

Medicare Fee-For-Service 2016 Improper Payments Report

EXECUTIVE SUMMARY

The Medicare Fee-For-Service Improper Payments Report

This report supplements improper payment information in the annual Department of Health and Human Services Agency Financial Report ([HHS AFR](#)). The Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), (hereafter collectively referred to as 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 fee-for-service (FFS) services and supplies that are the largest drivers of the 2016 improper payment rate. The [Supplementary Appendices for the Medicare Fee-for-Service 2016 Improper Payments Rate Report](#), available on the Centers for Medicare & Medicaid Services (CMS) website: www.cms.gov/cert, provide additional detailed information.

89.0 Percent Payment Accuracy Rate

The estimated 2016¹ Medicare FFS² payment accuracy rate – the percentage of Medicare FFS dollars paid correctly - was 89.0 percent. This calculation included claims submitted during the 12-month period from July 1, 2014 through June 30, 2015. This means that of the \$373.7 billion paid by Medicare FFS, an estimated \$332.6 billion was paid correctly during this period.

11.0 Percent Improper Payment Rate

The estimated 2016 Medicare FFS improper payment rate – the percentage of Medicare dollars paid incorrectly – was 11.0 percent. This means that Medicare paid an estimated \$41.1 billion

Improper Payments ≠ Fraud

It is important to note that while all payments made as a result of fraud are considered “improper payments,” not all improper payments constitute fraud. Improper payments typically do not involve fraud. The improper payment rate is a measure of compliance with and adherence to federal rules and requirements and should not be viewed primarily as expenses that should not have occurred in the first place.

¹ HHS publishes the 2016 Medicare FFS improper payment rate in the Federal Fiscal Year (FY) 2016 HHS Agency Financial Report. The FY runs from October 1 to September 30. 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, non-hospital 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.

incorrectly between July 1, 2014 and June 30, 2015. For 2016, CMS adjusted the improper payment rate by 0.2 percentage points (\$0.7 billion) from 11.2 percent to 11.0 percent to account for the effect of rebilling inpatient hospital claims denied under Medicare Part A (Part A to B rebilling)³. The methodology for calculating the 2016 FFS improper payment rate was the same as in 2015.

The Medicare FFS improper payment rate decreased from 12.1 percent in 2015 due to the successes of corrective actions implemented to address improper payments for inpatient hospital services. CMS plans to continue monitoring services that drive the improper payment rate, including home health and inpatient rehabilitation facility claims, in order to more effectively target our provider education efforts to address payment vulnerabilities as they are identified.

Common Causes of Improper Payments

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

The Comprehensive Error Rate Testing (CERT) program strictly adheres to IPERIA requirements and measures Medicare FFS payments to the highest standard. The Medicare FFS improper payment rate includes instances where reviews could not be completed due to no or insufficient documentation, improper payments of all dollar amounts (i.e., no dollar threshold under which errors will not be cited), and improper payments caused by policy changes as of the effective date of the new policy (i.e., no grace period permitted).

The major contributor to the Medicare FFS improper payment rate decrease from 12.1 percent in 2015 to 11.0 percent in 2016, were implementation of CMS' "Two Midnight" rule and corresponding educational efforts. These led to a reduction in improper payments for inpatient hospital claims, reducing the inpatient hospital claims improper payment rate for those services from 6.2 percent in 2015 to 3.8 percent in 2016.⁴ In addition, the home health improper payment rate decreased from 59.0 percent in 2015 to 42.0 percent in 2016. A policy revision to the home health face-to-face encounter requirements contributed to this decrease.

Unlike many other federal agencies that provide exceptions in their improper payment measurements for cases for which reviews cannot be completed (i.e., no or insufficient documentation), improper payments under a certain threshold amount, or improper payments caused by policy changes, the CERT program strictly adheres to IPERIA requirements. As a result, this strict adherence leads to a larger number of improper payments identified, a higher rate, and a greater opportunity for corrective actions than other agencies performing similar reviews. Reference: [GAO-16-708T](#)

³ CMS calculated the Part A to B rebilling adjustment factor 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 Hospital Inpatient Prospective Payment System (IPPS) improper payment rates). This methodology remains unchanged since 2012.

⁴ Adjusted for Medicare Part A to B rebilling of denied inpatient hospital claims.

While there was a reduction in the Medicare FFS improper payment rate for 2016, we must continue working to reduce the improper payment rate for the Medicare FFS program for future years.

As in previous years, during the 2016 report period, the most common cause of improper payments (accounting for 64.1 percent of total improper payments) was lack of documentation to support the services or supplies billed to Medicare. 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.

Part A (excluding hospital Inpatient Prospective Payment System (IPPS))⁵ services were the largest contributors to the 2016 improper payment rate. This category includes home health, non-IPPS hospital (including inpatient rehabilitation facilities), Hospital Outpatient Prospective Payment System (OPPS), skilled nursing facility, and hospice services.

Table 1 summarizes the 2016 improper payment rates by claim type.

⁵ Improper payment rate reporting for Part A (excluding hospital IPPS) 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 hospital IPPS) 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 hospital IPPS) improper payment rate measurement because they are submitted on the ASC X12 837 or UB-04.

