CERT program than in the HPMP program. The HPMP program pays providers for the cost of supplying medical records.

See Appendix E for specific reasons for non-response revealed in the CERT Non-Responder Special Study.

CMS took the following corrective actions in 2004 to address the non-response problem:

9. Carriers/DMERCs/FIs have been educating providers about the CERT program so that providers are not hesitant about supplying medical records.

10. The CERT contractor developed a Web-based mechanism to allow Carriers/DMERCs/FIs to see which providers respond to CERT documentation requests. CMS then required Carriers/DMERCs/FIs to assist in the process of contacting non-responding providers to encourage them to respond.

11. CMS revised the letters requesting medical records by emphasizing that faxing is the most effective way to submit medical records. The CERT contractor has established a fax line for providers that wish to fax medical records rather than mail them.

12. CMS required the CERT contractor to implement an appeals tracking system. The CERT 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 non-response. However, because this new system was not in place until late in the year, some of the Carriers/DMERCs/FIs were unable to enter all their appeals of CERT denials prior to the cut-off date for this report. The January update report will contain error rates that include these late appeals.

13. Carriers/DMERCs/FIs provided lists of non-responders with high dollar claims to the OIG for follow-up.

New for 2005, CMS plans the following:

14. One Medicare FI is conducting a small EMR Submission Pilot using secure claims transmission lines. CMS is considering a proposal from a Medicare carrier to perform an EMR Submission Pilot using a secure Web-based system. These pilots can help CMS test whether:
    a. A Medicare Carrier/DMERC/FI can realize efficiencies in their medical review program and lower their error rate by accepting computerized and imaged medical records, and
    b. It would be feasible for the CERT program to accept computerized or imaged medical records from providers via a secure Web system.
15. CMS will pilot test allowing a Carrier/FI to request and receive medical records needed by the CERT program from its providers. Under this pilot, the CERT Contractor will send a list of randomly selected claims from their jurisdiction. For its jurisdiction, the carrier/FI will send letters to providers requesting medical records, receive and image medical records, and make them available to the CERT Review Contractor.
16. In the past, if the CERT contractor had sent four letters to a provider and insufficient documentation arrived, the CERT contractor did not give providers a second opportunity to supplement the initial documentation. CMS now requires the CERT contractor to give every provider a "second chance" to submit sufficient documentation. The CERT contractor contacts the provider, indicates the information that is missing, and gives the provider 15 days to respond.

Incorrect Coding

The percentage of sampled dollars found to be in error due to incorrect coding remained constant this year at 0.7%.

CMS undertook an undercoding special study and learned that carriers made most of the $1 B in underpayments made in the 2004 reporting timeframe. The error rate for physician visits was the primary reason for the underpayments. See Appendix H for more details about the undercoding special study.

CMS plans the following corrective actions for 2005:

17. CMS will encourage the American Medical Association (AMA) – the owner of the physician coding system – to improve existing clinical examples and other

documentation guidelines to assist physicians in understanding how to correctly code the evaluation and management services they bill.

18. CMS will encourage carriers to remind physicians about the importance of billing correctly to avoid upcoding and undercoding.

Delay in Producing Error Rate Reports

Readers of this report should keep in mind that November 15, 2003, was the first time CMS produced detailed error rate statistics. CMS and the Medicare contractors analyzed the error rate data included in that report and developed corrective action plans based on the problems in their areas. However, since the FY 2004 report is based on claims submitted during CY 2003, CMS and the Medicare contractors had only a few weeks between the release of the FY 2003 report and the close of the claims submission period for the FY 2004 report to impact on problems identified in the FY 2003 report. Thus, the majority of the impact from CMS and contractor error rate reduction efforts will not be evident until the FY 2005 and later reports.

The delays in the production of the error rate reports are inherent in the current structure of the CERT and HPMP processes.

19. CMS plans to work with the CERT Review Contractor to identify ways to restructure the CERT process to produce more frequent and timelier error rate data, without jeopardizing the quality of the data produced.

Geographic Variation in Error Rates

In the FY 2004 report, CMS provided FI-specific error rates for the first time. CMS can now see the full range of error rates across all contractors. Contractor-specific error rates ranged from a low of 1.4% (Nebraska QIO) to a high of 26.8% (Mutual of Ohmaha). The variation is greatest among Carriers/DMERCs/FIs.

CMS is unsure of the reasons behind this geographic variation in error rates.

20. In order to gain a better understanding of these geographic variations, CMS has tasked the CERT Review Contractor with conducting a small area geographic analysis of the Carrier/DMERC/FI error rates. This analysis will produce maps that will more clearly depict where the error rate problems are. This will facilitate a clearer understanding of why error rates vary geographically and how CMS can reduce this variation.

21. The Medicare Modernization Act requires that CMS produce and post to a Website a list of over utilized codes. CMS plans to develop contractor-specific Lists of over utilized codes through the CERT contractor and post lists in early 2005 and annually thereafter (see www.cms.hhs.gov/cert).

General

CMS continues to take the following general corrective actions:

22. CMS has directed Medicare contractors to develop local efforts to lower the error rate and to submit to CMS Error Rate Reduction Plans that address the cause of the errors, identify the steps they are taking to fix the problems, and provide other recommendations that will ultimately lower the error rate. CMS closely monitors and evaluates each Carrier/DMERC/FI's development and implementation of their Contractor Error Rate Reduction Plan.

23. 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. The broad-based efforts include Websites that provide detailed information on Medicare payment policies, provider training sessions, open door forums, and written materials that explain payment policies in detail.

24. 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. CMS required its contractors to intensify their one-on-one educational programs to target known problems that contribute to error rates.

CMS plans the following new general corrective actions for the future:

25. CMS will develop and install new Correct Coding Initiative edits.

26. CMS will use the Carrier/DMERC/FI-specific error rates in the contractor performance evaluation program.

27. CMS will encourage contractors to address provider billing/payment questions more consistently.

28. 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 is planning 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 non-RAC states. CMS will also be looking to see if the Carriers/DMERCs/FIs/QIOs 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.

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