FY 2004
IMPROPER MEDICARE
FEE-FOR-SERVICE PAYMENT REPORT
EXECUTIVE VERSION

BACKGROUND

Since 1996, the Department of Health and Human Services (DHHS) has annually determined the error rate for fee-for-service (FFS) claims paid by Medicare contractors, the insurance organizations that process and pay Medicare claims. From 1996 until 2002, the DHHS Office of Inspector General (OIG) using a sample size of about 6,000 claims conducted the process used to measure Medicare payment error rates. In fiscal year (FY) 2003, and as part of the agency's enhanced efforts to improve payment accuracy, CMS began calculating the Medicare FFS error rate and estimate of improper claim payments using a methodology approved by the OIG involving 120,000 claims.

The information contained in this document is a summary of the overall findings for FY 2004. A more complete discussion, as well as additional data, is available in the *Improper Medicare Fee-for-Service Payments Report FY 2004* available shortly after the release of this document (*see www.cms.hhs.gov/cert*).

CMS has established two programs to monitor the accuracy of the Medicare 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).

DATA IMPROVEMENT ACTIONS FOR FY 2004 REPORT

The 2004 analysis includes data improvements that reflect input from Congress and other oversight partners. In particular:

- The sample of claims for FIs was doubled in FY 2004 (from 30,000 claims to 60,000 claims) so that FI-specific error rates could be calculated at the same levels as the carriers and DMERCs.
- The data now permits accounting for appeals involving all types of benefits (not just hospital benefits).
- CMS implemented a new system to allow contractors to "back out" appeals.
  - This new appeals system was not available until late in the year.
  - Not all contractors were able to enter their appeals information in time for this report.
- The FY 2004 report now includes fully denied claims in the CERT sample; the previous reports did not.
- 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.
- The CERT program now solicits **improved addresses** from Carriers/DMERC/FIs and providers themselves.

ACTIONS TO IMPROVE THE ERROR RATE MEASUREMENT PROCESS

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

- Hire an **Error Rate Documentation Contractor** whose primary focus will be lowering non-response and insufficient documentation rates. The Error Rate Documentation Contractor will image all medical records they receive using a state-of-the-art document management system and make them available for review to the Error Rate Review Contractor. 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. In addition, the Error Rate Documentation Contractor will:
    - Modify the medical record request letters to clarify the components of the record needed for review and to encourage the billing provider to forward the request to the appropriate location.
    - Always give providers a "second chance" to submit sufficient documentation.

- Conduct an **Insufficient Documentation Special Study** to better understand the causes of insufficient documentation.

- Release of a **List of Over-utilized Codes** which will show the error rates and improper payments by contractor by service.

- Release **error rate maps** to show which parts of the US have pockets of high error rates.

ACTIONS TO REDUCE THE "REAL" ERRORS

Medically Unnecessary Services

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

- CMS has developed a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data.
- CMS has developed projects with the QIOs that address state-specific hospital billing reports to help QIOs analyze administrative claims data.

Incorrect Coding

CMS undertook an Undercoding Special Study and learned that carriers were responsible for most of the $1 B in underpayments made in the 2004 reporting timeframe. The error rate for physician visits was the primary reason for this.

CMS plans the following corrective actions for 2005:

- 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.

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

General Actions

In addition to the steps listed above, CMS will:

- Open a **Los Angeles satellite office** focused on identifying and preventing improper payments to providers in the Los Angeles area.

- Develop **new data analysis procedures** to assist CMS in identifying payment aberrancies and use that information in order to stop improper payments before they occur.

- Conduct a demonstration in 3 states to see if using **Recovery Audit Contractors** can help lower the error rates in these states by:
    - improving provider compliance faster than states that don't have recovery audit contractors,
    - allowing regular contractors to spend fewer resources on postpayment review and focus more time and effort on prepayment review and education.

- Encourage Medicare contractors to **educate providers** about the documentation rules.