**Table 1: 2016 Improper Payment Rates and Projected⁶ Improper Payments by Claim Type
(Dollars in Billions)⁷**

Claim Type	Total Payment	Projected Improper Payment	Improper Payment Rate	95% Confidence Interval
Part A (Total)	\$272.3	\$26.4	9.7%	8.7% - 10.7%
Part A (Excluding Hospital IPPS)	\$157.5	\$22.0	14.0%	12.3% - 15.6%
Part A (Hospital IPPS) ⁸	\$114.8	\$4.4	3.8%	3.4% - 4.3%
Part B	\$93.3	\$10.9	11.7%	10.6% - 12.9%
DMEPOS	\$8.1	\$3.7	46.3%	44.3% - 48.2%
Overall	\$373.7	\$41.1	11.0%	10.2% - 11.8%

Corrective Actions to Improve the Payment Accuracy Rate

CMS is committed to reducing improper payments in all of its programs and CMS' new leadership will be re-examining the existing corrective action and exploring new and innovative approaches to reducing improper payments while minimizing burden for our partners. CMS employs multi-layered efforts to target all causes of improper payments, with a shifting emphasis towards prevention-oriented activities. As part of these efforts, HHS continues to work with law enforcement partners and other key stakeholders to focus on prevention, early detection, and data sharing, through initiatives like the Healthcare Fraud Prevention Partnership.

⁶ Based on the sample of claims reviewed.

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

⁸ Adjusted for Medicare Part A to B rebilling of denied inpatient hospital claims.

Following are brief descriptions of some of CMS' key efforts to prevent and reduce improper payments in the Medicare FFS program:

- **Healthcare Fraud Prevention Partnership (HFPP):** CMS continues to build the HFPP, a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. HFPP membership includes partner organizations from the public and private sectors, including federal and state partners, private payers, associations, and law enforcement organizations. HFPP members exchange data, information and anti-fraud practices in an effort to prevent and detect fraud across all payers.
- **Medical Review Strategies:** CMS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. 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 claims.
- **Provider Education:** CMS and its contractors leverage multiple efforts to increase provider education to prevent improper payments. For example, CMS issues Comparative Billing Reports (CBRs) to help Medicare Part B providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable these providers to examine their billing patterns compared to their peers in the state and across the nation. In addition, CMS and its contractors also conduct individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews (generally referred to as Probe and Educate reviews).
- **Policy Clarifications:** CMS reviews its improper payment findings and policies to determine if further clarification is needed. For example, in recent years CMS has clarified policies related to when hospital admissions are appropriate under Medicare Part A, as well as amended requirements for determining beneficiaries' eligibility for home health services.
- **Fraud Prevention System (FPS):** The FPS analyzes all Medicare FFS claims using risk-based algorithms developed by CMS and its contractors. CMS uses the FPS to target investigative resources, generating alerts for suspect claims or providers and suppliers in priority order, to investigate the most egregious, suspect, or aberrant activity. CMS and its program integrity contractors use the FPS information to prevent and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

Additional information on these and other corrective actions can also be found in [HHS' FY 2016 AFR](#).

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 cited statutes or regulations or Medicare coverage, coding and billing rules.

Complex medical review determinations provided as examples in this report reflect statutes or Medicare coverage, coding, and billing rules in effect for the billed date of service at the time of the determination.

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 2016 Improper Payments Report*](#).

This report supplements information in the fiscal year 2016 [HHS AFR](#) and reflects information available as of the date of release of the HHS AFR.

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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. In addition, the IPERIA also requires agencies to establish performance targets for reducing improper payments for programs that report improper payment estimates. The Medicare FFS GPRA performance goals and IPERIA reduction targets are the same.

The 2016 improper payment rate was 11.0 percent, which is lower than the previously established goal of 11.5 percent. 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 revises these goals annually based on data analysis and policy changes. The OMB implementing guidance requires that these goals are realistic and ambitious.

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

- 10.4 percent by FY 2017
- 9.4 percent by FY 2018
- 9.3 percent by FY 2019

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.

CMS is committed to reducing improper payments in the Medicare FFS program. CMS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories in the [HHS AFR](#). While CMS has fully implemented some corrective actions, others are still in the early stages of implementation. CMS believes these focused corrective actions will have a larger impact over time as they become operationalized.

The Medicare FFS Program

Features of the Medicare FFS Program

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

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

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. Contractors can perform these reviews 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 may include reviews that require some form of human intervention to verify claim information, and/or a review that is automated (i.e., done by computer). Appropriate non-complex reviews increase the efficiency and consistency of payment decisions.
- **Complex Medical Review:** The Medicare review contractor makes a claim determination after reviewing medical 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., dietitians or physician specialists) for advice. Medicare review contractors cannot perform complex medical review on every claim submitted because of the large number of claims submitted each day.

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 the MACs' corrective actions and educational efforts.

Improper Payment Measurement in the Medicare FFS Program

Statutory Background

The IPERIA 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, or
- Without supporting documentation; and
- Includes payments where documentation is missing or not available.

The IPERIA also requires federal agencies, including 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 2016 report period was unreviewable because the claim adjudication process was incomplete (e.g., the MAC returned the claim to the provider or supplier). The final CERT sample is comprised of claims

paid or denied by the MAC (see Table 2 below). This sampling methodology complies with all statutory requirements and OMB guidance.

Table 2: Claim Counts by Type for the 2016 Improper Payment Rate Calculation

Claim Type	Claims Reviewed
Part A (Excluding Hospital IPPS)	7,509
Part A (Hospital IPPS)	14,490
Part B	16,999
DMEPOS	10,999
Total	49,997

2. Medical Record Requests

After the CERT program identifies a claim as part of the sample, it requests, via a medical documentation request 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.

