Medicare Fee-For-Service 2014 Improper Payments Report

EXECUTIVE SUMMARY

87.3 Percent Accuracy Rate

The estimated 2014[1] Medicare fee-for-service (FFS)[2] accuracy rate – the percentage of Medicare FFS dollars paid correctly – was 87.3 percent. This calculation included claims submitted during the 12-month period from July 2012 through June 2013. This means that Medicare paid an estimated $314.4 billion correctly during this period.

Corrective Actions to Improve the Accuracy Rate

The Centers for Medicare & Medicaid Services (CMS) strives to improve the accuracy rate in the Medicare FFS program. The CMS uses data from the Comprehensive Error Rate Testing (CERT) program and other sources to reduce or eliminate improper payments through various corrective actions.

The CMS previously implemented corrective actions to improve the accuracy rate for the 2014 report period. Established corrective actions include educational publications, data analysis, prior authorization projects, targeted medical review by the Supplemental Medical Review Contractor (SMRC) and Recovery Auditors, National Correct Coding Initiative Edits (NCCI), and risk-based provider screening. In addition, CMS has developed other corrective actions expected to reduce improper payments in future report periods. New corrective actions include innovative educational products, new data analysis tools for contractors, expanding prior authorization, and the use of provider enrollment moratoria.

12.7 Percent Improper Payment Rate

The estimated 2014 Medicare FFS improper payment rate – the percentage of Medicare dollars paid incorrectly – was 12.7[3] percent. This means that Medicare paid an estimated $45.8 billion

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[1] HHS publishes the 2014 Medicare FFS improper payment rate in the Federal Fiscal Year (FY) 2014 HHS Agency Financial Report. The FY runs from October to September. The Medicare FFS sampling period does not correspond with the FY due to practical constraints with claims review and rate calculation methodologies.

[2] The Medicare program is divided into four parts, two of which (Part A and Part B) make up the Medicare FFS portion of the program. Part A coverage includes inpatient hospital and skilled nursing facility stays, home health visits, and hospice care. Part B coverage includes physician visits, outpatient care, preventive services, home health visits, and other medical services and supplies (including durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)). Part C (the Medicare Advantage program) and Part D (the Medicare prescription drug benefit) are not included in this analysis.

[3] As of the cutoff date for the FY 2014 Medicare FFS improper payment rate, approximately 670 claims were pending final Administrative Law Judge (ALJ) appeal adjudication. Historically, claims have been fully overturned

incorrectly between July 2012 and June 2013. For 2014, CMS adjusted the improper payment rate by 0.9 percentage points ($3.3 billion) from 13.6 percent to 12.7 percent to account for the effect of rebilling inpatient hospital claims denied under Medicare Part A (Part A to B rebilling). The methodology for calculating the 2014 FFS improper payment rate was the same as in 2013.

Common Causes of Improper Payments

It is important to note that the improper payment rate does not measure fraud. It estimates the payments that did not meet Medicare coverage, coding, and billing rules.

Once again, during the 2014 report period, the most common cause of improper payments (accounting for 60.1 percent of total improper payments) was lack of documentation to support the services or supplies billed to Medicare.

Part A (excluding hospital inpatient PPS)[4] services were the largest contributors to the 2014 improper payment rate, including home health, hospital outpatient, skilled nursing facility, non-PPS inpatient hospital (including inpatient rehabilitation facilities), and clinic End-Stage Renal Disease services.

The Medicare Fee-For-Service Improper Payments Report

This report supplements information in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). The Improper Payments Information Act of 2002 (IPIA), amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), requires improper payment reporting in the HHS AFR. The improper payment rate calculation complies with the requirements of Office of Management and Budget (OMB) Circular A-123, Appendix C.

This report highlights the Medicare FFS services and supplies with the greatest impact on the 2014 improper payment rate and describes CMS' corrective actions to reduce improper payments in the future. The *Supplementary Appendices for the Medicare Fee-for-Service 2014*

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by the ALJ at an average rate of 28.6 percent. If sufficient time was allowed for the pending appeals to complete final adjudication, the overall FY 2014 improper payment rate would be lowered by 0.2 percentage points to 12.5 percent, or $44.9 billion in projected improper payments.

[4] Improper payment rate reporting for Part A (excluding inpatient hospital DRG) providers is determined by the type of bill submitted to Medicare for payment. Providers, facilities, and suppliers that submit institutional claims via the electronic American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Health Care Claim: Institutional (837), or paper claim format Uniform Billing (UB)-04, are included in the Part A (excluding inpatient hospital DRG) improper payment rate calculation. Examples of providers, facilities, and suppliers that bill using these formats include hospitals, skilled nursing facilities, home health and hospice providers, renal dialysis facilities, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. These institutional claims may include professional services that may be paid under Part A or Part B, yet are ultimately included in the CERT Part A (excluding inpatient hospital DRG) improper payment rate measurement because they are submitted on the ASC X12 837 or UB-04.

Improper Payment Rate Report, available on the CMS website: www.cms.gov/cert, provide additional detailed information. Table 1, below, summarizes the 2014 improper payment rates by claim type:

Table 1: 2014 Improper Payment Rates and Projected[5] Improper Payments by Claim Type (Dollars in Billions)[6]

Claim Type	Total Payment	Projected Improper Payment	Improper Payment Rate	95% Confidence Interval
Part A (Total)	$259.7	$29.6	11.4%	10.4% - 12.5%
Part A (Excluding Inpatient Hospital PPS)	$146.5	$19.2	13.1%	11.4% - 14.8%
Part A (Inpatient Hospital PPS)[7]	$113.2	$10.4	9.2%	8.4% - 10.1%
Part B	$90.9	$11.0	12.1%	11.2% - 13.1%
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$9.6	$5.1	53.1%	51.0% - 55.1%
Overall	**$360.2**	**$45.8**	**12.7%**	**11.9% - 13.5%**

[5] Projected amounts are based on the sample of claims actually reviewed.

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

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

Disclaimers

All information provided in this report is for informational purposes only. This report does not constitute official CMS guidance, nor is it a substitute for the referenced statute or Medicare coverage, coding and billing rules.

Categories of improper payments in this report may not correspond exactly to categories (i.e., by Medicare Severity Diagnosis-Related-Groups (MS-DRGs), Berenson-Eggers Type of Service (BETOS) codes or Healthcare Common Procedure Coding System (HCPCS) codes) reported in the more detailed *Supplementary Appendices for the Medicare Fee-for-Service 2014 Improper Payment Rate Report*.

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Reducing Improper Payments in the Medicare Fee-For-Service Program

Government Performance and Results Act Improper Payment Rate Goals

The Government Performance and Results Act of 1993 (GPRA), as modified by the Government Performance and Results Modernization Act of 2010, requires federal agencies to establish performance goals. One of CMS' GPRA goals is to reduce the Medicare FFS improper payment rate.

The 2014 improper payment rate was 12.7 percent, which is higher than the previously established goal of 9.9 percent. The CMS has many successful improper payment reduction strategies in place. However, the factors contributing to improper payments are complex and may change from year to year. As a result, CMS examines and possibly revises these goals on an annual basis based on data analysis and policy changes. The law requires that these goals are realistic and ambitious.

Under this mandate, as well as to comply with the IPIA, CMS set the following targets for lowering improper payments over the next three fiscal years (FY):

- 12.5 percent by FY 2015
- 11.5 percent by FY 2016
- 8.5 percent by FY 2017

The CMS sets these targets by analyzing CERT program results and trends for each claim type and error category. These goals also incorporate the anticipated reductions that will result from corrective actions implemented by CMS.

The CMS strives to improve the accuracy rate in the Medicare FFS program. The CMS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Of particular importance are four corrective actions that CMS believes will have a considerable effect in preventing and reducing improper payments:

- First, CMS issued a final rule, "Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies" (CMS-1611-F, 79 FR 66031, issued on November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year (CY) 2015. This final rule also included three changes to the face-to-face requirements for episodes beginning on or after January 1, 2015. Since implementation of the face-to-face requirements in April 2011, CMS observed that the provider community had difficulty complying with the documentation requirements and these errors have increased the improper payment rate. The CMS believes clarifying the face-to-face requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare program.

- Second, CMS implemented two major policies in the FY 2014 final rule "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status" (CMS 1599-F,78 FR 50495, issued on August 19, 2013 and effective on October 1, 2013), pertaining to inpatient hospital claims that are expected to reduce improper payments:

  - The CMS allowed hospitals to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient.
  - The CMS clarified and modified the guidance regarding when an inpatient admission is generally appropriate for payment under Medicare Part A.

- Third, CMS is expanding the use of prior authorization in the Medicare FFS program for items under the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) benefit in two areas:

  - On September 1, 2012, CMS instituted a prior authorization demonstration program in seven states (California, Illinois, Michigan, New York, North Carolina, Florida, and Texas) designed to develop and demonstrate improved methods for the investigation and prosecution of fraud and to reducing improper payments for power mobility devices. Preliminary data suggests that this demonstration project led to a decrease in the expenditures for power mobility devices in both the demonstration and non-demonstration states. Specifically, based on claims submitted as of September 17, 2014, monthly expenditures for the power mobility devices included in the demonstration project decreased from $20 million in September 2012 to $5 million in March 2014 in the non-demonstration states, and from $12 million to $2 million in the demonstration states. Prior authorization reviews are being performed timely, industry feedback has been positive, and CMS has received no complaints from beneficiaries. The CMS leveraged this success by extending the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19.
  - The CMS also proposed to establish a prior authorization process for certain DMEPOS items that are frequently subject to unnecessary utilization. Through a proposed rule, CMS has solicited public comments on this prior authorization process, as well as criteria for establishing a list of durable medical items that are frequently subject to unnecessary utilization.

- Fourth, beginning in FY 2015, CMS will assess whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care by testing prior authorization for certain non-emergent services under the authority of the Center for Medicare and Medicaid Innovation. The CMS is testing prior authorization model for: 1) non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey; and 2) repetitive, scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and

South Carolina. Using a prior authorization process will ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

In addition to the major initiatives listed above to reduce improper payments, a detailed listing of ongoing and newly established corrective actions are discussed later in this report.

The Medicare FFS Program

Features of the Medicare FFS Program

The CMS calculates the Medicare FFS improper payment rates for four major claim types:

- Part A Inpatient Prospective Payment System (PPS) Hospital
- Part A Excluding Inpatient PPS Hospital (including skilled nursing facility stays, home health services, and hospital outpatient services)
- DMEPOS
- Part B Excluding DMEPOS (including physician, laboratory, and ambulance services)

Claim Payments in the Medicare FFS Program

Providers and suppliers submit claims to their respective Medicare Administrative Contractors (MACs) for Medicare FFS payment. MACs are responsible for preventing improper Medicare FFS payments through their claims payment decisions and processes. The primary goal of each MAC is to pay the correct amount for covered, medically necessary, and correctly coded services.

The MACs and other Medicare review contractors perform two main types of claim reviews. Both of these review types can be done either before or after payment is rendered (i.e., pre-payment or post-payment reviews):

- **Non-Complex Medical Review**: The Medicare review contractor makes a claim determination without clinical review of medical documentation submitted by the provider. This includes a review that requires some form of human intervention to verify claim information, and a review that is automated (i.e., done by computer) and does not require human intervention. MACs use this type of review more frequently than complex medical review because of the large number of claims that they must process every year.

- **Complex Medical Review**: The Medicare review contractor makes a claim determination after reviewing additional documentation associated with the claim. Complex medical reviews for the purpose of making coverage determinations are performed by licensed nurses (Registered Nurses and Licensed Practical Nurses) or physicians, unless this task is delegated to other licensed health care professionals. During a complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians or physician specialists) for advice. The MACs cannot perform complex medical review on every claim submitted because

of the large number of claims that they must process.

The MACs use improper payment data analysis to determine which claims to review on either a pre-payment or post-payment basis. Improper payment data analysis also guides MACs' corrective actions and educational efforts.

Improper Payment Measurement in the Medicare FFS Program

Statutory Background

The IPIA of 2002, as amended by the IPERA of 2010 and the IPERIA of 2012, requires federal agencies, including HHS, to review the programs they administer for improper payments every year. An improper payment is any payment made:

- In error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;
- To an ineligible recipient;
- For ineligible goods or services;
- For goods or services not received (except for such payments where authorized by law);
- That duplicates a payment; or
- That does not account for credit for applicable discounts.

The IPIA of 2002 also requires the HHS to:

- Identify programs that may be susceptible to significant improper payments,
- Estimate the amount of improper payments in those programs,
- Submit the estimates to Congress, and
- Report publicly the estimate and actions HHS is taking to reduce improper payments.

The Comprehensive Error Rate Testing (CERT) Program

CERT Program Objectives

The objective of the CERT program is to calculate the Medicare FFS program improper payment rate. The CERT program considers any payment that should not have been made or that was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment.

It is important to note that the improper payment rate does not measure fraud. It estimates the payments that did not meet Medicare coverage, coding, and billing rules.

Calculation of the Medicare FFS Improper Payment Rate

1. Claims Selection

The first step in the CERT process is the selection of a stratified random sample of Medicare

claims. Stratification ensures that the sample is representative of the population of claims submitted for Medicare payment. A portion of the claims sampled for the 2014 report period was unreviewable because the claim adjudication process was incomplete (e.g., the MAC returned the claim to the provider or supplier) (see Table 2 below). The final CERT sample is comprised of claims paid or denied by the MAC. This sampling methodology complies with all statutory requirements and OMB guidance.