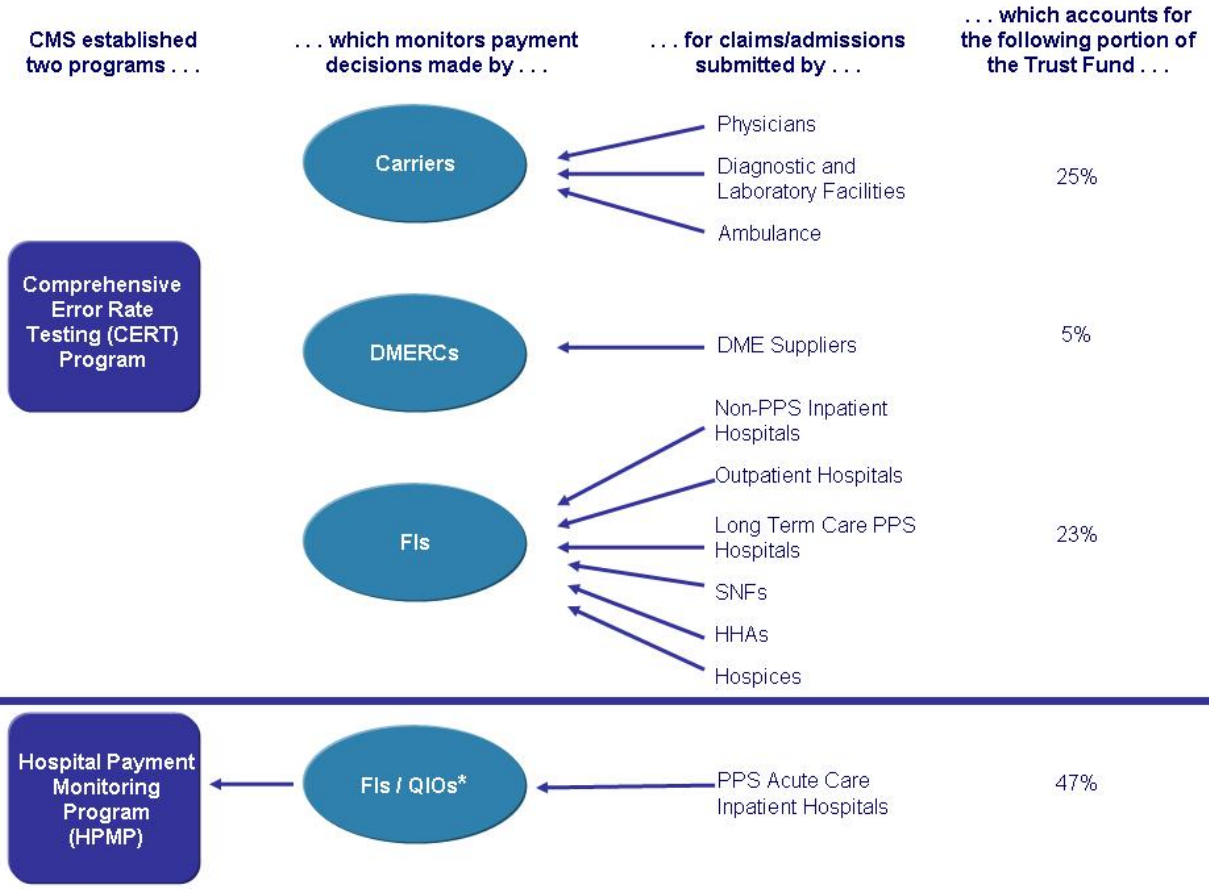
- Work with the AMA to **clarify Evaluation and Management (E&M) code documentation guidelines**.

- Consider contractor specific error rates in the **evaluation of contractors** beginning in 2005.

- For the first time CMS has proof that it is possible to **use best practices** to get to net error rates of;
    - 5.3 to 7.6 percent for carriers (where the average rate is 10.7 percent),
    - 6.6 to 7.3 percent for DMERCs (average rate 11.1%),
    - 6.8 to 8.6 percent for FIs (average rate 15.7 percent),
    - and 0.5 to 1.0 percent for QIOs (average rate 3.6 percent).

  Thus, practices in use now can lead to overall error rates that are about half of the current averages. CMS is therefore implementing contractor-specific actions using example best practices as a guide to lowering the individual contractor's overall error rate.

CMS' PROCESS FOR MONITORING THE ACCURACY OF MEDICARE PAYMENTS



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

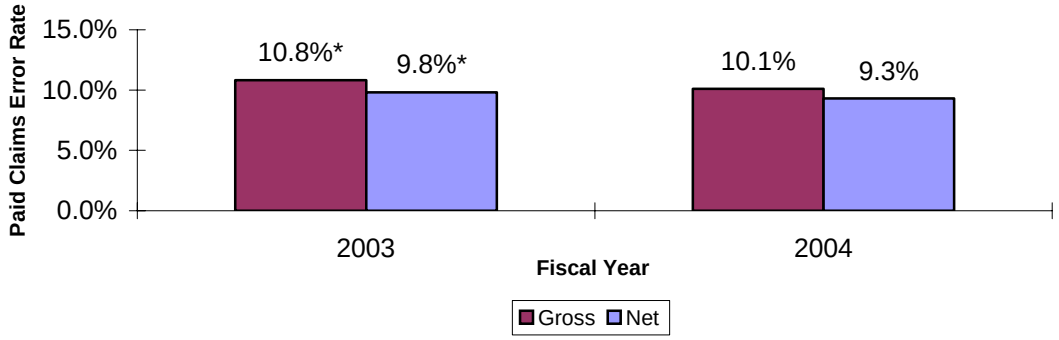
REPORT FINDINGS

Gross vs. Net Values (FY2003 - 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%