Should the CERT program receive no documentation within 75 days of its initial request, it scores the claim as an improper payment due to a “no documentation error” (explained below). Nevertheless, the CERT program still reviews late documentation 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.

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 or physicians, unless this task is delegated to other licensed health care professionals. 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),⁹ Local Coverage Determinations (LCDs),¹⁰ and provisions in the 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.

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

⁹ 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.

¹⁰ 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.

Claims are placed into this category if there is an improper payment and it does not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service, ineligible Medicare beneficiary).

The CERT program notifies the MACs of improper payments identified through the CERT process. The MACs then repay underpayments and recoup overpayments.

4. Tracking Appeals

Providers, suppliers, and beneficiaries have the right to appeal any improper payment determination made by the CERT program, provided they meet certain filing requirements. There are five levels of appeals for the Medicare FFS claims, starting at the MAC level through federal court. Historically, a small number of CERT program claims appeals have gone beyond the first three levels: (1) redeterminations at the MAC level, (2) reconsiderations at the Qualified Independent Contractor (QIC) level, and (3) administrative review at the HHS Office of Medicare Hearings and Appeals (OHMA) level. It should be noted that a minimum amount in controversy for the claims must be met for the disputed claims to be reviewed by OMHA.¹¹

Final appeal decisions are reflected in the calculation of the Medicare FFS improper payment rate.¹² 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 claims universe statistically. These calculations meet the national precision of 2.5 percentage points and 90 percent confidence as required by the IPERIA. These calculations also achieve 3-percentage point precision and 95 percent confidence for contractor-specific rates.¹³

¹¹ A small number of claims go beyond these first three levels. The fourth level of appeal consists of a claims review by the Medicare Appeals Council within the HHS Departmental Appeals Board, while the fifth level of appeal is a judicial review by a federal district court. The federal district court jurisdiction is appropriate only for claims that exceed a specified dollar amount.

¹² 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.

¹³ OMB issued guidance for IPERIA of 2002 implementation requirements, including attaining statistical validity, through OMB Circular A-123, Appendix C, on August 10, 2006 and issued subsequent implementing guidance on April 14, 2011 and October 20, 2014.

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 improper payments 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 repay underpayments and recoup overpayments. MACs can recover the overpayments identified in the CERT sample but cannot recoup projections made to the claims universe.¹⁴ The IPERIA requires agencies to include all improper payments that were identified in the sample in the reported estimate, regardless of whether the improper payment has been or is being recovered.

MACs recover most of the overpayments identified on claims sampled by the CERT program. Overpayments on claims sampled during the 2016 report period were \$25,552,562. As of the publication date of the FY2016 HHS AFR, actual MAC collections for these overpayments were \$22,015,290 or 86 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.

ANALYSIS AND SUMMARY OF RESULTS

All rates and amounts in the detailed analysis are unadjusted for the impact of Part A to B rebilling (see page 21 for an explanation of Part A to Part B rebilling).

¹⁴ 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.

Part A Drivers of the Medicare FFS Improper Payment Rate

Excluding Hospital IPPS Services¹⁵

The 2016 improper payment rate for Part A excluding hospital IPPS services was 14.0 percent, accounting for 52.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for Part A excluding hospital IPPS services during the 2016 report period was \$22.0 billion. Most of these improper payments services were due to insufficient documentation. Provider types in this category include, but are not limited to, home health agencies, skilled nursing facilities, hospital outpatient providers, inpatient rehabilitation facilities and hospices.

Home Health Services¹⁶

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 the following:

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

The improper payment rate for home health services was 42.0 percent, accounting for 18.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for home health services during the 2016 report period was \$7.7 billion. Insufficient documentation caused a large proportion of improper payments for home health services.

HHS issued a final rule, [CMS-1611-F](#) (79 FR 66032, November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year 2015. In this rule, HHS finalized changes to the face-to-face encounter requirements for home health episodes beginning on or after January 1, 2015. Specifically, HHS amended the home health agency regulation to remove the requirement for the certifying physician to document that

¹⁵ Improper payment rate reporting for Part A (excluding hospital IPPS) providers is determined by the type of bill submitted to Medicare for payment. Providers, facilities, and suppliers that submit institutional claims via the electronic ANSI ASC X12 Health Care Claim: Institutional (837) or paper claim format Uniform Billing (UB)-04, are included in the Part A (excluding hospital IPPS) 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 hospital IPPS) improper payment rate measurement because they are submitted on the ASC X12 837 or UB-04.

¹⁶ Home Health Services are defined as all services with a provider type of Home Health Agency.

a face-to-face encounter occurred by drafting a narrative explaining how the encounter supports the patient's homebound status and need for skilled care. However, a face-to-face visit continues to be required as part of the certification of patient eligibility for the benefit. Reviewers should consider documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to determine patient eligibility for the home health service.

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, the following:

- Physician certification/recertification of patient eligibility for the Medicare home health benefits
- Face-to-face encounter clinical note/discharge summary
- Therapy notes
- A comprehensive assessment of the beneficiary

Example

A home health agency submitted a claim for home health services for a beneficiary. The submitted medical records did not include sufficient documentation to support the beneficiary's homebound status, or the need for skilled services. The homebound status was documented as "It is unsafe for patient to ambulate on community surfaces" with no additional information to show that the beneficiary met Medicare's criteria for "confined to home." There was also no explanation of the beneficiary's need for skilled nursing and/or therapy services. The CERT program scored the claim as an improper payment due to insufficient documentation.