Table 2: Claim Counts by Type for the 2014 Improper Payment Rate Calculation

Claim Type	Claims Sampled	Claims Reviewed
Part A (Excluding Inpatient PPS Hospital)	8,872	7,752
Part A (Inpatient PPS Hospital)	19,430	14,359
Part B (Excluding DMEPOS)	18,103	17,454
DMEPOS	11,349	10,979
Total	**57,754**	**50,544**

2. Medical Record Requests

After the CERT program identifies a claim as part of the sample, it requests, via letter, the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim. The CERT program makes phone calls to validate the provider's or supplier's contact information and to address their questions or concerns about the request. The CERT program sends at least three subsequent letters if the provider or supplier fails to respond to the initial request. For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), in addition to the initial request sent to the billing provider and supplier, the referring provider who ordered the item or service may also receive a request for documentation. This is done because sometimes the referring provider maintains the documentation to support the medical necessity of the services billed.

If the CERT program receives no documentation within 75 days of the initial request, the claim is scored as an improper payment due to a "no documentation error" (explained below). However, the CERT program reviews late documentation that is received after the 75 days and this review is counted in the final improper payment rate calculation if it is received in time for the final calculations to be made. The CERT program tracks improper payment determination reversals based upon the receipt of late documentation, even if they occur after the cutoff date for the official improper payment rate calculation.

3. Review of Claims and Assignment of Error Categories

Medical review professionals review the claim and submitted documentation to make a determination of whether the claim was paid or denied appropriately. These review professionals include nurses, medical doctors, and certified coders. Before reviewing documentation, the CERT program examines the CMS claims systems to check for (1) Medicare beneficiary eligibility, (2) duplicate claims, and (3) Medicare as the primary insurer. When performing claim reviews, the CERT program checks for compliance with Medicare statutes and regulations, billing instructions, National Coverage Determinations (NCDs),[8] Local Coverage Determinations (LCDs),[9] and provisions in CMS instructional manuals.

The reason for the improper payment determines the error category for the claim. There are five major error categories.

No Documentation

Claims are placed into this category when the provider or supplier fails to respond to repeated requests for the medical records or when the provider or supplier responds that they do not have the requested documentation.

Insufficient Documentation

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

Medical Necessity

Claims are placed into this category when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.

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[8] An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. All MACs are required to follow NCDs. If an NCD does not specifically exclude or limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the MAC to make an LCD.

[9] An LCD is a decision by the MAC to cover or non-cover a particular service, procedure or technology on a contractor–wide basis in accordance with the Social Security Act section 1862(a)(1)(A), which describes the reasonable and necessary conditions of coverage.

Incorrect Coding

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

Other

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

4. Tracking Appeals

Providers and suppliers have the right to appeal any improper payment determination made by the CERT program. There are five levels of appeals for the Medicare FFS claims, starting at the MAC level through federal court. CERT program claims are generally appealed to the first three levels: (1) redeterminations at the MAC level, (2) reconsiderations at the Qualified Independent Contractor (QIC) level, and (3) administrative hearings by Federal Administrative Law Judges (ALJs).[10]

Final appeal decisions figure into the calculation of the Medicare FFS improper payment rate.[11] The CERT program tracks appeals throughout all levels. The improper payment rate reported in the HHS AFR incorporates the most recent payment information as of the official cutoff date. The CERT program also tracks claim determination reversals based on late documentation.

5. Determining the Improper Payment Rate

Each MAC's contribution to the overall improper payment rate is proportional to their share of total Medicare payments. The CERT program projects the sample to the universe statistically. These calculations meet the national precision of 2.5 percentage points and 90 percent confidence as required by the IPIA of 2002. These calculations also achieve 3-percentage point precision and 95 percent confidence for contractor-specific rates.[12]

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[10] A small number of claims go beyond these first three levels. The fourth level of appeal consists of a claims review by the HHS Departmental Appeals Board, while the fifth level of appeal is a judicial review by a federal district court. Judicial review by a federal district court is only for claims that are greater than a specified dollar amount.

[11] Common reasons for the reversal of claim denials on appeal include the acquisition of additional supporting documentation by the appeal entities and expert (third party) testimony establishing that the denied services were reasonable and necessary.

[12] OMB issued guidance for IPIA of 2002 implementation requirements, including attaining statistical validity,

6. Reporting the Results

The claims universe includes all claims that have undergone final adjudication by the MACs, regardless of the final decision (i.e., the decision to pay, reduce, or deny the claim). Therefore, the improper payment rate includes both overpayments (improper claim approvals) and underpayments (improper claim denials).

Net improper payments equal the overpayments less the absolute value of underpayments. The net improper payment rate equals the net improper payments in the CERT sample divided by the total dollars paid in the CERT sample. This rate shows the net impact of overpayments on the Medicare Trust Funds.

Gross improper payments equal overpayments plus the absolute value of underpayments. The gross improper payment rate equals the gross improper payments in the CERT sample divided by the total dollars paid in the CERT sample. This rate shows the impact of both overpayments and underpayments on the Medicare Trust Funds. The official improper payment rate is the gross improper payment rate.

7. Reconciliation of Improper Payments

The CERT program notifies the MACs of improper payments identified through the CERT process. The MACs then reimburse underpayments and recoup overpayments. MACs can recover the overpayments identified in the CERT sample but cannot recoup projections made to the claims universe.[13]

MACs recover most of the overpayments identified on claims sampled by the CERT program. MACs cannot recover projected overpayments. Overpayments on claims sampled during the 2014 report period were $53,725,898. As of the publication date of the FY 2014 HHS AFR, actual MAC collections for these overpayments were $44,243,005 or 82 percent of the actual overpayment dollars identified. MACs do not collect overpayments if they cannot locate providers or suppliers who have gone out of business. MACs also do not collect overpayments when a claim decision is overturned on appeal. When active Medicare providers or suppliers fail to respond to requests for repayment and do not appeal, MACs may recoup overpayments by offsetting future payments.

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through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011. and October 20, 2014.

[13] For example, if a hospital submits an erroneous claim that leads to an overpayment, the MAC can only collect the amount due for that particular claim. The MAC cannot use this claim denial to extrapolate and collect the estimated amount of overall overpayments that hospital may have submitted during the report period.

ANALYSIS AND SUMMARY OF RESULTS

All rates and amounts in the detailed analysis are unadjusted for the impact of Part A to B rebilling (Part A to Part B rebilling was explained on Page 2 of the report).

Part A Drivers of the Medicare FFS Improper Payment Rate

Excluding Inpatient PPS Hospital Services[14]

Home Health Services[15]

The Medicare FFS home health benefit pays for certain health care services in the home setting that meet all rules, including the reasonable and necessary criteria. Covered services can include:

- Skilled nursing care
- Medical-social services
- Medical supplies
- Physical, occupational, and speech-language therapies

The improper payment rate for home health services was 51.4 percent, accounting for 19.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during the 2014 report period was $9.4 billion.

Coverage of home health services depends on factors such as the "confined to home" status of the beneficiary and an intermittent need for skilled care. Some examples of required documentation to support home health services include, but are not limited to:

- Physician certification/recertification of "confined to home" status and the need for home health services

[14] Improper payment rate reporting for Part A (excluding inpatient hospital DRG) providers is determined by the type of bill submitted to Medicare for payment. Providers, facilities, and suppliers that submit institutional claims via the electronic American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Health Care Claim: Institutional (837), or paper claim format Uniform Billing (UB)-04, are included in the Part A (excluding inpatient hospital DRG) improper payment rate calculation. Examples of providers, facilities, and suppliers that bill using these formats include hospitals, skilled nursing facilities, home health and hospice providers, renal dialysis facilities, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. These institutional claims may include professional services that may be paid under Part A or Part B, yet are ultimately included in the CERT Part A (excluding inpatient hospital DRG) improper payment rate measurement because they are submitted on the ASC X12 837 or UB-04. .

[15] Home Health Services is defined as all services with a provider type of Home Health Agency.

- Face-to-face encounter documentation
- Therapy notes
- A comprehensive assessment of the beneficiary

Insufficient documentation caused a large proportion of improper payments for home health services. Face-to-face encounter documentation that did not meet guidelines was the most common reason for insufficient documentation errors.

Example

A home health agency submitted a claim for services. The face-to-face encounter note did not include the date of the encounter, clinical findings, or sufficient documentation to support homebound status as required by Medicare guidelines. Documentation stated: "Patient on dialysis. Seen on dialysis Tuesday/Thursday. Has Parkinson's/renal failure & anemia. Needs assistance with ADLs [activities of daily living] & home PT [Physical Therapy]." Medicare guidelines state that "[t]he physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter, and including an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services .... " The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Hospital Outpatient Services

Medicare FFS Part A provides coverage for some services provided in the outpatient hospital setting. Covered services include, but are not limited to:

- Medication administration
- Laboratory and other diagnostic testing
- Therapy services

The improper payment rate for outpatient services was 7.7 percent, accounting for 7.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for outpatient services during the 2014 report period was $3.5 billion.

The majority of improper payments for outpatient services were due to insufficient documentation errors. Many hospital outpatient claims with insufficient documentation lacked a physician's order or documentation supporting the physician's intent to order laboratory or other diagnostic tests.

Example

A provider billed for an infusion of a medication that is provided in the outpatient setting. The submitted documentation included a visit note that supported the medical necessity of the

medication. However, the documentation was missing the physician's order and the administration record for the infusion. The CERT program scored the claim an improper payment due to an "insufficient documentation error."

Skilled Nursing Facility Services[16]

The Medicare SNF benefit pays for certain skilled services provided in various skilled nursing settings, including swing-bed hospitals, nursing homes, and other freestanding facilities. Covered SNF services require the skills of qualified technical or professional health personnel. The SNF benefit does not cover custodial services alone, such as assistance with bathing, dressing, and using the bathroom.

The improper payment rate for SNF services was 6.9 percent, accounting for 5.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2014 report period was $2.6 billion.

The majority of improper payments for SNF services were due to insufficient documentation. Providers of SNF services are required to submit medical records to support the medical necessity of SNF services provided. For example, required documents include, but are not limited to:

- A certification that the beneficiary needed daily skilled care that could only be provided in a SNF setting
- An authenticatedplan of care
- The time (in minutes) for the therapy service provided

Example

A SNF submitted a claim for skilled services provided to a beneficiary. The SNF admission was after a seven day acute inpatient hospital admission for pneumonia. Documentation submitted to support the SNF claim included SNF admission orders; SNF History & Physical; SNF physician notes; nursing records; records from the prior acute inpatient admission; and physical therapy and occupational therapy initial evaluations, plans of care and treatment logs. The submitted documents did not contain a certification statement by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The submitted physician notes and orders were insufficient to show that the beneficiary met the SNF level of care requirements. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Example

A SNF submitted a claim for skilled services provided to a beneficiary. The SNF billed the claim based on the beneficiary receiving 12 hours of therapy per week by at least two therapy disciplines. The submitted documentation supported that the beneficiary was receiving only speech therapy for two hours per week. The claim was re-coded based on the submitted documentation. The CERT

[16] Skilled Nursing Facility is defined as all services with a provider type of SNF.

program scored the claim as an improper payment due to an "incorrect coding error."

Inpatient Rehabilitation Facility Services[17]

The Medicare Inpatient Rehabilitation Facility (IRF) benefit provides intensive rehabilitation therapy in an inpatient environment. The IRF benefit is for a beneficiary who requires and can benefit from an inpatient stay and an interdisciplinary approach to rehabilitation care.

The improper payment rate for IRFs was 20.7 percent, accounting for 2.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for IRFs during the 2014 report period was $1.3 billion. Most of the improper payments for IRFs were due to insufficient documentation.

IRF coverage depends on factors such as multiple ongoing therapy disciplines, participation in intensive therapy (usually three hours per day at least five days per week), and supervision by a rehabilitation physician. Required documentation elements for an IRF claim include, but are not limited to:

- Preadmission screening
- Post-admission physician evaluation
- Individualized plan of care
- Admission orders
- A comprehensive assessment

Example

A provider billed for an inpatient rehabilitation stay. The submitted documentation showed that the beneficiary was discharged from an acute inpatient care facility and admitted to the IRF on the same day. The beneficiary met the IRF medical necessity criteria (i.e., multiple therapy disciplines, physician supervision, and an interdisciplinary team approach to the delivery of care). However, the beneficiary did not meet the criteria for intensive rehabilitative therapy with the ability to participate in the therapy program. The required documentation (i.e., preadmission screening, post admission physician evaluation, individualized overall plan of care, physician's orders, and IRF-Patient Assessment Instrument) was present in the medical record, but the documentation was insufficient to support that the beneficiary received the intensity of rehabilitation therapy services uniquely provided in an IRF. The CERT program scored the claim an improper payment due to an "insufficient documentation error."

End-Stage Renal Disease Services

Medicare provides End-Stage Renal Disease (ESRD) benefits for all renal dialysis services for

[17] Inpatient Rehabilitation Facility is defined as any service with a provider type of either Inpatient Rehabilitation Hospitals or Inpatient Rehabilitation Unit.

outpatient maintenance dialysis. Medicare-certified ESRD facilities or special purpose dialysis facilities are responsible for furnishing all renal dialysis services to ESRD beneficiaries either directly or under arrangement with other providers or suppliers. The most common elements of dialysis treatment are:

- Laboratory tests
- Drugs
- Equipment and supplies
- Services provided by registered nurses, licensed practical nurses, technicians, social workers, and dietitians

The improper payment rate for ESRD services was 10.7 percent, accounting for 2.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for ESRD services during the 2014 report period was $1.2 billion.

The majority of improper payments for ESRD services were due to insufficient documentation errors. Providers of ESRD services are required to submit documentation to support the medical necessity of ESRD services provided. For example, required documents include:

- An authenticated plan of care
- Orders for dialysis, medications, and laboratory tests
- Medication administration records

Example

A dialysis clinic submitted a claim for one month of dialysis services for a beneficiary. The submitted documentation did not include any physician orders for hemodialysis, laboratory studies, or medications. The medical record included nursing treatment notes, the plan of care, team notes, the results of the laboratory tests, and the physician face-to-face notes. However, no orders or signed physician protocols were found, even after multiple additional documentation requests. The CERT program scored the claim an improper payment due to an "insufficient documentation error."