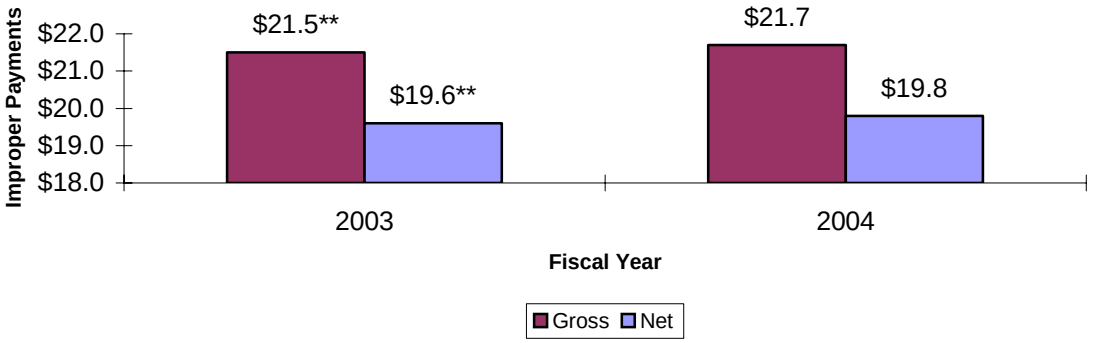
* These figures have not been adjusted to account for the high provider non-response experienced in 2003.

Gross and Net National Medicare FFS Error Rates



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

Gross and Net National Projected Improper Payments*



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

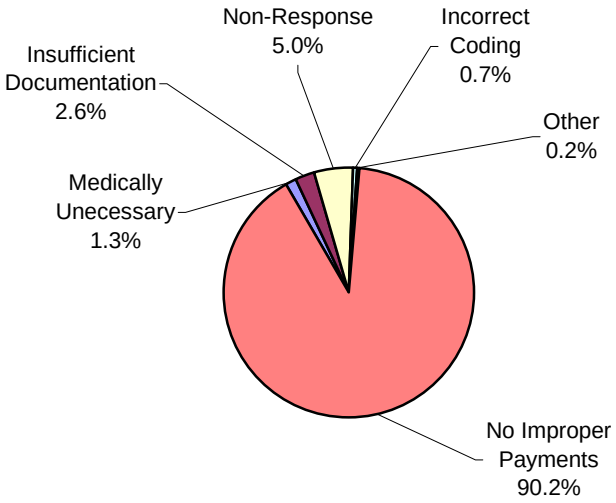
** These figures have not been adjusted to account for the high provider non-response experienced in 2003. Had the adjustment been made, the improper payments would have been $12.7 B (gross) and $11.6 B (net).

Percentage of Net Errors by Category for Each Fiscal Year

Type of Error	2003*	2004
Insufficient Documentation	25.9%	43.7%
Non-Response	54.7%	29.7%
Medically Unnecessary	11.3%	17.2%
Incorrect Coding	6.7%	7.7%
Other	1.4%	1.6%
Total (%)	100.0%	100.0%

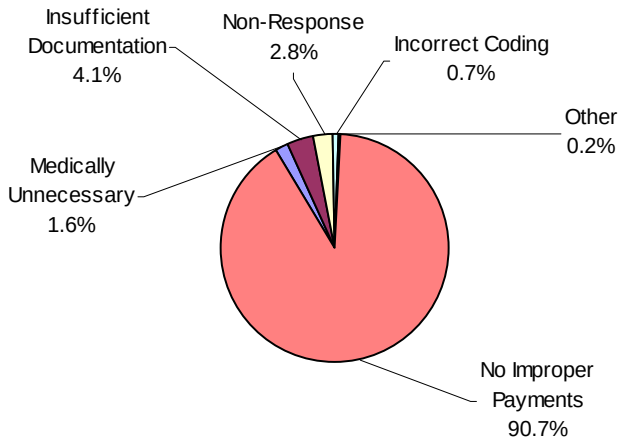
* These figures have not been adjusted to account for the high provider non-response experienced in 2003. Had the adjustments been made, 18.5% of the 5.8% paid claims error rate would have been due to non-response, 45.0% due to insufficient documentation, 21.7% due to medically unecessary services, 12.1% due to incorrect coding, and 2.7% due to other errors.