Inpatient Rehabilitation Facility Services¹⁷

The Medicare Inpatient Rehabilitation Facility (IRF) benefit provides intensive rehabilitation therapy in an inpatient environment and includes Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units. 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 62.4 percent, accounting for 11.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for IRFs during the 2016 report period was \$4.6 billion. Most of the improper payments for IRFs were due to medical necessity errors. Medicare rules require there be a reasonable expectation that the patient meets all of the requirements in 42 CFR 412.622(a)(3) at the time of admission to the IRF.

IRF coverage criteria includes requirements such as the active and ongoing therapeutic intervention of multiple therapy disciplines, participation in an individualized intensive rehabilitation therapy

¹⁷ Inpatient Rehabilitation Facility services are defined as any service with a provider type of either Inpatient Rehabilitation Hospitals or Inpatient Rehabilitation Unit.

program, and supervision by a physician with specialized training and experience in inpatient rehabilitation.

Required documentation elements for an IRF claim include, but are not limited to, the following:

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

Example

A provider admitted a beneficiary to an IRF after a stay in an acute care hospital. The acute care hospital stay was prompted by a medical emergency due to uncontrolled diabetes and acute brain dysfunction. The medical record submitted contained face-to-face visits that were conducted by a physician's assistant and co-signed by a physician. This did not meet Medicare's requirement physician supervision that a rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF. Therefore, the CERT program scored this claim as an improper payment due to medical necessity.

Hospital Outpatient Services¹⁸

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

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

The improper payment rate for hospital outpatient services was 5.4 percent, accounting for 7.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for outpatient services during the 2016 report period was \$3.1 billion. The majority of improper payments for hospital 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 hospital outpatient department billed for a cystourethroscopy (an examination of the inside of the urinary bladder and urethra). The medical record was missing medical records for the billed

¹⁸ Hospital Outpatient Services are defined as all services billed with type of bill 12x through 19x (e.g., OPPTS, Laboratory, and others)

date of service. The hospital outpatient department submitted the following medical records for a different date of service: physician's progress notes, a procedure note for the cystourethroscopy, post-operative notes, and discharge instructions. The hospital outpatient department also sent a handwritten note stating that the patient was not seen on the billed date of service and that the billed date should have been the date indicated on the submitted medical records. The CERT program scored the claim as an improper payment due to insufficient documentation.

Skilled Nursing Facility (SNF) Services¹⁹

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 7.8 percent, accounting for 6.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for SNF services during the 2016 report period was \$2.8 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, documents required in the medical record include, but are not limited to, the following:

- A certification that the beneficiary needed daily skilled care that could only be provided in a SNF setting
- An authenticated plan 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 documentation submitted as the physician's certification for SNF care contained a pre-populated date for the physician signature. This form was not signed by the physician. In response to an additional documentation request, the provider submitted a duplicate physician's certification form with the same pre-populated date now containing a physician's signature; this did not meet Medicare's signature or timely SNF certification requirements. There was no explanation of the reason(s) for the delayed certification. The CERT program scored the claim as an improper payment due to insufficient documentation.

¹⁹ Skilled Nursing Facility services are defined as all services with a provider type of SNF.

Hospice Services²⁰

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, the following:

- 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 15.9 percent, accounting for 6.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for hospice services during the 2016 report period was \$2.5 billion. Most of the improper payments for hospice services 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 as part of the certification and recertification forms;
- 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, recertification is required. 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 insufficient documentation errors, the submitted certification or recertification did not adequately address the requirements listed above.

Example

A beneficiary had elected hospice care and continued to receive palliative care. The submitted medical records documented that the beneficiary had a diagnosis of Hereditary Muscular

²⁰ Hospice services are defined as all services with a provider type of Hospice.

Dystrophy. The documentation did not contain the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the recertification forms. Also, the plan of care for the recertification period was not signed. The CERT program scored this claim as an improper payment due to insufficient documentation.

Hospital IPPS 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 IPPS. The IPPS categorizes patient care into a 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.

CMS implemented two policies in the [CMS 1599-F](#) (78 FR 50495, issued on August 2, 2013 and effective on October 1, 2013) pertaining to inpatient hospital claims to reduce improper payments.

- CMS allowed all hospitals participating in Medicare 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 assess inpatient hospital claims for payment purposes.

These policy changes applied to most claims reviewed for the 2016 Medicare FFS Improper Payments Report. As a result, the Hospital IPPS improper payment rate (unadjusted for Part A to B rebilling) decreased from 7.4 percent for the 2015 report period to 4.5 percent for the 2016 report period. In addition, the improper payment rate for inpatient hospital stays of one day or less (unadjusted for Part A to B rebilling) decreased from 27.8 percent for the 2015 report period to 18.6 percent for the 2016 report period.

The 2016 hospital IPPS 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.²¹

²¹ 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 Hospital IPPS improper payment rates). This methodology is unchanged from 2012, 2013, 2014, and 2015.

The 2016 improper payment rate for hospital IPPS services was 3.8 percent²², accounting for 10.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for hospital IPPS services during the 2016 report period was \$4.4 billion (adjusted for Part A to B rebilling).