Non-Hospital-Based Hospice Services

Hospice care is a Medicare FFS elected benefit for Part A beneficiaries. Covered hospice services for the palliation and management of the terminal illness and related conditions include, but are not limited to:

- Hospice physician services
- Nursing care
- Drugs for symptom control and pain relief
- Medical equipment and supplies
- Grief and loss counseling for the beneficiary and his or her family
- Physical, occupational, and speech-language therapies

The improper payment rate for hospice services was 3.8 percent, accounting for 1.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for hospice services during the 2014 report period was $471.1 million. Most of the improper payments for hospice claims were due to insufficient documentation.

A physician must certify a beneficiary as terminally ill to receive the hospice benefit. The first period of hospice coverage requires two such certifications - one from the medical director of the hospice or the physician member of the hospice interdisciplinary group and one from the beneficiary's attending physician (if the beneficiary has an attending physician). The written certification must include:

- Certification that the beneficiary is terminally ill with a prognosis of six months or less if the terminal illness runs its normal course;
- Clinical findings and other documentation that support a life expectancy of six months or less;
- A brief narrative explanation of the clinical findings, composed by the physician, that supports a life expectancy of six months or less;
- The signature of the physician and the date the certification was signed; and
- The benefit period dates to which the certification applies.

For subsequent benefit periods, either the medical director of the hospice, the physician member of the hospice interdisciplinary group, or the beneficiary's attending physician can complete the recertification. To qualify for a third benefit period, a beneficiary must have a face-to-face encounter with a hospice physician or hospice nurse practitioner. For most claims with insufficient documentation, the submitted certification or recertification did not adequately address the requirements listed above.

Example

A nursing facility submitted a claim for hospice services (third benefit period) provided to a beneficiary. The submitted medical records contained the physician's Certification of Terminal Illness, the election of hospice benefit notice, orders, nursing notes, and other interdisciplinary visit notes. However, there was no record of a physician face-to-face encounter. An additional request for documentation of a physician face-to-face encounter resulted in no further documentation. The CERT program scored the claim an improper payment due to an "insufficient documentation error."

Inpatient PPS Hospital Services

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates known as the inpatient prospective payment system (PPS). The inpatient PPS categorizes patient care into a Medicare Severity (MS)-DRG based upon the procedures performed, the severity of the beneficiary's condition, and other factors. Each MS-DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that MS-DRG. Hospitals must meet all documentation requirements specified in Medicare policy to receive Medicare payment for an inpatient hospital stay.

The 2014 improper payment rate for inpatient PPS hospital services was 9.2 percent, accounting for 21.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for inpatient PPS hospital services during the 2014 report period was $10.4 billion (adjusted for Part A to B rebilling).

The 2014 inpatient PPS hospital improper payment rate and amount are adjusted for Part A to B rebilling. This adjustment accounts for the difference between the improper inpatient payment made under Medicare Part A and the amount that would have been payable if the hospital claim was rebilled as a Medicare Part B claim. The Part A to B rebilling adjustment only applies to the overall improper payment rate for Part A inpatient services and not to procedure-specific rates.[18]

The CERT program identified many improper payments due to inpatient hospital incorrect status errors (i.e., patient status errors). Patient status errors occur when the physician admits a Medicare beneficiary as inpatient when the medical record supports the provision of care in an outpatient or other non-hospital based setting. The CERT program categorizes these situations as "medical necessity errors." The CERT program denied 2,677 claims for this reason during the 2014 report period. These sampled errors totaled $29.9 million in actual overpayments, which projected to $8.8 billion in overpayments for the universe of Medicare FFS claims (not adjusted for Part A to B rebilling).

The CMS implemented two major policies in CMS 1599-F (78 FR 50495, issued on August 2, 2013 and effective on October 1, 2013) pertaining to inpatient hospital claims that are expected to reduce improper payments:

- CMS allowed all hospital participants to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient.

- CMS clarified and modified the policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A and how Medicare review contractors will assess inpatient hospital claims for payment purposes.

This new rule and policy change will affect claims reviewed for the 2015 Medicare FFS Improper Payments Report. The CMS anticipates that patient status errors will decrease as a result of this policy in future report periods.

Patient status errors are more likely to occur when the length of stay is shorter. Particularly, elective surgical procedures cause many incorrect status errors. In these cases, the beneficiary is sometimes admitted as an inpatient after the procedure is completed for post-operative overnight monitoring, and discharged the next day. There was sometimes no need for the beneficiary to be

[18] The Part A to B rebilling adjustment factor was calculated by selecting a random sub-sample of Part A inpatient claims selected by the CERT program and repricing the individual services provided under Part B. Because this repricing process was not applied to all of the Part A inpatient claims selected by the CERT program, the Part A to B rebilling adjustment factor could only be applied to the high-level calculations (i.e., the overall, Part A Total, and Part A Inpatient Hospital Service improper payment rates). This methodology is unchanged from 2012 and 2013.

admitted as an inpatient for post-procedure monitoring even if the procedure itself was reasonable and necessary. Generally, billing an outpatient claim for these services is appropriate in this situation.

Table 3: Projected Improper Payments by Length of Stay[19]

Part A Inpatient PPS Hospital Length of Stay	Improper Payment Rate	Projected Improper Payment	Proportion of Overall CERT Error
All CERT	**13.6%**	**$49.1**	**100.0%**
Overall Inpatient Hospital PPS	**12.2%**	**$13.8**	**28.1%**
0 or 1 day	37.1%	$3.3	6.8%
2 days	20.2%	$2.6	5.3%
3 days	12.9%	$2.0	4.1%
4 days	10.9%	$1.3	2.6%
5 days	7.5%	$0.7	1.5%
More than 5 days	7.1%	$3.9	7.9%

The two examples below illustrate improper payments for MS-DRG groups during the 2014 reporting period.

Heart Failure & Shock: MS-DRGs 291, 292, and 293

Heart failure is a condition where the heart cannot pump blood effectively, resulting in symptoms such as shortness of breath, fatigue, and swelling of the lower extremities. Heart failure may be due to diseases that damage the heart muscle such as heart attacks or long standing high blood pressure. The medical term "shock" means that the heart is not pumping enough blood and oxygen to supply vital organs such as the brain and kidneys.

The improper payment rate for services for MS-DRGs 291, 292, and 293 was 15.8 percent, accounting for 1.1 percent of the overall Medicare FFS improper payment rate. The projected

[19] Unadjusted for Part A to B rebilling

improper payment amount for these services during the 2014 report period was $541.4 million (without the Part A to B rebilling adjustment).

The majority of the improper payments identified for MS-DRGs 291, 292, and 293 were medical necessity errors. Most of the medical necessity errors during this report period (i.e., prior to the application of FY2014 Hospital Inpatient PPS final rule CMS-1599-F) occurred when the beneficiary had a brief hospitalization and the medical record documentation failed to support billing for a MS-DRG rather than outpatient services. These errors contributed to the improper payment rate for stays of one day or less.

Permanent Cardiac Pacemaker Implantation: MS-DRGs 242, 243, and 244

Cardiac pacemakers are battery-operated implanted devices that send electrical pulses to the heart. A pacemaker helps monitor and control a person's heartbeat. They are often classified by the number of chambers of the heart that the devices stimulate. Single- chamber pacemakers typically target either the right atrium or right ventricle. Dual-chamber pacemakers stimulate both the right atrium and the right ventricle. The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization.

The improper payment rate for MS-DRGs 242, 243, and 244 was 36.5 percent, accounting for 0.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2014 report period was $415.2 million (without the Part A to B rebilling adjustment).

Medicare has specific coverage criteria that provide the medical reasons for which Medicare will pay for pacemaker implantation. The majority of the improper payments identified for MS-DRGs 242, 243, and 244 were medical necessity errors due to the placement of a dual chamber pacemaker when the NCD requirements were not met.[20] Most of the medical necessity errors during this report period occurred when Medicare only covered a single-chamber pacemaker for the particular beneficiary but the beneficiary received a dual-chamber pacemaker. Other medical necessity errors occurred due to patient status errors.

Part B Drivers of the Medicare FFS Improper Payment Rate

DMEPOS

DMEPOS is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Medicare provides coverage for medically necessary DMEPOS items under the Part B benefit. Medicare pays for DMEPOS items only if the beneficiary's medical record contains sufficient documentation of the patient's medical condition

[20] Effective on August 13, 2013, CMS revised the NCD (NCD 20.8.3) for dual chamber permanent cardiac pacemakers. The CMS anticipates that the improper payment rate for dual-chamber pacemakers will decrease in future report periods due to this revision.

to support the need for the type or quantity of items ordered. In addition, all documentation requirements outlined in Medicare policies must be present for the claim to be paid.

The improper payment rate for DMEPOS was 53.1 percent, accounting for 10.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for DMEPOS during the 2014 report period was $5.1 billion. Insufficient documentation errors caused the vast majority (92.4 percent) of improper payments for DMEPOS. In these cases, the supplier or provider did not submit a complete medical record or the record did not adequately support the supplies or services billed. Other insufficient documentation errors were found when the medical record lacked required documentation elements such as a documented face-to-face physician evaluation within a specified timeframe or a physician signature on a supplier form.

Documentation created by the DMEPOS supplier alone is insufficient for payment of the claim under Medicare requirements. It is often difficult to obtain proper documentation for DMEPOS claims because the supplier that billed for the item must obtain detailed documentation from the medical professional who ordered the item. As such, the involvement of multiple parties can contribute to missing or incomplete documentation and delays in the receipt of documentation. Due to the importance of documentation to support the necessity for DMEPOS items billed, CERT notifies ordering providers, physicians, and practitioners of claims selected for review. This notification reminds these individuals and entities of their responsibilities to document medical necessity for the DMEPOS items ordered and to submit requested documentation to the supplier.

The six DMEPOS groups with the highest improper payments were oxygen supplies and equipment, glucose monitors and testing supplies, positive airway pressure devices and supplies for beneficiaries with obstructive sleep apnea, enteral nutrition supplies, nebulizers and related drugs, and infusion pumps and related drugs. These six DMEPOS groups combined accounted for 52.7 percent of the DMEPOS improper payments in the 2014 report period.

Oxygen Supplies and Equipment

Medicare FFS provides coverage for home and portable oxygen supplies and equipment for beneficiaries with severe lung disease or conditions related to low oxygen levels that improve with oxygen therapy.

The improper payment rate for oxygen supplies was 62.1 percent, accounting for 1.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for oxygen supplies and equipment during the 2014 report period was $951.9 million.

For Medicare coverage, the patient's medical record must contain timely documentation of the patient's medical condition to support the continued need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as physician orders for the oxygen supplies, oxygen saturation results, physician evaluations demonstrating oversight of the beneficiary and their continued need for oxygen supplies, and the appropriateness of home and/or portable oxygen supplies.

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

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

Example

A supplier submitted a claim for monthly charges for an oxygen concentrator. The beneficiary had been using oxygen for more than a year. The initial CMN, an appropriately dated recertification CMN, a delivery ticket, and a nocturnal oxygen saturation study were received. Medicare requires that a physician re-evaluate the beneficiary within 90 days prior to completing the recertification CMN. Timely documentation showing that the beneficiary continues to need and use the oxygen is also required. An additional documentation request resulted in a note from the physician that stated: "I haven't seen this patient since 2009." The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Glucose Monitors and Testing Supplies

Medicare provides coverage for glucose monitors and supplies (e.g., test strips and lancets) for Medicare beneficiaries with diabetes at a frequency of testing that is medically necessary.

The improper payment rate for glucose testing supplies was 56.9 percent, accounting for 1.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for glucose testing supplies during the 2014 report period was $674.7 million.

For Medicare coverage, the beneficiary's medical record must contain timely documentation of the beneficiary's medical condition to support the continued need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as a physician's order for the glucose testing supplies, evaluations demonstrating physician oversight of the beneficiary, and the need for glucose testing supplies.

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

- The order for the glucose testing supplies stating the number of times per day the beneficiary is to test his or her glucose level

- Physician's notes showing the beneficiary's diabetic condition and the need for glucose testing supplies at the frequency billed
- Physician's notes showing periodic reviews of the glucose testing orders within Medicare's designated timeframes

Example

A supplier billed for 100 blood glucose test strips and indicated on the claim that it was a one-month supply of blood glucose test strips for a diabetic beneficiary who was not treated with insulin. A diabetic beneficiary who is not treated with insulin is covered for 100 blood glucose test strips every three months unless specific criteria are met. The documentation provided included a verbal order from the supplier that was not signed by the physician and that did not specify the frequency of blood glucose testing. There were office visit notes supporting that the beneficiary was a diabetic taking an oral prescription medication, but the notes did not indicate the specific reason for ordering more than the covered amount of blood glucose test strips. The documentation was insufficient to support the quantity of blood glucose test strips supplied. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Positive Airway Pressure Devices

The term positive airway pressure (PAP) refers to both continuous PAP (CPAP) and bi-level positive airway pressure (BPAP) devices.

The improper payment rate for CPAP/BPAP supplies was 47.3 percent, accounting for 0.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for CPAP/BPAP supplies during the 2014 report period was $366 million.

For Medicare coverage of CPAP/BPAP devices for a diagnosis of obstructive sleep apnea the beneficiary's medical record must contain a sleep test that meets the Medicare coverage criteria in effect for the date of service. The initial coverage period is for three months. For coverage beyond three months, the treating physician must perform a re-evaluation within a specified timeframe. Documentation must show that the beneficiary is benefitting from the therapy and adhering to the usage guidelines.