Error Rate Reasons (FY 2003, National)*



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

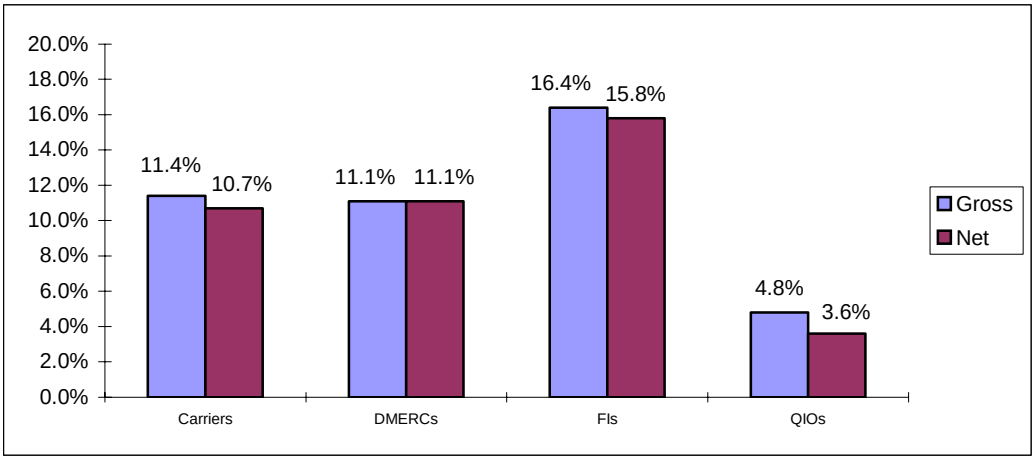
Error Rate Reasons (FY 2004, National)



Underpayments and Overpayments by Contractor Type (FY 2004)

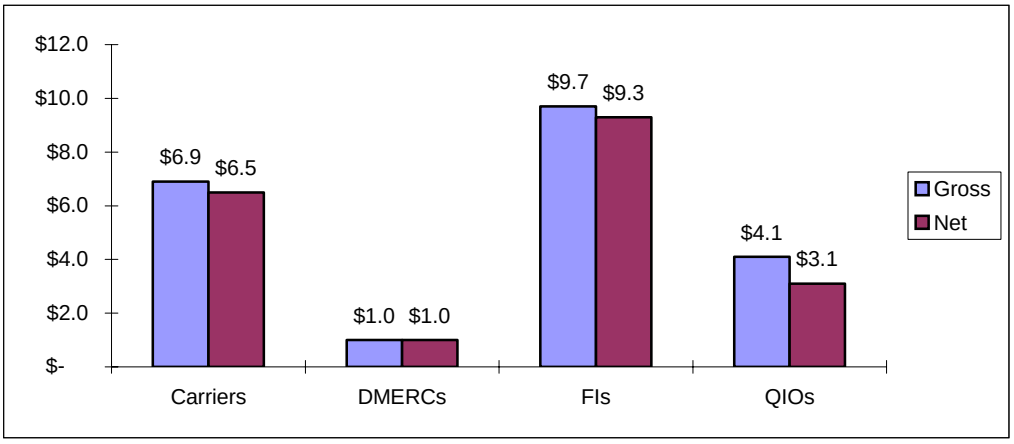
	Overpayments	Underpayments	Gross (Overpayments + Underpayments)		Net (Overpayments – Underpayments)	
			Improper Payments	Error Rate	Improper Payments	Error Rate
Carrier	$6.7 B	$0.2 B	$6.9 B	11.4%	$6.5 B	10.7%
DMERC	$1.0 B	$0.0 B[1]	$1.0 B	11.1%	$1.0 B	11.1%
FI	$9.5B	$0.2 B	$9.7 B	16.4%	$9.3 B	15.8%
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%

Error Rates by Contractor Type (FY 2004)*



*All data in these charts has been adjusted to exclude beneficiary copay, deductible, and reductions to recover previous overpayments.

Improper Payments by Contractor Type (FY 2004)*



*All data in these charts has been adjusted to exclude beneficiary copay, deductible, and reductions to recover previous overpayments.

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

RATIONALE FOR CONTRACTOR SPECIFIC FINDINGS

Medicare pays more than 1 billion claims each year. In FY 2004, CMS reviewed approximately 160,000 Medicare claims from the preceding year to determine where errors were being made. This review was the most extensive ever, providing CMS with more accurate information about contractor-specific error rates, error rates by provider type, and error rates by service type. This level of detail and accuracy is critical for CMS and its contractors to identify where problems exist and target improvement efforts more effectively. It reflects the agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments.

Beginning in FY 2005, annual contractor-specific error rates will be used as one of the evaluation criteria for assessing overall contractor performance in the Medicare program. Error rate analysis, as well as contractor progress under their Error Rate Reduction Plan will be reflected in the annual Report of Contractor Performance for FY 2005. This increased focus on contractor-specific error rates will make contractors more accountable to the taxpayers, beneficiaries, and providers.