The majority of hospital IPPS improper payments are due to the admission of a Medicare beneficiary as an inpatient when the medical record does not support a reasonable expectation that the admitting practitioner expected the patient to require a hospital stay that crossed two midnights. The CERT program categorizes these situations as “medical necessity errors.” The CERT program denied 733 claims for this reason during the 2016 report period. These sampled errors totaled \$7.4 million in actual overpayments, which projected to \$2.1 billion in overpayments for the universe of Medicare FFS claims (unadjusted for Part A to B rebilling). These errors are more likely to occur when the length of stay is shorter and when there is an elective surgical procedure. Sometimes, providers admit beneficiaries as inpatients post-operatively for overnight monitoring and discharge them the next day. Even if the procedure itself was reasonable and necessary, the post-operative inpatient admission for monitoring may not be medically necessary.

Table 3: Projected Improper Payments by Length of Stay²³

Part A Hospital IPPS Length of Stay	Improper Payment Rate	Projected Improper Payment	Proportion of Overall CERT Error
All CERT	11.2%	\$41.8	100.0%
Overall Hospital IPPS	4.5%	\$5.2	12.3%
0 or 1 day	18.6%	\$1.3	3.2%
2 days	7.1%	\$0.9	2.1%
3 days	4.5%	\$0.7	1.8%
4 days	3.4%	\$0.4	1.0%

²² Adjusted for Medicare Part A to B rebilling of denied inpatient hospital claims.

²³ Unadjusted for Part A to B rebilling

Part A Hospital IPPS Length of Stay	Improper Payment Rate	Projected Improper Payment	Proportion of Overall CERT Error
5 days	2.9%	\$0.3	0.7%
More than 5 days	2.7%	\$1.5	3.6%

The three examples below illustrate improper payments for MS-DRG groups during the 2016 reporting period.

Psychoses: MS-DRG 885

The medical record must clearly support the need for active treatment and all documentation must meet the content and timing requirements of 42 CFR 424.14 (e.g., diagnostic study, intensive treatment services, inpatient admission, and related services). In addition, the CERT program identifies improper payments because of the failure to meet requirements for the plan of care and certification and/or recertification requirements. If this required documentation and/or the physician’s signature are not present in the medical records, then the payment is improper.

The improper payment rate for MS-DRG 885 was 8.8 percent, accounting for 0.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2016 report period was \$358.5 million (unadjusted for Part A to B rebilling).

Example

A provider admitted a beneficiary to an inpatient psychiatric facility because of anxiety due to living alone after his parents’ illness. The beneficiary had a medical history of cerebral palsy and schizo-affective disorder. Although the beneficiary was anxious when discussing his parents and his future living situation, he was medically stable and not a danger to himself or others. The medical records described the beneficiary as calm and cooperative and interacting in appropriate manners. The medical record documentation did not support the need for inpatient services. Therefore, the CERT program scored this claim as an improper payment due to a medical necessity error.

Major Joint Replacement or Reattachment of Lower Extremity: MS-DRGs 469 and 470

The improper payment rate for MS-DRGs 469 and 470 (combined) was 3.1 percent, accounting for 0.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2016 report period was \$200.6 million (unadjusted Part A to B rebilling adjustment).

Example

A provider admitted a beneficiary for an elective (i.e., planned, non-emergent) total knee replacement performed on the day of admission without complication. The medical record submitted was missing documentation to support the medical necessity for the procedure. CERT requested the supporting documentation such as the surgeon's preoperative office notes, preoperative imaging reports, and the surgeon's findings during the operative procedure. There was no response to the additional documentation request. The CERT program scored this claim as an improper payment due to insufficient documentation.

Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders: MS-DRGs 391 and 392

The improper payment rate for MS-DRGs 391 and 392 (combined) was 10.1 percent, accounting for 0.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for these services during the 2016 report period was \$148.9 million (without the Part A to B rebilling adjustment).

Example

A beneficiary with a past medical history of diverticulitis, chronic obstructive pulmonary disease and congestive heart failure presented to the hospital Emergency Department (ED) with left lower quadrant abdominal pain. The beneficiary did not have a fever and was not in any acute distress as noted in the ED notes. Laboratory results were normal and did not indicate signs of significant infection. The computerized tomography (CT) scan report showed mild diverticulitis. The beneficiary was tolerating an oral diet. The medical record documentation did not support the need for inpatient services. Therefore, the CERT program scored this claim as an improper payment due to a medical necessity error.

Part B Drivers of the Medicare FFS Improper Payment Rate

Part B Excluding DMEPOS

Medicare provides coverage for medically necessary services such as laboratory tests, physician services, ambulance services, and procedures under the Part B benefit. Medicare pays for these services only if the beneficiary's medical record contains sufficient documentation of the patient's medical condition to support the need for the services. In addition, all documentation requirements outlined in Medicare policies must be present for the claim to be paid.

The improper payment rate for Part B (excluding DMEPOS) was 11.7 percent, accounting for 26.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for Part B (excluding DMEPOS) during the 2016 report period was \$10.9 billion. Insufficient documentation errors caused the vast majority (68.2 percent) of improper payments for Part B (excluding DMEPOS).

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 14.3 percent, accounting for 10.9 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2016 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 key components that determine the correct E&M service code are:

- History (includes information such as the nature of presenting problem, past history, family history, social history, review of systems);
- Physical examination; and
- 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).