To be covered, the medical record must include documentation of the qualifying sleep test, the physician's evaluation of the beneficiary's sleep apnea, the supplier's instruction on the proper use and care of the equipment, and the ineffectiveness of CPAP (when a BPAP device is ordered).

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

- The signed and dated order for the CPAP/BPAP device and each accessory billed
- Physician evaluation performed prior to the sleep test, assessing the beneficiary for sleep apnea

- Physician re-evaluation performed within the required timeframe to support that the beneficiary benefits from the therapy and adheres to specified usage guidelines
- Qualifying sleep test that meets Medicare requirements

Example

A supplier billed for six disposable filters for a CPAP device. The submitted documentation was missing the order for the filters and documentation from the physician's records that the beneficiary continued to need and use CPAP. The submitted documentation included the physician's order for CPAP and one filter that was dated three years prior to the billed date of service. The submitted documentation did not meet the criteria for coverage. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Enteral Nutrition

Medicare provides coverage for the administration of medically necessary enteral nutrition formulas and supplies (i.e., feeding a patient through a tube into the stomach or small intestine).

The improper payment rate for enteral nutrition was 62.1 percent, accounting for 0.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for enteral nutrition during the 2014 report period was $240.4 million.

The majority of improper payments for enteral nutrition and supplies were due to insufficient documentation. The patient must meet numerous Medicare criteria for a permanent impairment that requires tube feedings. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements. Documentation in the medical record must show that the beneficiary meets all Medicare criteria, including details of the beneficiary's medical condition, the reason for enteral nutrition, and that there is continued need for the enteral nutrition formula and supplies. There must be a written order from the treating physician and there must be a valid detailed written order dated before the billing date.

Example

A provider billed for enteral nutrition and supply kits for feeding using a pump. The documentation received included a nurse's note that supported tube feeding due to the beneficiary's non-responsive state. An unauthenticated nutritional assessment was also received. The reviewer requested the physician's detailed written order (including the number of calories per day), the DME Information Form, and the physician's timely documentation of the need for enteral nutrition. In response to the additional request for documentation, only the physician's order for the enteral nutrition was received. The submitted documentation did not meet the criteria for coverage. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Nebulizer Machines and Related Medications

Medicare provides coverage for medically necessary nebulizer machines and related medications

for those beneficiaries with respiratory problems such as asthma. A nebulizer machine is a device that uses pressurized air to convert liquid medicine into a fine mist that is easily inhaled.

The improper payment rate for nebulizer machines and related medications was 42.2 percent, accounting for 0.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for nebulizer machines and related medications during the 2014 report period was $237 million.

The majority of improper payments for nebulizer machines and related medications were due to insufficient documentation. There must be a written order from the treating physician that specifies the name of the dispensed solution, the correct dosage and frequency, and the instructions for administration. Medicare also requires documentation from the treating physician that supports the medical necessity of the nebulizer and inhalation medications.

Example

A supplier billed for a nebulizer and compressor. The submitted documentation included a detailed written order for inhalation medication and nebulizer kits. However, there was no timely documentation from the treating physician to support the beneficiary's continued need for and use of the nebulizer. The physician's progress notes did not mention a respiratory disease or nebulizer use and there was no proof of delivery. Submitted documentation did not meet the criteria for coverage. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Infusion Pumps and Related Medications

Medicare provides coverage for specific types of medically necessary infusion pumps. These devices deliver fluids, including medications (e.g., insulin, chemotherapy drugs, pain relievers, antibiotics), into a patient's body in controlled amounts.

The improper payment rate for infusion pumps and related medications was 58.4 percent, accounting for 0.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for infusion pumps and related medications during the 2014 report period was $213.6 million.

The majority of improper payments for infusion pumps and related medications were due to insufficient documentation. The beneficiary must meet specific Medicare criteria for an infusion pump and the beneficiary's medical record must contain timely documentation of the beneficiary's medical condition, evaluations demonstrating physician oversight of the beneficiary, and continued need for the infusion pump and the medication. There must be a written order from the treating physician and there must be a valid detailed written order dated before the billing date.

Example

A supplier billed for supplies for a medication infusion pump. The documentation received did

not include the DME Information Form, the treating physician's order, or the treating physician's medical records to support the need for the infusion pump and supplies. The submitted documentation from the supplier included an order from a different physician than the one indicated on the claim, and medical records which did not support the need for the infusion pump. Submitted documentation did not meet the criteria for coverage. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Evaluation and Management Services

Evaluation and Management (E&M) services are visits and consultations by physicians and other qualified non-physician practitioners (NPPs) to Medicare beneficiaries.

The improper payment rate for E&M services was 14.6 percent, accounting for 9.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $4.5 billion.

The type of service, place of service, patient's status, content of the service, and the time required to provide the service determine the category of E&M service. The components that determine the correct E&M service are:

- History (includes information such as the nature of presenting problem, past history, family history, social history, review of systems),
- Physical examination,
- Medical decision making (includes such factors as the number of possible diagnoses and management options that must be considered; the amount and complexity of the medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed; the risk of significant complications, morbidity, and mortality, the beneficiary's comorbidities that are associated with the presenting problems; and the possible management options),
- Counseling provided,
- Coordination of care, and
- The amount of time spent working on the beneficiary's case

Incorrect coding and insufficient documentation caused most of the improper payments for E&M services during the 2014 report period. Often the physician submitted medical documentation that supported a different E&M code than the one billed. Many other claims were found to have insufficient documentation errors because the submitted records lacked a physician signature. For other claims, physicians provided services in settings other than their own offices and did not submit records maintained by hospitals or other facilities.

Non-Physician Practitioners

The CERT program identified many improper payments for E&M services billed using physicians' National Provider Identifiers (NPIs) but provided solely by non-physician practitioners. For certain E&M visits and settings, if a physician and a qualified NPP each perform and document a substantive part of an E&M visit face-to-face with the same beneficiary on the same date of service, then the physician can bill this visit under his or her NPI. NPPs

must bill under their own NPIs if they provide an E&M service (in person) for a physician's patient in hospital and the physician does not also perform (and document) a substantive part of an E&M visit face-to-face with the same beneficiary on the same date of service.

E&M: Hospital Visit – Subsequent

The improper payment rate for subsequent hospital visits was 20.7 percent, accounting for 2.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $1.2 billion.

The majority of improper payments for subsequent hospital visits were due to insufficient documentation.

Example

A provider billed HCPCS code 99232 (subsequent hospital care, per day for the evaluation and management of a patient). The submitted documentation included handwritten, partially legible progress notes and diagnostic test results which were all for other dates of service. An additional documentation request resulted in office progress notes for different dates of service. The submitted documentation was insufficient to support the services billed. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

E&M: Office Visits – Established

The improper payment rate for office visits with established patients was 7.2 percent, accounting for 2.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $1.0 billion.

The majority of improper payments for office visits with established patients were due to incorrect coding.

Example

A provider billed HCPCS code 99214 (office or other outpatient visit for the evaluation and management of an established patient). The submitted documentation did not include at least 2 of the 3 required key components. The patient was seen for a routine follow up, was stable, and no changes in treatment or medications were required. The CERT program scored the claim as an improper payment due to an "incorrect coding error."

E&M: Hospital Visit – Initial

The improper payment rate for initial hospital visits was 31.3 percent, accounting for 1.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $912.1 million.

The majority of improper payments for initial hospital visits were due to incorrect coding.

Example

A provider billed HCPCS code 99223 (initial hospital care, per day, for the evaluation and management of a patient). The beneficiary was admitted for rehabilitation services following surgery of an incarcerated incisional hernia as well as significant gait mobility deficits. The submitted documentation did not meet the requirements for 99223 but met the requirements for HCPCS code 99221. The CERT program downcoded the claim and scored it as an improper payment due to an "incorrect coding error."

Laboratory Tests - Other

This is a very broad category of Part B services, which includes HCPCS codes for pathology and laboratory services. The category is BETOS Code category T1H "Lab tests - other (non-Medicare fee schedule)". Examples of these services are urine drug screening, medication assays, genetic tests, tissue examination, blood tests, and others.

The improper payment rate for "lab tests – other" was 36.1 percent, accounting for 2.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $1.1 billion.

The majority of improper payments for "lab tests – other" were due to insufficient documentation. All lab tests require documentation in the beneficiary's medical record indicating the intent to order the test and supporting the medical necessity for the test. The treating physician or NPP must sign medical record documentation showing the intent to order the test (e.g., including office visit notes, progress notes, or testing protocols). Some specialized lab tests have precise documentation requirements and coverage criteria.

Routine screening tests (unless specifically covered by Medicare) or tests for quality assurance or quality control are not considered medically reasonable and necessary.

Example

A laboratory billed for a lipid panel. The submitted documentation included a "Physician's Order Sheet" with orders to increase the insulin dose and an unsigned lab requisition for a hepatic panel and thyroid panel on the billed date of service. Following an additional documentation request, the ordering physician's office submitted a note that stated "No additional documentation is available for this date of service.." The submitted documentation was insufficient to support the services billed. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Minor Procedures - Other (Medicare Fee Schedule)

This is a very broad category of Part B services, which includes HCPCS codes for specific therapy services, minor excisions, procedures, diagnostic studies, and treatments. The category is BETOS Code category P6C "Minor procedures – other (Medicare fee schedule)."

The improper payment rate for "minor procedures – other (Medicare fee schedule)" was 25.5 percent, accounting for 1.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $815.5 million.

The majority of improper payments for "minor procedures – other (Medicare fee schedule)" were due to insufficient documentation. For Medicare coverage, the beneficiary's medical record must contain documentation of the service provided including relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Example

A provider billed for a therapeutic intramuscular injection. The submitted documentation included the nurse's hand written note documenting: "Injection given on left hip, next injection 3 weeks". Following a request for additional documentation, a visit note was received for a date of service other than the billed date of service. Although the additional documentation supported medical management of the beneficiary's condition, without the physician's order, the documentation was insufficient to support the services billed. The CERT program scored this claim as an improper payment due to an "insufficient documentation error".

Example

A physical therapist billed for HCPCS 97112 (i.e., therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities), with GP modifier (Services Delivered Under an Outpatient Physical Therapy Plan of Care); 3 units of service. The submitted documentation included the therapy progress note supporting 45 minutes of massage therapy which does not support a bill for HCPCS 97112. Also submitted were radiology reports and a neurology note documenting the plan to order physical therapy for "Instruction - Massage Therapy." There was no therapy plan of care and no physician order containing the elements of a therapy plan of care. Additional requests for supporting documentation returned only duplicates of the previously submitted records. The CERT program scored the claim as an improper payment due to an "insufficient documentation error."

Ambulance Services

The improper payment rate for ambulance services was 12.4 percent, accounting for 1.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $716.9 million.

Medicare covers ambulance services only for beneficiaries whose medical condition is such that use of any other means of transportation is contraindicated. The beneficiary's condition at the time of transport determines whether the service is medically necessary.

The majority of improper payments for ambulance services were due to insufficient documentation. For Medicare coverage, in addition to other requirements, the documentation must support the medical necessity for ambulance services, include details of the beneficiary's

condition, and explain the need for special items or services. In order for an ambulance supplier or provider to submit a claim to Medicare for ambulance services, Medicare requires the signature of the beneficiary, or that of a person authorized to sign the claim form on behalf of the beneficiary.

Example

A supplier of ambulance services billed for HCPCS A0429 Basic Life Support, emergency transport, with origin and destination modifier HH (Hospital to Hospital). The submitted documentation included an unsigned patient care record for the billed date of service. As required, the beneficiary signed the claim to authorize the supplier to submit it to Medicare, but the signature was illegible. Despite requests for the specific items that were missing, and for signature attestations, no additional documentation was received. The CERT program scored the claim an improper payment due to an "insufficient documentation error."

Psychiatry and Psychotherapy Services

The improper payment rate for psychiatry and psychotherapy services was 28.7 percent, accounting for 0.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2014 report period was $316.2 million.

The majority of improper payments for psychiatry and psychotherapy services were due to insufficient documentation. The time spent providing psychotherapy determines the psychotherapy code. Providers must clearly document in the beneficiary's medical record the time spent providing the psychotherapy service rather than entering one time period also including an E&M service.

Example

The provider billed HCPCS 90833 - psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service. Initial documentation received was a progress note for the billed date of service that was missing documentation of time spent during the encounter. Following additional documentation requests for documentation of time spent during the encounter and the treatment plan (containing frequency & duration of treatment as well as measurable goals), no additional documentation was received. The submitted documentation was insufficient to support the services billed. The CERT program scored the claim an improper payment due to an "insufficient documentation error."

Corrective Actions to Improve the Accuracy Rate

In addition to the four major initiatives discussed on pages 8 – 9 above, CMS has also developed other corrective actions expected to reduce improper payments in future report periods. While some of these corrective actions are planned or newly established, others have been in place for longer periods of time.

New Corrective Actions Include:

Agency-wide Collaboration Corrective Action - Program Integrity Board

In November 2014, CMS established a Program Integrity (PI) Board (the Board) to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in the Agency's programs including the Medicare FFS program. The Board is comprised of CMS executive leaders, all of whom have a stake in the identification and prevention of improper and fraudulent payments. The Board directs corrective actions to combat high priority vulnerabilities and is responsible for directing program integrity activities, prioritizing vulnerabilities, resolving incidents, and addressing emerging issues.

Underneath the Board, a PI Workgroup will consider payment trends, vulnerabilities and strategic issues to make recommendations for new corrective actions for the PI Board's consideration. The PI Workgroup will also implement the decisions and priorities articulated from the Board across the agency. The PI Workgroup will establish multiple Integrated Project Teams to focus on one particular vulnerability area and research and develop possible solutions. The Integrated Project Teams focus on operational aspects of program integrity vulnerabilities.