Carriers and DMERCs used the information in the FY 2003 Improper Medicare FFS Payments Report and List of Over Utilized Codes to determine which services were experiencing high error rates. They then performed comprehensive data analysis to identify specific providers for probe review. In a probe reviews, a contractor samples a small number of claims from a given provider for a given service and reviews them to determine if the provider is billing in error. When the probe review indicated that corrective action needed to be taken, the contractor took the corrective action they deemed most appropriate. For example, at one carrier:

- If a probe review indicated that a provider has a moderate error rate (21%-45%) the carrier placed the provider on a prepayment review of all future claims of that type.

- If a probe review indicated that a provider had a high error rate (>46%) and substantial potential overpaid dollars (>$10,000), the carrier performed a statistically valid random sample review and collected the overpayments.

- The contractor initiated widespread group education of providers about E&M codes. A total of three group sessions around the state were conducted, representing 60 unique provider entities.

- Specialty level Comparative Billing Reports regarding E&M services were developed and will be disseminated via the contractor website and the various associations during FY 2005. Individual providers not included in the probe reviews will be identified to receive individual CBRs based on data analysis.

- Educational articles and/or FAQs were developed if the findings indicate billing/coverage issues that may be applicable to other providers rendering these services.

- The Local Coverage Determinations for injection procedures (which were contributing to the carrier's error rate) were revised with notice and comment. The carrier monitored data to determine if any additional corrective actions were indicated.

Because there were no FI-specific error rates and no FI List of Over Utilized Codes in FY 2003, the FIs were limited in terms of using error rate data to target their corrective actions.

Gross Error Rates: Carriers (FY 2004)

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	Excluding 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.

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.

Net Error Rates: Carriers (FY 2004)

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.

Gross and Net Error Rates: DMERCs (FY 2004)

DMERCs	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
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.

Please note: Gross and Net figures were the same since there were no significant DMERC underpayments.

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.

Gross Error Rates: FIs (FY 2004)

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.

Net Error Rates: FIs (FY 2004)

FI Clusters	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
Mutual of Omaha	26.8%	$3,161,718,603	3.2%	20.4% - 33.1%	19.2%	N/A	N/A	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	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	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	N/A	N/A
UGS MI/WI	13.5%	$668,592,686	2.5%	8.7% - 18.4%	9.5%	N/A	N/A	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	N/A	N/A
Palmetto GBA SC	10.3%	$638,080,566	1.1%	8.1% - 12.6%	6.0%	N/A	N/A	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	N/A	N/A
CareFirst MD/DC	25.3%	$546,367,039	4.9%	15.8% - 34.8%	18.5%	N/A	N/A	N/A	N/A
Palmetto GBA NC	16.7%	$532,741,242	3.0%	10.9% - 22.5%	13.1%	N/A	N/A	N/A	N/A
Riverbend TN/NJ	9.7%	$351,337,074	3.0%	3.9% - 15.5%	9.4%	N/A	N/A	N/A	N/A
Veritus PA	14.7%	$305,632,405	2.7%	9.4% - 19.9%	13.0%	N/A	N/A	N/A	N/A
Anthem MA/ME	10.4%	$296,640,588	2.2%	6.0% - 14.7%	6.8%	N/A	N/A	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	N/A	N/A
UGS VA/WV	16.6%	$240,673,512	2.8%	11.1% - 22.2%	13.5%	N/A	N/A	N/A	N/A
Cahaba GBA IA	5.6%	$239,317,062	1.1%	3.5% - 7.7%	4.1%	N/A	N/A	N/A	N/A
Noridian MN/ND	16.2%	$212,211,798	3.3%	9.7% - 22.7%	9.2%	N/A	N/A	N/A	N/A
BCBS RI	19.3%	$150,888,605	3.2%	13.0% - 25.6%	15.9%	N/A	N/A	N/A	N/A
BCBS GA	6.9%	$145,283,562	1.5%	3.9% - 10.0%	4.4%	N/A	N/A	N/A	N/A
BCBS AR	26.1%	$125,656,436	5.5%	15.39% - 36.8%	12.0%	N/A	N/A	N/A	N/A
Cahaba GBA AL	15.5%	$109,279,442	2.2%	11.1% - 19.9%	8.5%	N/A	N/A	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	N/A	N/A
BCBS OK	8.6%	$95,396,035	2.2%	4.4% - 12.9%	7.7%	N/A	N/A	N/A	N/A
Premera WA/AK	7.3%	$73,362,688	3.1%	1.3% - 13.3%	6.0%	N/A	N/A	N/A	N/A
Anthem NH/VT	9.0%	$57,763,000	1.7%	5.7% - 12.3%	4.6%	N/A	N/A	N/A	N/A
BCBS KS	10.0%	$51,258,470	2.2%	5.6% - 14.3%	7.6%	N/A	N/A	N/A	N/A
BCBS NE	12.8%	$38,282,494	2.7%	7.5% - 18.0%	6.1%	N/A	N/A	N/A	N/A
BCBS AZ	7.3%	$23,730,180	1.4%	4.5% - 10.1%	5.6%	N/A	N/A	N/A	N/A
COSVI PR/VI	11.9%	$18,899,869	2.1%	7.8% - 16.0%	4.9%	N/A	N/A	N/A	N/A
BCBS MT	6.8%	$15,619,297	1.7%	3.5% - 10.1%	6.0%	N/A	N/A	N/A	N/A
BCBS WY	14.7%	$12,201,445	2.8%	9.2% - 20.2%	13.3%	N/A	N/A	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	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.