Incorrect coding and insufficient documentation caused most of the improper payments for E&M services during the 2016 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.

E&M: Office Visits – Established

The improper payment rate for office visits with established patients was 8.8 percent, accounting for 3.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2016 report period was \$1.3 billion.

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

The servicing provider specialties of Internal Medicine, Family Practice, and Cardiology comprise 48.9 percent of improper payments for office visits with established patients.

Example

A provider billed for Healthcare Common Procedure Coding System (HCPCS) code 99214 (office or other outpatient visit requiring two of three key components: detailed history, detailed examination, and medical decision making of a moderate complexity). The beneficiary was seen for a follow-up visit for chronic knee pain. There were no changes in medication or management and the beneficiary was asked to return for follow up in three months. The submitted documentation did not meet the requirements for 99214 but met the requirements for 99213.

HCPCS 99213 requires two of three key components: expanded problem focused history, expanded problem focused examination and medical decision making of a low complexity. The CERT program downcoded the claim and scored it as an improper payment due to incorrect coding.

E&M: Hospital Visit – Subsequent

The improper payment rate for subsequent hospital visits was 17.2 percent, accounting for 2.4 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2016 report period was \$990.9 million.

The majority of improper payments for subsequent hospital visits were due to insufficient documentation. In particular, documentation of the key component “medical decision making” did not meet the level required to support the billed E&M service.

The servicing provider specialty of Internal Medicine comprises 47.9 percent of improper payments for subsequent hospital visits.

Example

A provider billed for HCPCS code 99232 (subsequent hospital care, per day, which requires at least 2 of these 3 key components: an expanded problem focused interval history, an expanded problem focused examination, and medical decision making of a moderate complexity). The submitted documentation included lab results for the billed date of service and a handwritten note stating “all other records are at the hospital.” A request was made for the provider’s hospital progress note for the date of service billed. The hospital submitted a handwritten note stating “we have no records for the date of service requested.” The CERT program scored this claim as an improper payment due to insufficient documentation.

E&M: Hospital Visit – Initial

The improper payment rate for initial hospital visits was 29.6 percent, accounting for 2.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2016 report period was \$869.5 million.

The majority of improper payments for initial hospital visits were due to incorrect coding. In particular, CERT identified incorrect coding due to failure to meet the requirements for medical decision making of high complexity.

The servicing provider specialties of Internal Medicine and Cardiology comprise 42.9 percent of improper payments for initial hospital visits.

Example

A provider billed for HCPCS 99223 (initial hospital care, per day, which requires 3 key components: a comprehensive history, a comprehensive examination, and a medical decision making of a high complexity). The billing provider was a Nurse Practitioner (NP). The submitted

documentation included a progress note from a physician for the billed date of service. The CERT program requested the authenticated copy of the initial hospital care visit note by the NP for the billed date of service and received a letter stating “the charge was entered under the NP in error instead of the physician.” The CERT program scored this claim as an improper payment due to no documentation.

Laboratory Tests – Other (Non-Medicare Fee Schedule)

This is a very broad category of Part B services, which includes HCPCS codes for pathology and laboratory services. The category is Berenson-Eggers Type of Service (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 35.5 percent, accounting for 3.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2016 report period was \$1.3 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 to support 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.

The ordering and referring provider specialties of Internal Medicine and Family Practice comprise 45.5 percent of improper payments for “lab tests – other”. In order to reduce the improper payment rate for “lab tests – other”, the referring providers must respond to requests for documentation.

Example

A laboratory submitted a claim for a urine drug screen, qualitative; multiple drug classes by high complexity test method. The submitted documentation included the laboratory report and a physician’s office note for the billed date of service indicating a follow-up visit for chronic neck pain. The submitted documentation was missing the physician’s order and the submitted clinical documentation did not support the intent to order the billed lab tests. There was no response to an additional request for documentation. The CERT program scored this claim as an improper payment due to insufficient documentation.

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 21.4 percent, accounting for 1.8 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount during the 2016 report period was \$733.2 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.

The ordering and referring provider specialties of General Surgery, Family Practice, and Internal Medicine comprise 68.5 percent of improper payments for “minor procedures – other (Medicare fee schedule).” In order to reduce the improper payment rate for “minor procedures – other (Medicare fee schedule),” the referring providers must respond to requests for documentation.

Example

The provider billed for HCPCS 97110 (therapeutic exercise, 1 or more areas, each 15 minutes) for 2 units of service and HCPCS 97116 (gait training, each 15 minutes) for 1 unit of service with the GP modifier (services delivered under an outpatient physical therapy plan of care). The submitted documentation included the authenticated physical therapy daily progress note for the billed date of service supporting 25 minutes of therapeutic exercise and 20 minutes of gait training. The CERT program requested additional documentation such as the evaluations applicable to the billed date of service and the physician’s signed and dated plan of care. There was no response to an additional request for documentation. The CERT program scored this claim as an improper payment due to insufficient documentation.

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 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 46.3 percent, accounting for 8.9 percent of the overall Medicare FFS improper payment rate. This is an increase from the 2015 report period when the improper payment rate for DMEPOS was 39.9 percent and accounted for 7.1 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for DMEPOS increased from \$3.2 billion during the 2015 report period to \$3.7 billion during the 2016 report period.