The PI Workgroup and Integrated Project Teams will utilize data provided by an Improper Payments Corrective Action Team to target drivers and root causes of improper payments. The Improper Payments Corrective Action Team analyses and communicates data gathered from improper payment measurements such as the CERT program.

CMS will utilize the PI Board to leverage all of the Agency's resources to explore new and innovative ways to improve program integrity to prevent and reduce improper payments.

Provider Outreach and Education

- The CMS began publishing a new Medicare Learning Network® (MLN) series titled "Provider Compliance Tips" to increase provide compliance with documentation requirements. The first topic, Computed Tomography (CT) Scans, was published in April 2014.
- The CMS responded to Home Health errors by issuing claim determination education letters, implementing probe edits, and conducting one-on-one provider education sessions.
- The CMS conducted a "probe and educate" program to ensure understanding and compliance

with the inpatient hospital admission rules outlined in CMS-1599-F (i.e., "The 2-Midnight Rule"). As part of this program, the MACs reviewed a small sample of Medicare Part A inpatient hospital claims (10 to 25 claims per hospital) spanning 0 or 1 midnight after formal inpatient admission to determine the medical necessity of the inpatient status in accordance with the 2 midnight benchmark. Based on the results of these initial reviews, CMS conducted individualized educational outreach efforts in order to inform providers of the reasons for denials, provide pertinent education and reference materials, and answer provider questions.

Improving and Applying Data Analysis

- The CMS developed a live data dashboard that provides real-time national and contractor-specific CERT data on improper payments. Full implementation of the dashboard began in October 2014 and access is restricted to MAC and CMS staff.

Targeting the Drivers of Improper Payments

- The CMS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. In February 2014, CMS announced a number of changes to the Medicare FFS Recovery Audit program that will take effect with the new contract awards as a result of stakeholder feedback. The CMS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.
- The CMS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. The CMS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) claims.
- The CMS contracted with a Supplemental Medical Review/Specialty Contractor (SMRC) to perform medical reviews focused on vulnerabilities identified by CMS internal data analysis, the CERT program, professional organizations, and Federal oversight agencies. The SMRC evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. In FY 2014, the SMRC performed post payment reviews on five home health claims from every HHA, specifically to identify the presence of an adequate face-to-face encounter. The contractor also reviewed physician claims for the more expensive level 4 and 5 evaluation and management services. Other projects completed by the SMRC included Power Mobility Devices, Hyperbaric Oxygen Therapy Services, Part B Outpatient Rehabilitation Therapy Services, Inpatient Rehabilitation Facility Services, Non-emergent Magnetic Resonance Imaging of the Lumbar Spine, Non-emergent Myocardial Single Photon Emission Computed Tomography (SPECT), Spinal Fusion, and Chronic Obstructive Pulmonary Disease.
- As part of the Affordable Care Act Bundled Payments for Care Improvement (BPCI) Initiative, Participants in BPCI Model 2 may qualify for a waiver of the Medicare payment policy requiring a 3-day inpatient hospital stay prior to coverage of SNF services for a given beneficiary.
- The CMS is currently collaborating with the Office of the National Coordinator for Health IT

(ONC) and the electronic Determination of Coverage (eDoC) workgroup in developing the interoperability standards necessary for an electronic clinical template. The electronic clinical template will assist physicians with the electronic submission of the medical documentation obtained during the face-to-face examination with a patient. Electronic Clinical Templates are in development for:

- Power Mobility Devices
- Lower Limb Prostheses
- Home Health

Program Integrity Efforts

- The Affordable Care Act (ACA) required CMS to revalidate all 1.5 million existing Medicare suppliers and providers under new risk-based screening requirements. Since March 25, 2011, more than 930,000 providers and suppliers have been reviewed under the new screening requirements. Since the implementation of these requirements, CMS has revoked the ability of 20,219 providers and suppliers to bill the Medicare program as a result of felony convictions; practice locations that were determined to be non-operational at the address CMS had on file; or non-compliance with CMS rules, such as licensure requirements.
- The CMS published CMS-6010-F, "Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements and Changes in Provider Agreements" (77 FR 25283), on April 27, 2012. Effective January 6, 2014, this rule requires physicians and other professionals who order and certify certain covered items and services for Medicare beneficiaries to be Medicare enrolled. These items and services include home health, clinical laboratory, imaging, and DMEPOS. The rule also establishes document retention and access to documentation requirements for physicians and eligible professionals that order and certify certain items and services for Medicare beneficiaries and for the providers and suppliers that furnish those services.
- The CMS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including federal and state partners, private payers, associations, and law enforcement exchange data and anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.
- The CMS made significant progress in identifying fraud with the opening of the CMS Program Integrity Command Center in 2012. The Command Center is focused on driving innovation and improvement in reducing fraud and improper payments by providing a collaborative environment for multi-disciplinary teams to develop consistent approaches for investigation and action.
- In January 2015, CMS extended existing moratoria for newly enrolling ground ambulances in the metropolitan areas of Philadelphia and Houston and home health agencies in the metropolitan areas of Chicago, Fort Lauderdale, Detroit, Dallas, Houston, Miami, and Philadelphia. This powerful tool helps fight fraud and safeguard taxpayer dollars while ensuring uninterrupted access to care.

Established Corrective Actions Include:

Targeting Insufficient Documentation

- The CMS coordinates provider outreach and education taskforces. These taskforces consist of MAC medical review professionals who meet regularly to develop provider education strategies and materials addressing areas prone to improper payments. The taskforces hold open door forums to discuss documentation requirements and answer provider and supplier questions, and distribute informational articles as needed to improve documentation and to educate providers on Medicare policies. The articles are maintained online on the Medicare Learning Network® and can be accessed by the public on the Medicare Learning Network® website.
- The CMS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- The CMS publishes articles in the Medicare Learning Network® Medicare Quarterly Provider Compliance Newsletter. The articles discuss documentation requirements, CERT findings, and common errors. Article topics published in 2014 included Unbundling, CT Scans, Preventive Measures, Psychiatry & Psychotherapy codes, Obesity Studies, Bariatric Surgery, and Vertebroplasty & Kyphoplasty.
- The CMS publishes Medicare Learning Network® MLN Matters® and Special Edition articles to educate providers and suppliers on how to avoid insufficient documentation errors.
- The CMS revises medical record request letters, as needed, to clarify the components of the medical record required for review. The letter serves as a checklist for the provider or supplier to ensure their record submission is complete. Follow-up medical record request letters have also been developed to explain what missing documentation needs to be submitted.

Improving and Applying Data Analysis

- The CMS provides MACs with quarterly contractor-specific improper payment reports to help them focus on problematic areas and identify emerging vulnerabilities.
- The CMS continues to develop and issue Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements to enable providers to examine their billing patterns compared to their peers in the state and nation.
- The CMS developed the NCCI edits to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual).
- The CMS continues to leverage the Fraud Prevention System (FPS) for predictive analytics technology developed to identify and prevent the payment of improper claims in the Medicare

FFS program on a pre-payment basis. For the first time in the history of the program, CMS is systematically applying advanced analytics against Medicare FFS claims on a streaming, nationwide basis.

- The CMS works with state Medicaid data in the Medicare-Medicaid Data Match program (Medi-Medi program). The CMS designed the program to collaborate with participating state Medicaid agencies on billing trends across the Medicare and Medicaid programs. The CMS analyzes matched data to identify potential fraud, waste, and abuse patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the program an important tool in identifying and preventing fraud and improper payments.

Acronyms

ACA	Affordable Care Act
AFR	Agency Financial Report
ALJ	Administrative Law Judge
BPAP	Bi-Level Positive Airway Pressure
BPCI	Bundled Payments for Care Improvement
CBRs	Comparative Billing Reports
CERT	Comprehensive Error Rate Testing
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CPAP	Continuous Positive Airway Pressure
CPT	Current Procedural Terminology
CT	Computed Tomography
CWF	Common Working File
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
E&M	Evaluation and Management

eDoC	Electronic Determination of Coverage
ESRD	End Stage Renal Disease
FFS	Fee-For-Service
GPRA	Government Performance and Results Act of 1993
HCPCS	Healthcare Common Procedure Coding System
HFPP	Healthcare Fraud Prevention Partnership
HHS	Department of Health and Human Services
HHS DAB	Departmental Appeals Board
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPERIA	Improper Payments Elimination and Recovery Improvement Act of 2012
IPF	Inpatient Psychiatric Facility
IPIA	Improper Payments Information Act of 2002
IRF	Inpatient Rehabilitation Facility
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MS-DRG	Medicare Severity Diagnosis Related Group

NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
OIG	HHS Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health IT
PAP	Positive Airway Pressure
PMD	Power Mobility Device
QIC	Qualified Independent Contractor
SMRC	Supplemental Medical Review/Specialty Contractor
SNF	Skilled Nursing Facility

Appendix

Table 4: Summary of National Improper Payment Rates by Year and by Error Category

Fiscal Year and Rate Type (Net/Gross)		No Document Errors	Insufficient Document Errors	Medical Necessity Errors	Incorrect Coding Errors	Other Errors	Improper Payment Rate	Correct Payment Rate
1996[21]	Net	1.9%	4.5%	5.1%	1.2%	1.1%	**13.8%**	86.2%
1997	Net	2.1%	2.9%	4.2%	1.7%	0.5%	**11.4%**	88.6%
1998	Net	0.4%	0.8%	3.9%	1.3%	0.7%	**7.1%**	92.9%
1999	Net	0.6%	2.6%	2.6%	1.3%	0.9%	**8.0%**	92%
2000	Net	1.2%	1.3%	2.9%	1%	0.4%	**6.8%**	93.2%
2001	Net	0.8%	1.9%	2.7%	1.1%	-0.2%	**6.3%**	93.7%
2002	Net	0.5%	1.3%	3.6%	0.9%	0.0%	**6.3%**	93.7%
2003	Net	5.4%	2.5%	1.1%	0.7%	0.1%	**9.8%**	90.2%
2004[22]	Gross	3.1%	4.1%	1.6%	1.2%	0.2%	**10.1%**	89.9%
2005	Gross	0.7%	1.1%	1.6%	1.5%	0.2%	**5.2%**	94.8%
2006	Gross	0.6%	0.6%	1.4%	1.6%	0.2%	**4.4%**	95.6%
2007	Gross	0.6%	0.4%	1.3%	1.5%	0.2%	**3.9%**	96.1%
2008	Gross	0.2%	0.6%	1.4%	1.3%	0.1%	**3.6%**	96.4%
2009	Gross	0.2%	4.3%	6.3%	1.5%	0.1%	**12.4%**	87.6%
2010	Gross	0.1%	4.6%	4.2%	1.6%	0.1%	**10.5%**	89.5%
2011[23]	Gross	0.2%	5.0%	3.4%	1.2%	0.1%	**9.9%**	90.1%
2012[24]	Gross	0.2%	5.0%	2.6%	1.3%	0.1%	**9.3%**	90.7%
2013[25]	Gross	0.2%	6.1%	2.8%	1.5%	0.2%	**10.7%**	89.3%
2014[26]	Gross	0.1%	8.2%	3.6%	1.6%	0.2%	**13.6%**	86.4%

[21] FY 1996-2003 Improper payments were calculated as Overpayments – Underpayments.
[22] FY 2004-2014 Improper Improper payments were calculated as Overpayments + absolute value of Underpayments.
[23] The FY 2011 improper payment rate reported in the HHS Agency Financial Report was 8.6 percent, which was adjusted for the prospective impact of late appeals and documentation. Because this adjustment could not be applied on a lower level than the overall improper payment rate, the FY 2011 rates in this table are unadjusted.
[24] The FY 2012 improper payment rate reported in the HHS Agency Financial Report was 8.5 percent. The rate of 8.5 percent represented the rate that was adjusted for the impact of denied Part A inpatient claims under Part B. Because this adjustment could not be applied on a lower level than the overall and the Part A improper payment rates, the FY 2012 rates in this table are unadjusted.
[25] Unadjusted for impact of Part A to B rebilling.
[26] Unadjusted for impact of Part A to B rebilling.

Table 5: Comparison of 2013 and 2014 National Improper Payment Rates[27]

Error Category	2013	2014				
	Total	Total	Part A Excl Inpatient PPS Hospital	Part A Inpatient PPS Hospital	Part B	DMEPOS
No Documentation	0.2%	0.1%	0.0%	0.0%	0.1%	0.0%
Insufficient Documentation	6.1%	8.2%	4.6%	0.2%	2.1%	1.3%
Medical Necessity	2.8%	3.6%	0.5%	2.9%	0.1%	0.1%
Incorrect Coding	1.5%	1.6%	0.1%	0.6%	0.8%	0.0%
Other	0.2%	0.2%	0.1%	0.0%	0.1%	0.0%
Total	**10.7%**	**13.6%**	**5.3%**	**3.8%**	**3.1%**	**1.4%**

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

Table 6: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions)[28]

Claim Type	Overall Improper Payments			Overpayments		Underpayments	
	Total Amount Paid	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
Part A (Total)	$259.7	$33.0	12.7%	$31.6	12.2%	$1.3	0.5%
Part A (Excluding Inpatient PPS Hospital)	$146.5	$19.2	13.1%	$19.1	13.0%	$0.1	0.0%
Part A (Inpatient PPS Hospital)	$113.2	$13.8	12.2%	$12.5	11.1%	$1.3	1.1%
Part B	$90.9	$11.0	12.1%	$10.8	11.9%	$0.2	0.2%
DMEPOS	$9.6	$5.1	53.1%	$5.1	53.1%	$0.0	0.0%
Total	**$360.2**	**$49.1**	**13.6%**	**$47.6**	**13.2%**	**$1.5**	**0.4%**

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

Table 7: 2014 Projected Improper Payments (Dollars in Billions) by Type of Error and Clinical Setting[29]

Examining the types of CERT review errors and their impact on improper payments is a crucial step toward reducing the improper payment rate in the Medicare FFS program. Improper payments vary by clinical setting. Insufficient documentation errors and medical necessity errors are the main drivers of projected improper payments.