Gross Error Rates: QIOs (FY 2004)

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
Georgia	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
Maryland	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
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 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.

Net Error Rates: QIOs (FY 2004)

States	Paid/Allowed Claims Error Rate					Provider Compliance Error Rate		Services Processed 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	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	N/A	N/A
Florida	5.1%	$290,535,982	0.9%	3.2% - 6.9%	N/A	N/A	N/A	N/A	N/A
Texas	4.2%	$234,091,761	1.0%	2.3% - 6.0%	N/A	N/A	N/A	N/A	N/A
Massachusetts	8.6%	$183,673,991	0.9%	6.8% -10.4%	N/A	N/A	N/A	N/A	N/A
Illinois	4.4%	$170,035,027	0.7%	3.0% - 5.7%	N/A	N/A	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	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
Michigan	3.9%	$135,235,007	0.7%	2.5% - 5.2%	N/A	N/A	N/A	N/A	N/A
Ohio	3.2%	$111,026,699	0.6%	2.0% - 4.4%	N/A	N/A	N/A	N/A	N/A
Pennsylvania	2.5%	$107,271,067	0.7%	1.2% - 3.8%	N/A	N/A	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	N/A	N/A
Louisiana	5.8%	$80,521,615	0.9%	3.9% - 7.6%	N/A	N/A	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	N/A	N/A
Indiana	4.1%	$73,170,814	0.7%	2.7% - 5.4%	N/A	N/A	N/A	N/A	N/A
Virginia	3.5%	$67,669,309	0.7%	2.1% - 5.0%	N/A	N/A	N/A	N/A	N/A
Maryland	3.0%	$62,015,611	0.5%	2.0% - 4.0%	N/A	N/A	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	N/A	N/A
Alabama	3.2%	$51,324,209	0.6%	2.1% - 4.4%	N/A	N/A	N/A	N/A	N/A
Georgia	2.1%	$46,520,538	0.7%	0.9% - 3.4%	N/A	N/A	N/A	N/A	N/A
Connecticut	3.2%	$41,448,637	0.7%	1.8% - 4.7%	N/A	N/A	N/A	N/A	N/A
Arkansas	4.5%	$38,301,517	0.7%	3.2% - 5.8%	N/A	N/A	N/A	N/A	N/A
Tennessee	1.7%	$35,589,733	0.6%	0.6% - 2.8%	N/A	N/A	N/A	N/A	N/A
Oklahoma	3.5%	$33,766,182	0.7%	2.2% - 4.9%	N/A	N/A	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	N/A	N/A
Iowa	3.6%	$29,239,066	0.6%	2.3% - 4.9%	N/A	N/A	N/A	N/A	N/A
Washington	2.1%	$26,327,311	0.5%	1.1% - 3.1%	N/A	N/A	N/A	N/A	N/A
Arizona	2.4%	$25,953,324	0.8%	0.9% - 4.0%	N/A	N/A	N/A	N/A	N/A
Kansas	2.8%	$21,346,720	0.9%	1.1% - 4.6%	N/A	N/A	N/A	N/A	N/A
Missouri	1.1%	$21,292,383	0.4%	0.4% - 1.8%	N/A	N/A	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	N/A	N/A
Maine	4.6%	$19,218,885	0.7%	3.2% - 5.9%	N/A	N/A	N/A	N/A	N/A
Nevada	4.6%	$18,530,547	0.8%	3.1% - 6.1%	N/A	N/A	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	N/A	N/A
Oregon	2.5%	$17,246,626	0.6%	1.2% - 3.7%	N/A	N/A	N/A	N/A	N/A
Wisconsin	1.0%	$15,755,190	0.4%	0.3% - 1.8%	N/A	N/A	N/A	N/A	N/A
Utah	3.8%	$14,802,053	0.8%	2.3% - 5.3%	N/A	N/A	N/A	N/A	N/A
Minnesota	1.0%	$14,128,604	0.5%	0.0% - 2.1%	N/A	N/A	N/A	N/A	N/A
Delaware	4.2%	$11,415,592	0.7%	2.8% - 5.6%	N/A	N/A	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	N/A	N/A
New Hampshire	3.4%	$11,159,593	0.6%	2.2% - 4.6%	N/A	N/A	N/A	N/A	N/A
Mississippi	1.2%	$10,617,505	1.0%	-0.7% - 3.1%	N/A	N/A	N/A	N/A	N/A
Colorado	1.3%	$9,141,169	0.7%	-0.1% - 2.7%	N/A	N/A	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	N/A	N/A
Nebraska	1.4%	$7,004,919	0.4%	0.6% - 2.1%	N/A	N/A	N/A	N/A	N/A
Idaho	2.6%	$6,167,158	0.6%	1.5% - 3.7%	N/A	N/A	N/A	N/A	N/A
Vermont	3.3%	$5,435,123	0.6%	2.2% - 4.4%	N/A	N/A	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	N/A	N/A
North Dakota	2.0%	$4,324,930	0.4%	1.2% - 2.8%	N/A	N/A	N/A	N/A	N/A
Alaska	3.5%	$3,534,476	0.7%	2.2% - 4.7%	N/A	N/A	N/A	N/A	N/A
Montana	0.7%	$1,588,198	0.5%	-0.2% - 1.5%	N/A	N/A	N/A	N/A	N/A
Wyoming	1.1%	$1,098,497	0.4%	0.4% - 1.9%	N/A	N/A	N/A	N/A	N/A
Hawaii	0.5%	$1,015,054	0.3%	-0.2% - 1.1%	N/A	N/A	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	N/A	N/A