Insufficient documentation errors caused the vast majority (80.4 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 identified when the medical record lacked the required documentation elements such as a documented face-to-face physician evaluation within a specified timeframe, proof of delivery 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 or suppliers of claims selected for review. This notification reminds these individuals of their responsibilities to document medical necessity for the DMEPOS items ordered and to submit requested documentation to the supplier.

The three DMEPOS groups with the highest improper payments were (in order) as follows:

- Oxygen Supplies and Equipment
- Positive Airway Pressure Devices and Supplies for Beneficiaries with Obstructive Sleep Apnea
- Lower Limb Orthoses

These three DMEPOS groups combined accounted for 31.5 percent of the DMEPOS improper payments in the 2016 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 and equipment was 45.0 percent, accounting for 1.2 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for oxygen supplies and equipment during the 2016 report period was \$521.9 million.

For Medicare coverage, the patient'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 elements such as physician orders for the oxygen supplies, oxygen saturation results, physician evaluations demonstrating oversight of the beneficiary and the beneficiary's continued medical necessity 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 following:

- The order for the oxygen supplies and equipment

- The Certificate of Medical Necessity (CMN)
- 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 monitoring of the beneficiary's continued medical necessity for oxygen supplies

The ordering and referring provider specialties of Internal Medicine and Family Practice comprise 76.6 percent of improper payments for oxygen supplies and equipment. In order to reduce the improper payment rate for oxygen supplies and equipment, the referring providers must respond to requests for documentation.

Example

A supplier submitted a claim for the monthly charge for stationary oxygen contents and portable oxygen contents (gaseous oxygen). The submitted documentation included an initial CMN dated and a recertification CMN. The CERT program requested the proof of delivery for the billed oxygen, the qualifying oximetry study as recorded on the recertification CMN, the treating physician's clinical documentation to support the re-evaluation for oxygen treatment within 90 days prior to the date of recertification CMN, and timely documentation from the treating physician to support the continued need of oxygen. No additional documentation was received following the request. Therefore, the CERT program scored this claim as an improper payment due to insufficient documentation.

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 devices and supplies was 59.6 percent, accounting for 1.0 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for CPAP/BPAP supplies during the 2016 report period was \$414.6 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 following:

- 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

The ordering and referring provider specialties of Internal Medicine and Family Practice comprise 76.6 percent of improper payments for CPAP/BPAP devices and supplies. In order to reduce the improper payment rate for CPAP/BPAP devices and supplies, the referring providers must respond to requests for documentation.

Example

The supplier submitted a claim for monthly rental of a CPAP device. The physician's face-to-face evaluation documented symptoms suggestive of obstructive sleep apnea and planned for a sleep study; the sleep study report supported moderate obstructive sleep apnea. The submitted detailed written order was missing the physician's NPI and was not date stamped upon receipt by the supplier. Also missing were the proof of delivery and timely documentation supporting continued medical necessity for the CPAP device. The CERT program made an additional request for documentation. However, the submitted additional documentation were duplicates of the previously received clinical records. The CERT program scored this claim as an improper payment due to insufficient documentation.

Lower Limb Orthoses

Orthoses are externally applied devices commonly referred to as braces or supports. Medicare provides coverage for lower limb orthoses when medically necessary.

The improper payment rate for lower limb orthoses was 69.6 percent, accounting for 0.6 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for lower limb orthoses during the 2016 report period was \$241.0 million.

The majority of improper payments for lower limb orthoses were due to insufficient documentation. There must be a written order from the treating physician. Medicare also requires documentation from the treating physician that supports the medical necessity of lower limb orthoses.

The ordering and referring provider specialties of General Surgery, Internal Medicine, and Family Practice comprise 72.3 percent of improper payments for lower limb orthoses. In order to reduce the improper payment rate for lower limb orthoses, the referring providers must respond to requests for documentation.

Example

A supplier billed for HCPCS L1960 (an ankle foot orthosis, posterior solid ankle, plastic, custom fabricated) for the right ankle and foot. The submitted documentation included an illegible prescription and the referring physician's detailed written order that was missing the start date, order date and signature. A request for additional documentation from the CERT program returned the supplier's initial evaluation and documentation of casting for the right ankle foot orthosis and the supplier's documentation of fitting the beneficiary with the orthosis. The treating physician also submitted clinical records documenting that the beneficiary was status post plastic surgery revision of a complicated open wound of the right ankle/heel areas and partial removal of the calcaneus for osteomyelitis. The completed detailed written order, which is a requirement, was missing. The CERT program scored this claim as an improper payment due to insufficient documentation.

Resources for Providers and Suppliers

The following links provide information that is available for providers and suppliers to educate them on the CERT process, major drivers of improper payments and actions to improve the payment accuracy rate.

CERT Provider Website

The CERT Provider Website provides the Medicare Provider Community a source for verifying and updating their contact information for the CERT program. It also includes links to newsletters, sample attestations, sample documentation request letters and information on the CERT Documentation Contractor call center.

<https://www.certprovider.com/>

Medicare Quarterly Provider Compliance Newsletter

This newsletter is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare FFS Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf

Payment Accuracy Website

This website provides an overview of improper payments measurements across the federal government.