Error Category	DMEPOS	Home Health Agencies	Hospital Outpatient Departments	Inpatient PPS Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	$0.03	$0.03	$0.02	$0.03	$0.18	$0.00	$0.00	$0.30
Insufficient Documentation	$4.71	$8.46	$5.36	$1.41	$5.64	$2.00	$1.92	$29.49
Medical Necessity	$0.18	$0.84	$0.22	$11.30	$0.06	$0.09	$0.19	$12.87
Incorrect Coding	$0.01	$0.01	$0.15	$2.19	$2.75	$0.38	$0.12	$5.61
Other	$0.16	$0.06	$0.03	$0.17	$0.21	$0.18	$0.01	$0.82
Total	**$5.09**	**$9.40**	**$5.77**	**$15.09**	**$8.85**	**$2.65**	**$2.25**	**$49.09**

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

Figure 1: Proportion of Improper Payments Attributed to Insufficient Documentation in 2014, by Clinical Setting

Insufficient documentation errors accounted for the greatest proportion of improper payments during the **2014** report period.

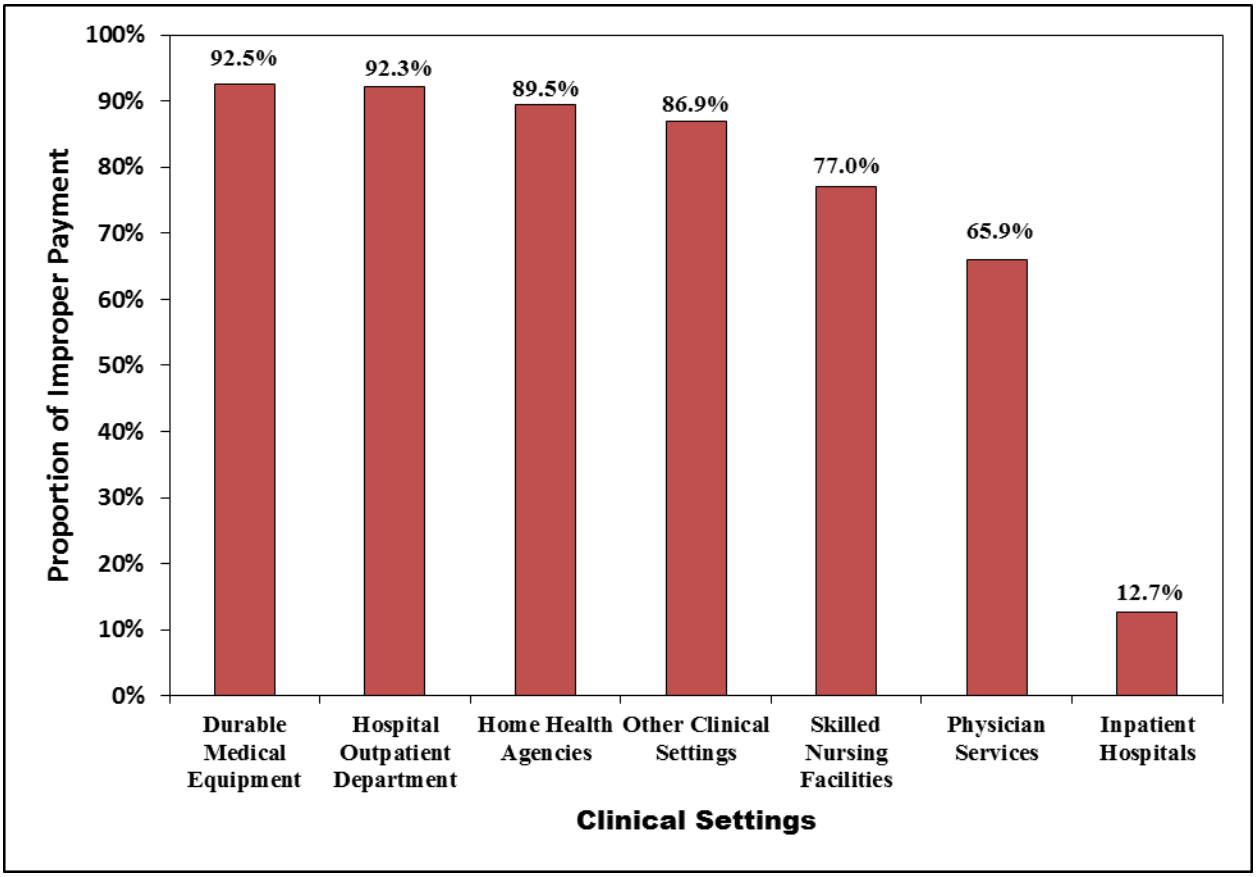

Table 8: Projected Improper Payments, Overpayments and Underpayments by Top 10 States (Dollars in Millions)[30]

	Overall		Overpayments		Underpayments	
	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
CA	$5,155.1	16.0%	$5,033.9	16.0%	$121.2	0.0%
TX	$4,416.5	15.7%	$4,399.1	16.0%	$17.4	0.0%
FL	$3,631.2	13.9%	$3,505.5	13.0%	$125.8	1.0%
NY	$3,282.1	14.0%	$3,015.8	13.0%	$266.3	1.0%
IL	$2,484.4	14.4%	$2,399.5	14.0%	$85.0	1.0%
MI	$2,049.4	14.9%	$1,868.5	14.0%	$180.9	1.0%
PA	$1,948.4	12.2%	$1,888.5	12.0%	$59.9	0.0%
OH	$1,790.1	13.5%	$1,768.8	13.0%	$21.3	0.0%
NC	$1,657.9	12.7%	$1,644.0	13.0%	$13.9	0.0%
NJ	$1,565.7	14.3%	$1,505.1	14.0%	$60.6	1.0%
Overall	**$49,091.4**	**13.6%**	**$47,551.1**	**13.0%**	**$1,540.4**	**0.0%**

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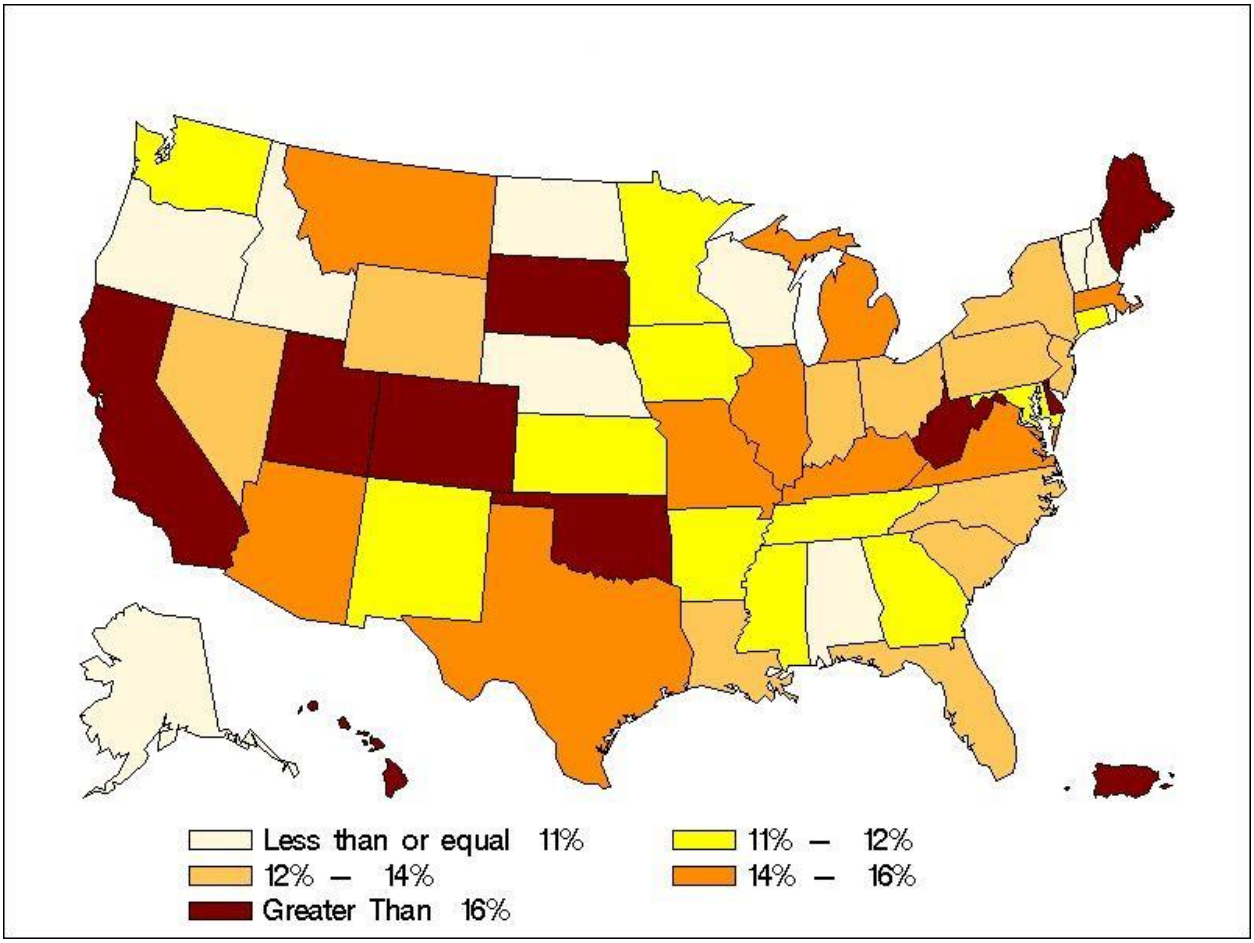
[30] Some columns and/or rows may not sum correctly due to rounding. The improper payment rates in this table are unadjusted for the impact of Part A to B rebilling .

Geographic Trends[31]

Figure 2: 2014 Improper Payment Rates by State



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[31] Cutpoints and colors for maps are assigned using quintiles. Part A Inpatient Hospital maps are unadjusted for Part A to B rebilling; the adjustment does not apply to Part A Excluding Inpatient Hospital PPS, DMEPOS, and Part B

Figure 3: 2014 Improper Payment Amounts by State (Dollars in Millions)