* This data has 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.

QUESTIONS & ANSWERS

Q1. What was the reporting period for this report?
A1. For Carriers/DMERCs/FIs, the report included claims submitted between 01/01/03-12/31/03. For QIOs, the report included inpatient PPS hospital discharges between 7/1/02 – 6/30/03.

Q2. Will these rates be updated to reflect late documentation?
A2. Yes. Although CMS will not amend the written report, the rates will be updated quarterly to reflect late documentation. The updates will be available at http://www.cms.hhs.gov/cert/reports.asp. The following table is the update schedule for National Medicare FFS Paid Claims Error Rate and Carrier-Specific, DMERC-Specific and FI-Specific 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	November 16, 2004
April 1, 2005	January 23, 2005	March 16, 2005
July 1, 2005	April 23, 2005	June 16, 2005
October 1, 2005	July 23, 2005	September 16, 2005

Q3. Why did the error rate go from 5.8%/9.8% in FY 2003 to 9.3% in FY 2004? Why did CMS not meet its 2004 goal of 4.8%?
A3. There are three primary reasons:

- The **non-response** problem continues to be a significant portion of the error rate.
- There was an increase in errors for **insufficient documentation**. (Most on claims for which FIs are responsible) This problem was caused by the following:
  - **An artifact of increased scrutiny:** The FY 2003 report contained only 7 months worth of data due to the implementation schedule.
  - Facilities that failed to meet Medicare's **documentation requirements**. For example, a provider sent an unsigned plan of care.
  - In cases where the billing provider was not the provider that maintained the requested medical record components, they did not **contact a 3rd party** to obtain the requested components.

Q4. How has CMS fixed the non-response problem?
A4. 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.

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

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

- 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.
- 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.
- 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 had been correctly processed. 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.
- 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:

- One Medicare FI is conducting a small Electronic Medical Record (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 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
    - It would be feasible for the CERT program to accept computerized or imaged medical records from providers via a secure Web system.
- 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 the Carrier/FI a list of randomly selected claims from their jurisdiction. The Carrier/FI will then send letters to providers requesting medical records, receive and image medical records, and make them available to the CERT Review Contractor.
- 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.

Q5. What educational efforts is CMS undertaking to help lower the error rate?

A5. CMS continues to develop Medicare provider educational material with the official CMS brand, "The Medicare Learning Network". As part of this initiative, CMS has developed over 250 national provider education articles annually which outline, on a flow basis and in plain language, the coverage, billing and coding rules associated with Medicare program changes. These articles can be easily accessed through a search engine on

www.cms.hhs.gov/medlearn/matters, which will pull articles, by year, based on user entered key words or phrases.

In 2005 CMS will step up its efforts to expand the current FAQ database available on www.cms.hhs.gov by generating and posting FAQs of interest to FFS Medicare providers. FAQs will be automatically generated from Medlearn Matters article, solicited from FIs and carriers (who interact directly with the providers who bill them), and from over 50 national associations.
As part of the effort to centrally locate information and make it easily accessible, CMS has established customized provider webpages on www.cms.gov/providers that house much of the information individual provider types need including links to relevant program instructions, FAQs, and educational resource material.