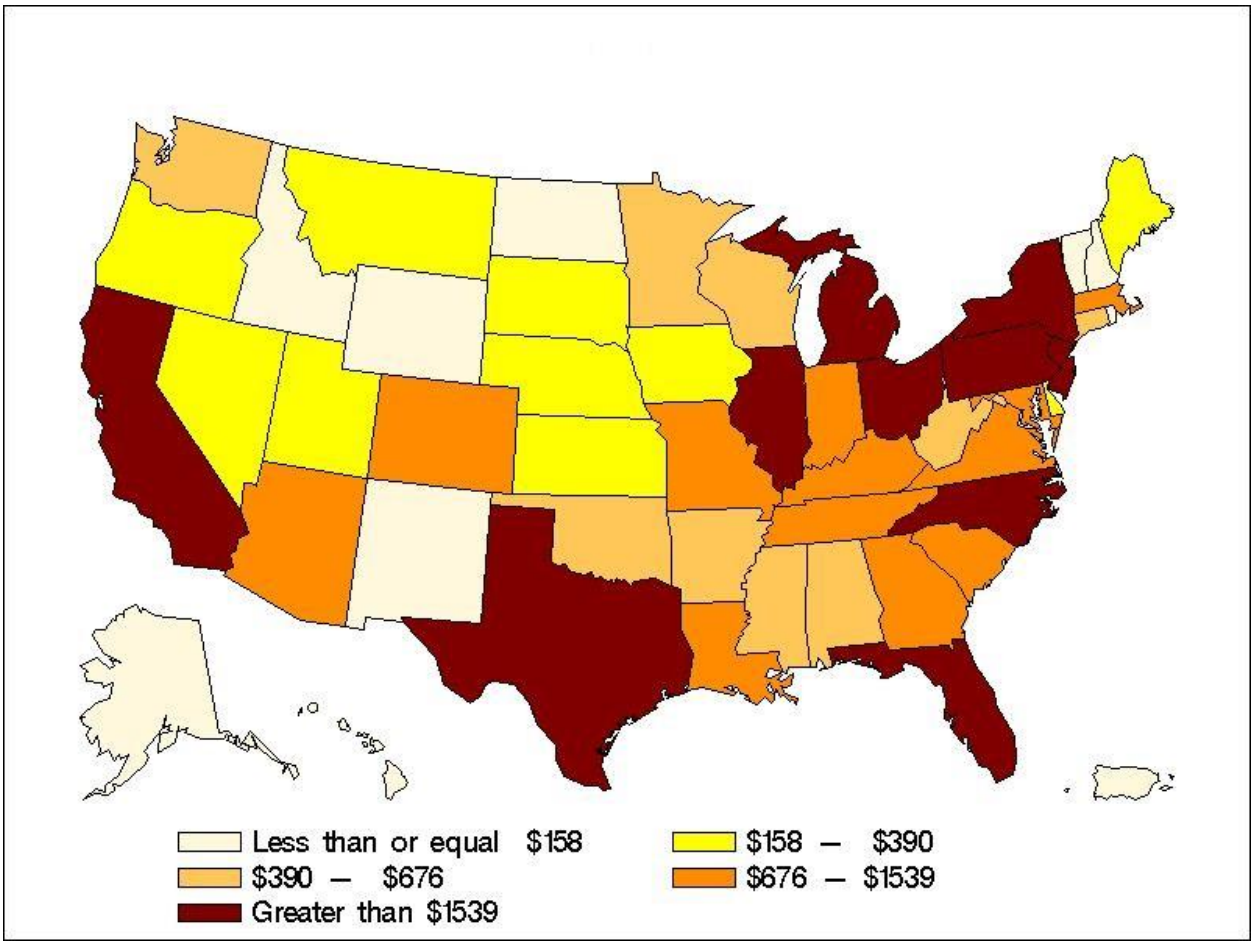
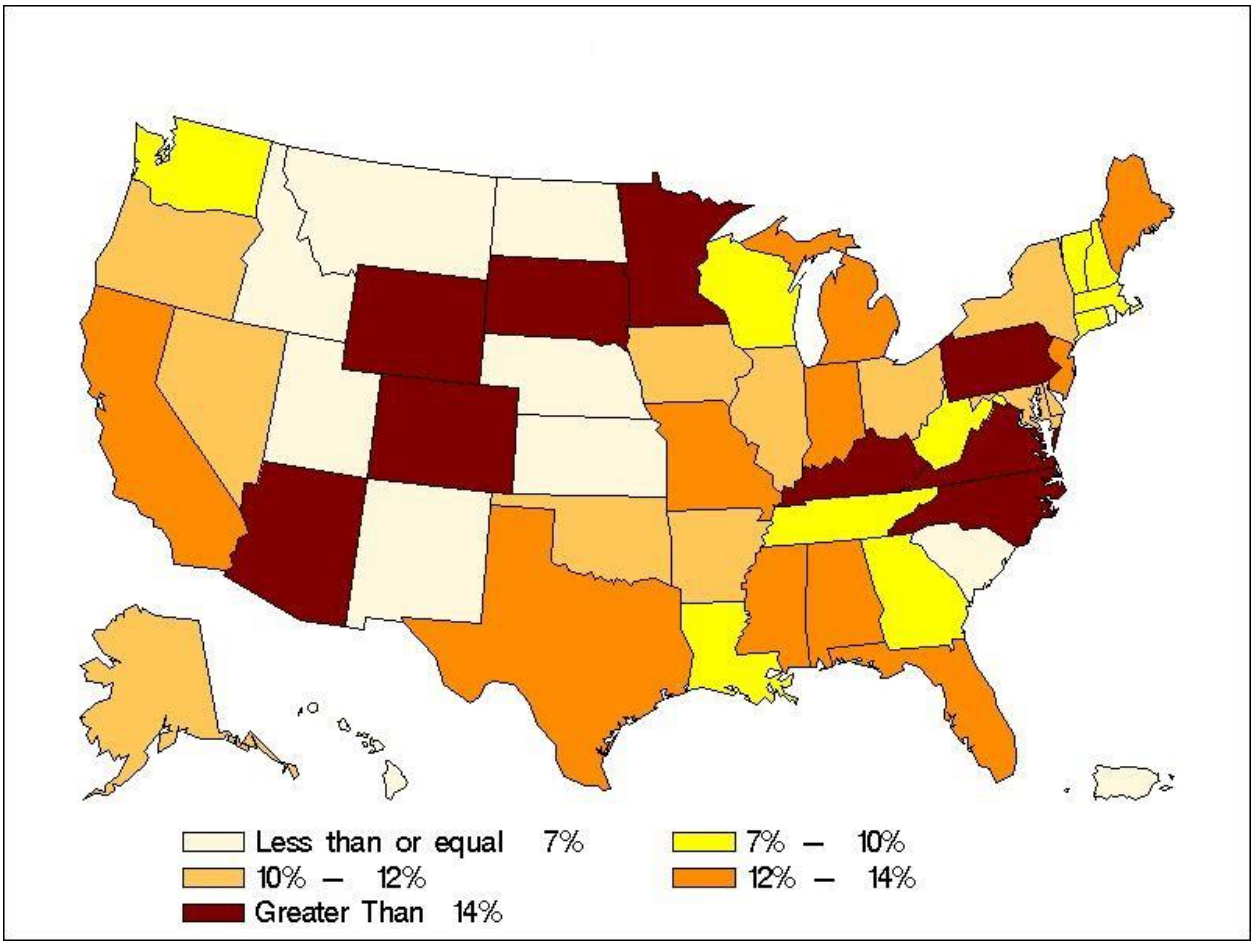
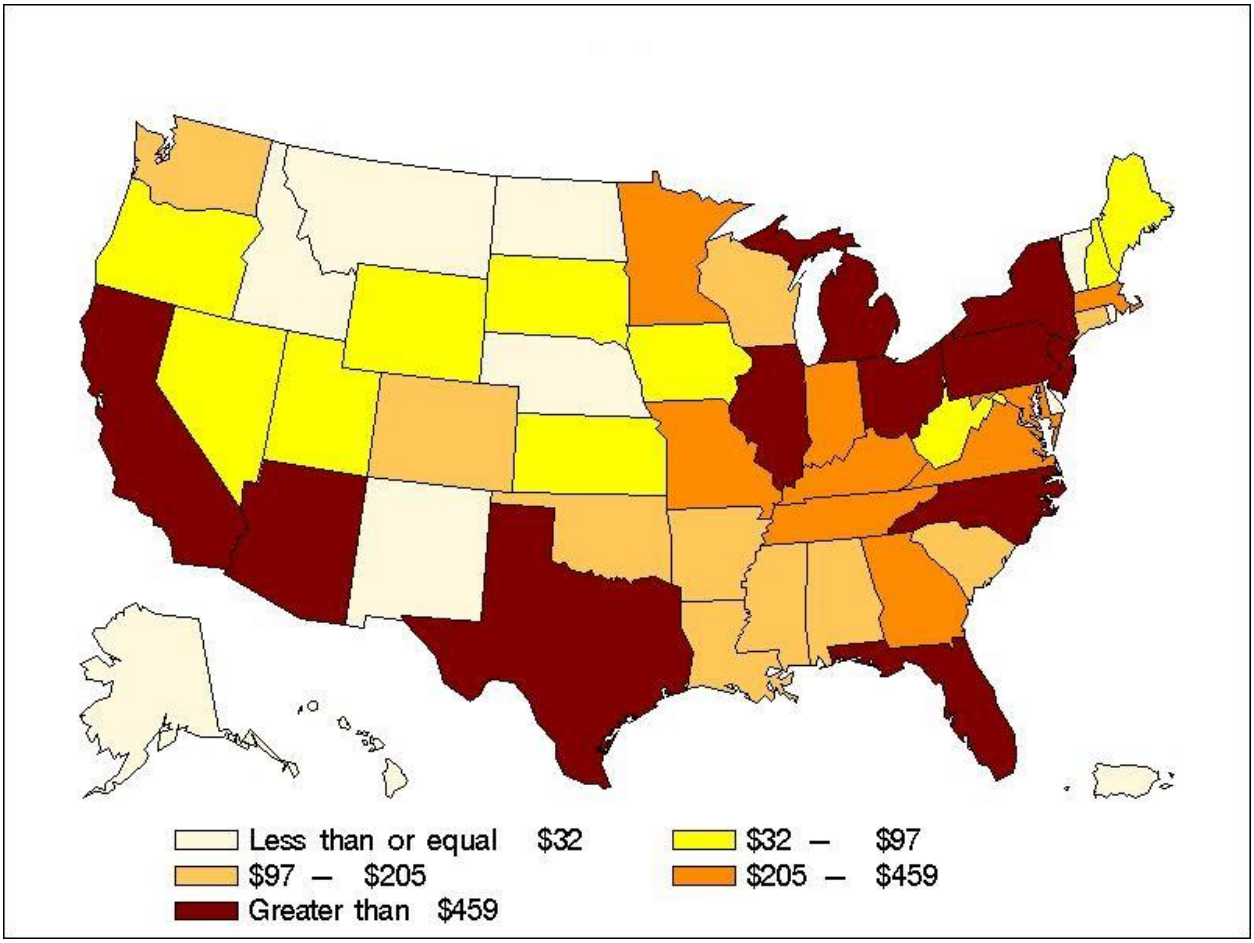


Figure 4: Part A Inpatient PPS Hospital Improper Payment Rates by State[32]



[32] The improper payment amounts in this figure are unadjusted for the impact of Part A to B rebilling

Figure 5: Part A Inpatient PPS Hospital Improper Payment Amounts by State (Dollars in Millions)[33]



[33] The improper payment amounts in this figure are unadjusted for the impact of Part A to B rebilling

Figure 6: Part A (Excluding Inpatient PPS Hospital) Improper Payment Rates by State

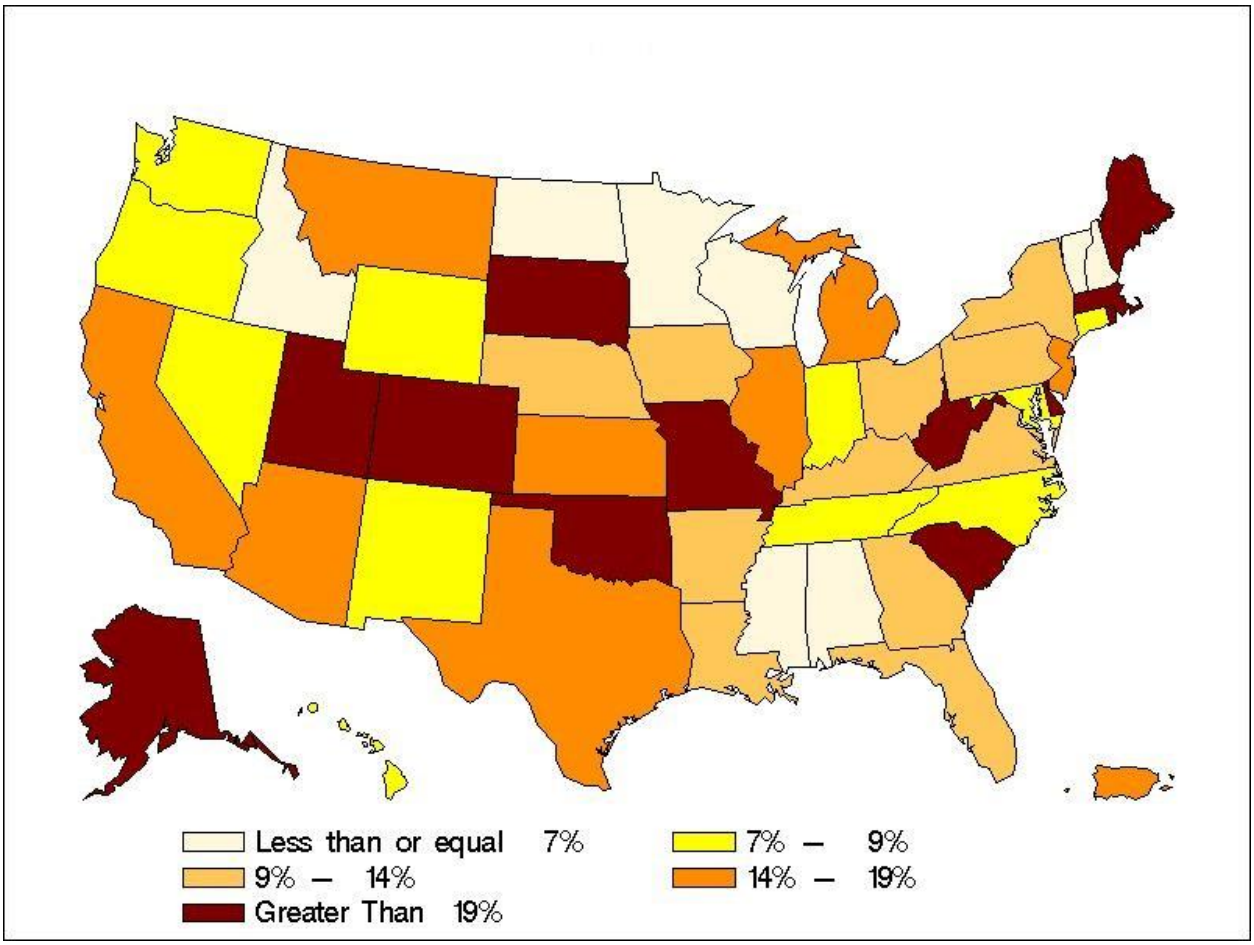


Figure 7: Part A Excluding Inpatient PPS Hospital Improper Payment Amounts by State (Dollars in Millions)