Q6. Why is CMS presenting both net and gross error rates?
A6. In order to promote consistency in improper payment reporting across federal agencies, Improper Payments Information Act (IPIA) requires agencies to follow a number of methodological requirements when calculating error rates and improper payment estimates. 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, this Improper Medicare Fee-for-Service Payments Report FY 2004, states both gross and net figures from 1996 – 2004. However, CMS expects to report primarily gross numbers in the FY 2005 and future reports.

Q7. Why was there a significant increase in the projected FI improper payments from the FY 2003 report to the FY 2004 report?
A7. CMS discovered that the FY 2003 Improper Medicare FFS Payments report underestimated the improper payments made by FIs. This problem was caused by:

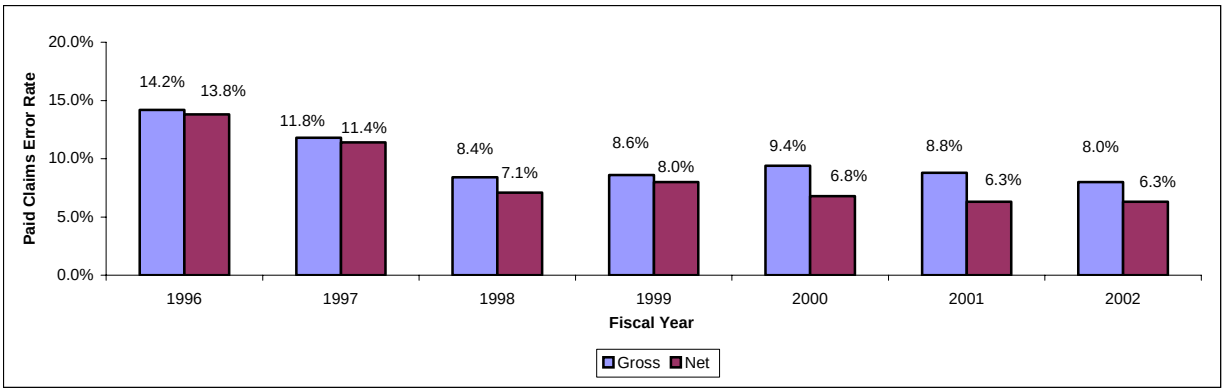
- The CERT program using the wrong field from a file to calculate the denominator.
- The FIs reporting inaccurate charges in the files used by the CERT contractor to calculate the numerator.

The impact on the FY 2003 improper payments by FIs was significant. Readers should disregard the improper payment figures for FIs in the FY 2003 report.
These problems have been fixed and they did not occur in 2004. CMS does not anticipate that these errors will occur in any future reports.

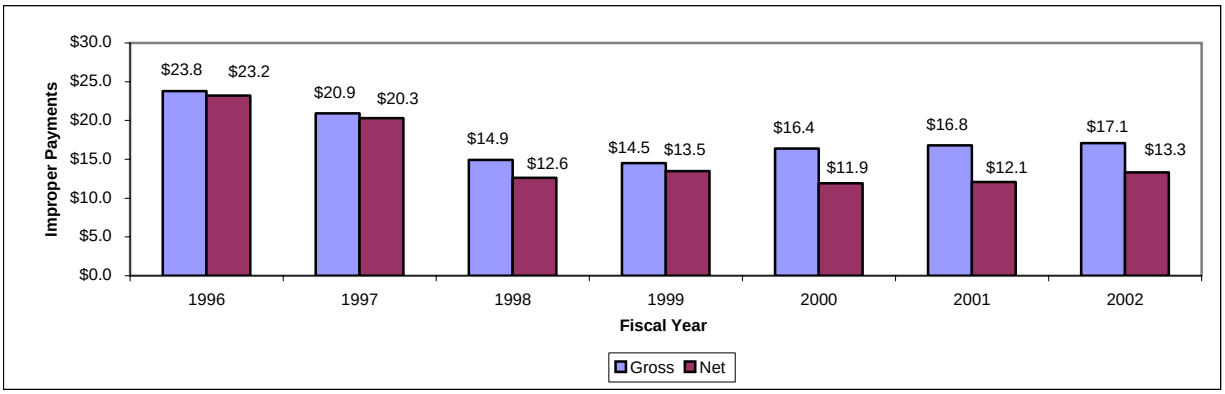
Q8. How does Q7 impact the error rate as a percentage?
A8. The error rate when reported as a percentage is unaffected by the problem with the estimated improper payments because the problem occurred in both the numerator and the denominator of the error rate calculations.

APPENDIX

Gross and Net National Medicare FFS Error Rates (1996 – 2002)



Gross and Net National Projected Improper Payments (1996 – 2002)



The 1996 – 2002 data was based on a sample size of 6,000 claims. The 2003 and 2004 data was based on a much larger sampel size of 120,000 or more claims and is much more precise than earlier samples.