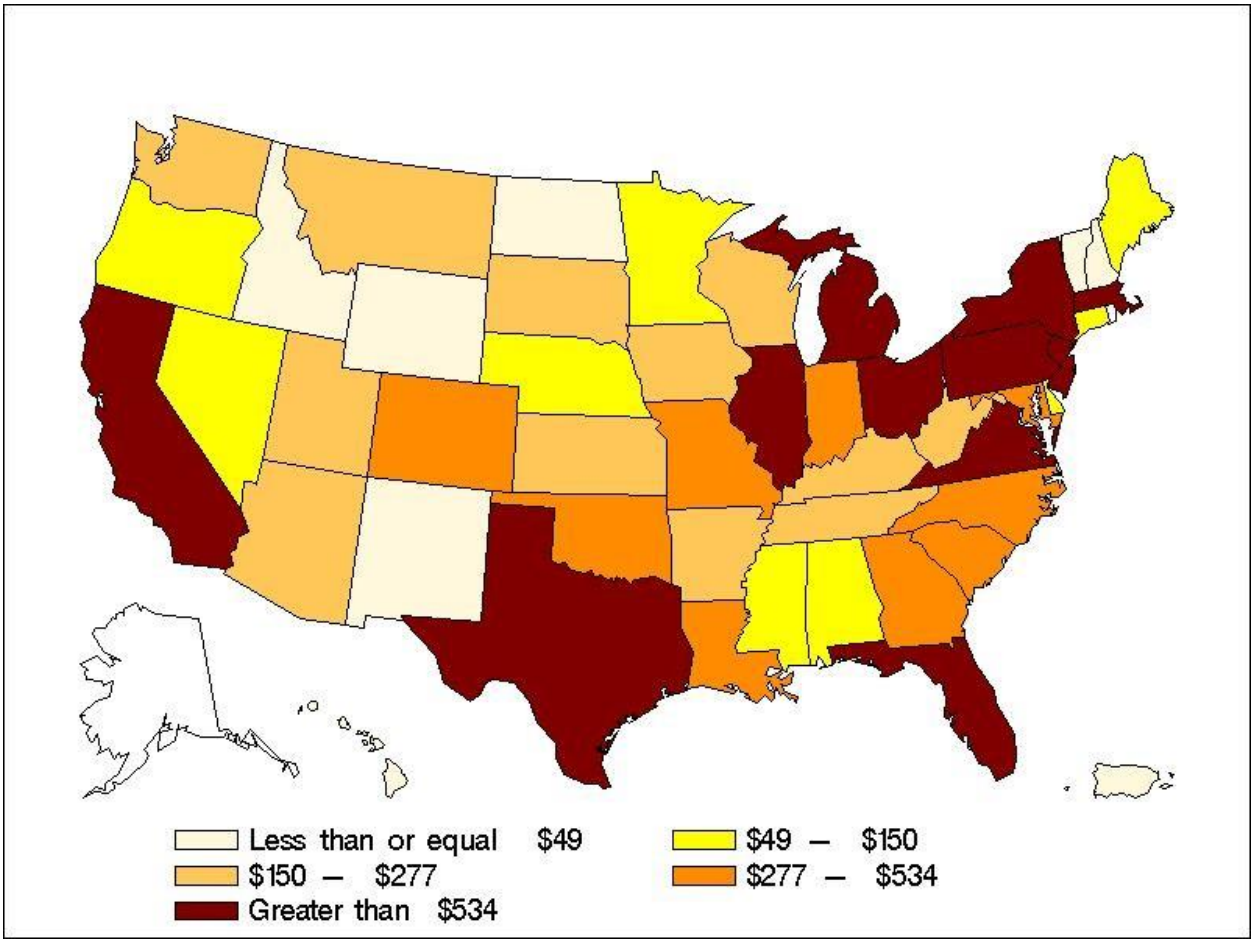


Figure 8: DMEPOS Improper Payment Rates by State

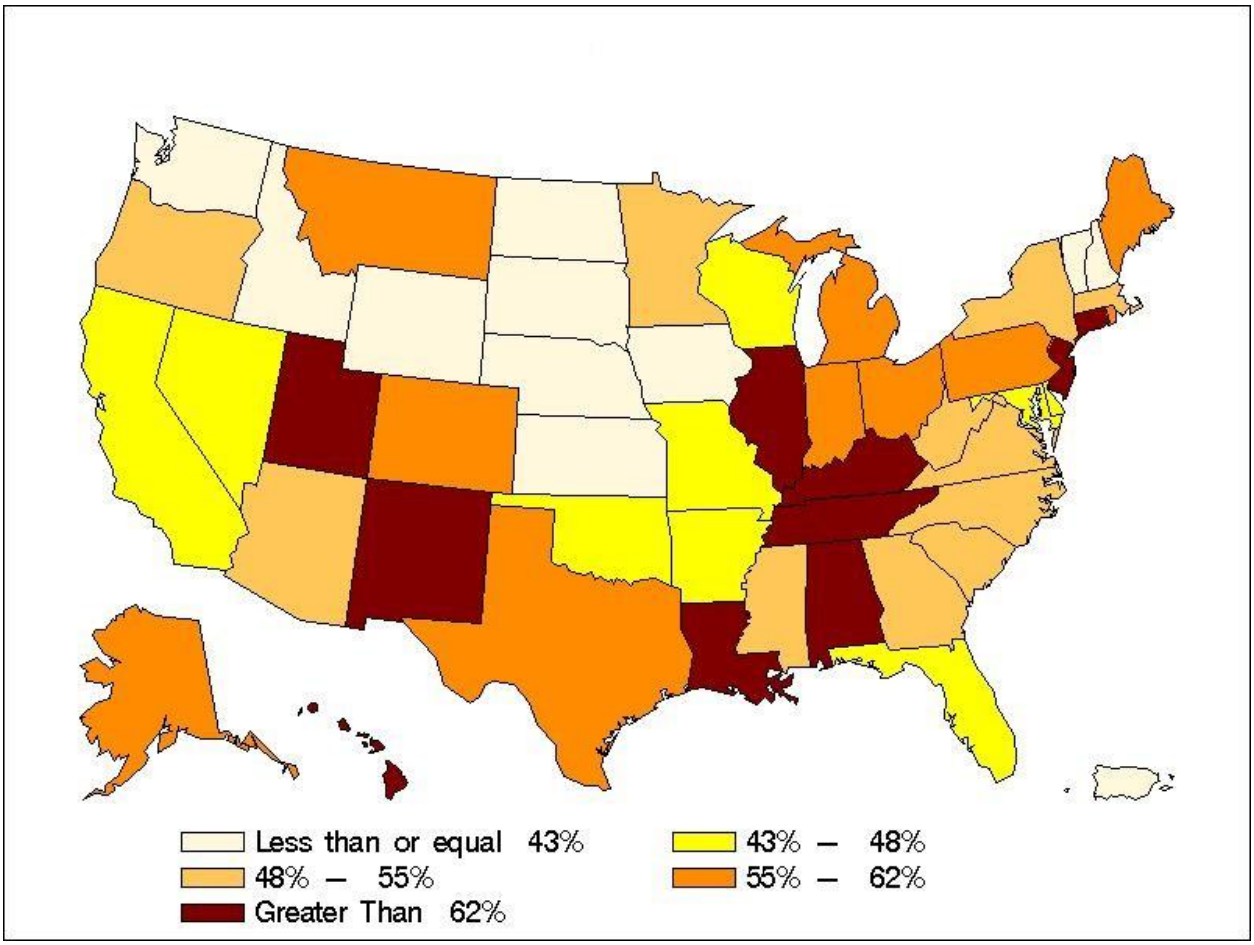


Figure 9: DMEPOS Improper Payment Amounts by State (Dollars in Millions)

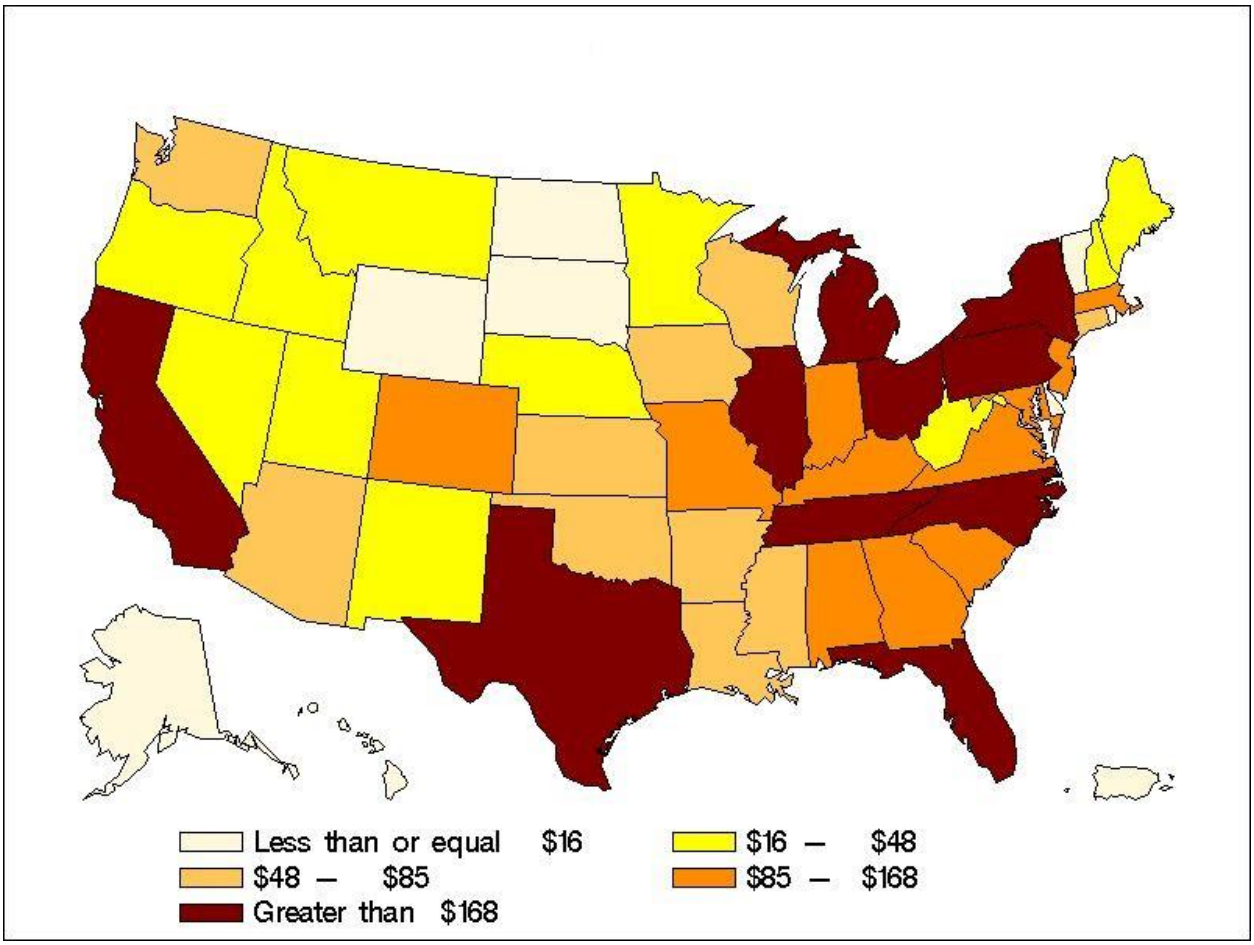


Figure 10: Part B Improper Payment Rates by State

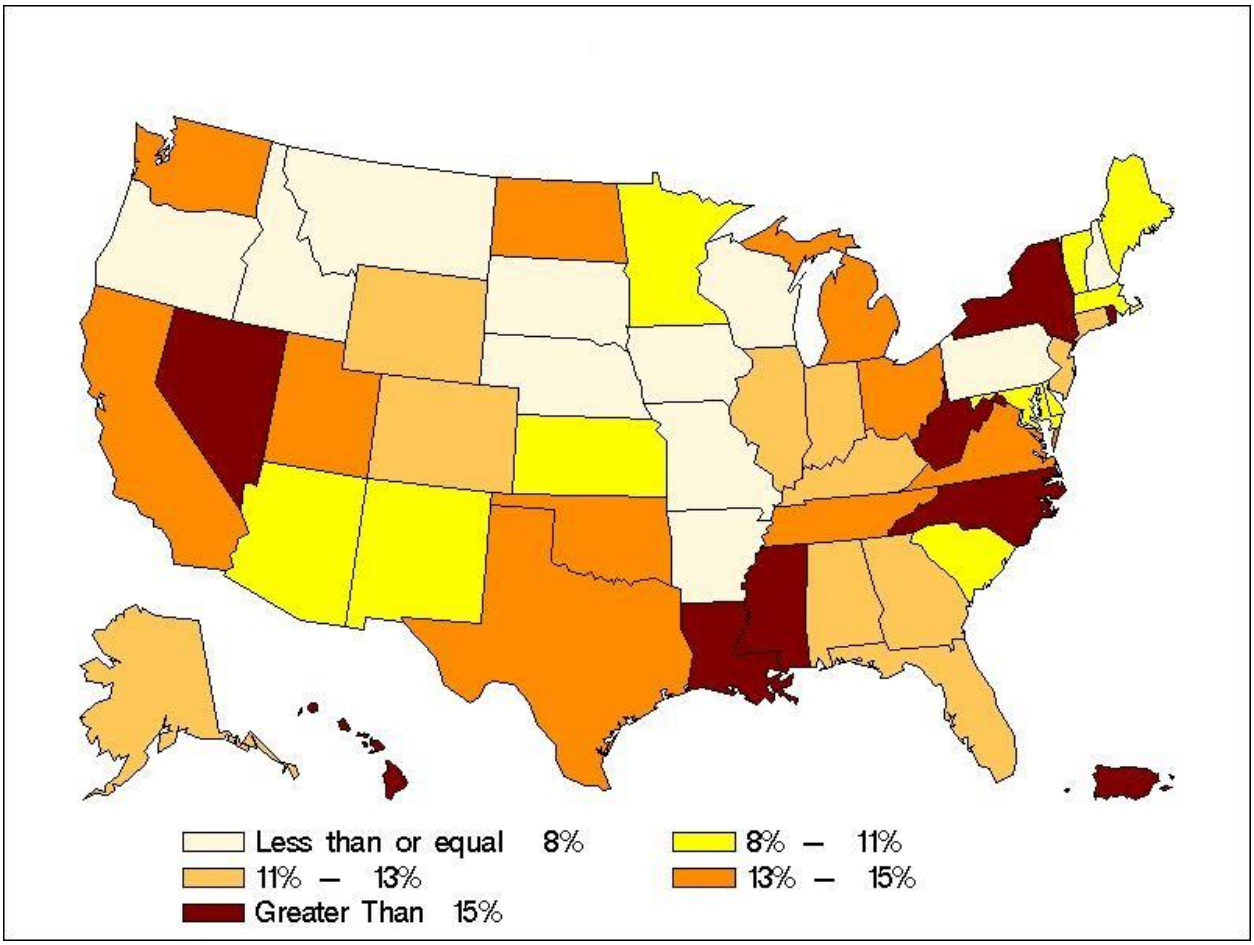


Figure 11: Part B Improper Payment Amounts by State (Dollars in Millions)