<https://paymentaccuracy.gov/>

Acronyms

Acronym	Description
ACA	Affordable Care Act
ASC	Accredited Standards Committee
AFR	Agency Financial Report
ANSI	American National Standards Institute
BETOS	Berenson-Eggers Type of Service
BPAP	Bi-Level Positive Airway Pressure
CBRs	Comparative Billing Reports
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulation
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CPAP	Continuous Positive Airway Pressure
CPT	Current Procedural Terminology
CT	Computed Tomography

Acronym	Description
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DWO	Detailed Written Order
E&M	Evaluation and Management
ED	Emergency Department
FFS	Fee-For-Service
FR	Federal Regulation
FY	Fiscal Year
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
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

Acronym	Description
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IPRS	Improper Payment Reduction Strategy
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MR	Medical Review
MS-DRG	Medicare Severity Diagnosis Related Group
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
OIG	HHS Office of Inspector General
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System

Acronym	Description
PAP	Positive Airway Pressure
PMD	Power Mobility Device
QIC	Qualified Independent Contractor
RAC	Recovery Audit 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 ²⁴	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 ²⁵	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 ²⁶	Gross	0.2%	5.0%	3.4%	1.2%	0.1%	9.9%	90.1%
2012 ²⁷	Gross	0.2%	5.0%	2.6%	1.3%	0.1%	9.3%	90.7%
2013 ²⁷	Gross	0.2%	6.1%	2.8%	1.5%	0.2%	10.7%	89.3%
2014 ²⁷	Gross	0.1%	8.2%	3.6%	1.6%	0.2%	13.6%	86.4%
2015 ²⁷	Gross	0.2%	8.2%	2.5%	1.3%	0.4%	12.5%	87.5%
2016 ²⁷	Gross	0.1%	7.2%	2.4%	1.1%	0.4%	11.2%	88.8%

²⁴ FY 1996-2003 Improper payments were calculated as Overpayments – Underpayments.

²⁵ FY 2004-2016 Improper payments were calculated as Overpayments + Underpayments.

²⁶ The FY 2011 improper payment rate reported in the HHS AFR 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.

²⁷ The FY 2012, 2013, 2014, 2015, and 2016 improper payment rates reported in the HHS AFR were 8.5 percent, 10.1 percent, 12.7 percent, 12.1 percent, and 11.0 percent, respectively. These rates 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, 2013, 2014, 2015, and 2016 rates in this table are unadjusted.

Table 5: Comparison of 2015 and 2016 National Improper Payment Rates²⁸

Error Category	2015	2016				
	Total	Total	Part A Excl. Hospital IPPS	Part A Hospital IPPS	Part B	DMEPOS
No Documentation	0.2%	0.1%	0.0%	0.0%	0.1%	0.0%
Insufficient Documentation	8.2%	7.2%	4.2%	0.1%	2.0%	0.8%
Medical Necessity	2.5%	2.4%	1.4%	0.9%	0.1%	0.0%
Incorrect Coding	1.3%	1.1%	0.1%	0.3%	0.7%	0.0%
Other	0.4%	0.4%	0.1%	0.1%	0.0%	0.2%
Total	12.5%	11.2%	5.9%	1.4%	2.9%	1.0%

²⁸ Some columns and/or rows may not sum correctly due to rounding. Unadjusted for Medicare Part A to B rebilling of denied inpatient hospital claims.

Table 6: Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions)²⁹

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)	\$272.3	\$27.2	10.0%	\$26.5	9.7%	\$0.7	0.3%
Part A (Excluding Hospital IPPS)	\$157.5	\$22.0	14.0%	\$22.0	13.9%	\$0.0	0.0%
Part A (Hospital IPPS)	\$114.8	\$5.2	4.5%	\$4.5	3.9%	\$0.7	0.6%
Part B	\$93.3	\$10.9	11.7%	\$10.4	11.2%	\$0.5	0.6%
DMEPOS	\$8.1	\$3.7	46.3%	\$3.7	46.1%	\$0.0	0.1%
Total	\$373.7	\$41.8	11.2%	\$40.6	10.9%	\$1.2	0.3%

²⁹ Some columns and/or rows may not sum correctly due to rounding. Unadjusted for Medicare Part A to B rebilling of denied inpatient claims.

Table 7: 2016 Projected Improper Payments by Type of Error and Clinical Setting (Dollars in Billions)³⁰

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	IPPS Hospitals	Physician Services (All Settings)	Skilled Nursing Facilities	Other Clinical Settings	Overall
No Documentation	\$0.0	\$0.0	\$0.1	\$0.0	\$0.3	\$0.0	\$0.0	\$0.5
Insufficient Documentation	\$3.0	\$7.4	\$5.9	\$0.9	\$5.5	\$2.1	\$2.0	\$26.8
Medical Necessity	\$0.1	\$0.2	\$0.6	\$7.7	\$0.1	\$0.0	\$0.1	\$8.9
Incorrect Coding	\$0.0	\$0.0	\$0.1	\$1.0	\$2.7	\$0.3	\$0.1	\$4.2
Other	\$0.6	\$0.1	\$0.1	\$0.2	\$0.1	\$0.4	\$0.0	\$1.4
Total	\$3.7	\$7.7	\$6.8	\$9.9	\$8.7	\$2.8	\$2.3	\$41.8

³⁰ Some columns and/or rows may not sum correctly due to rounding. Unadjusted for Medicare Part A to B rebilling of denied inpatient hospital claims.

Figure 1: Proportion of Improper Payments Attributed to Insufficient Documentation in 2016, by Clinical Setting

Insufficient documentation errors accounted for the greatest proportion of improper payments during the 2016 report period.

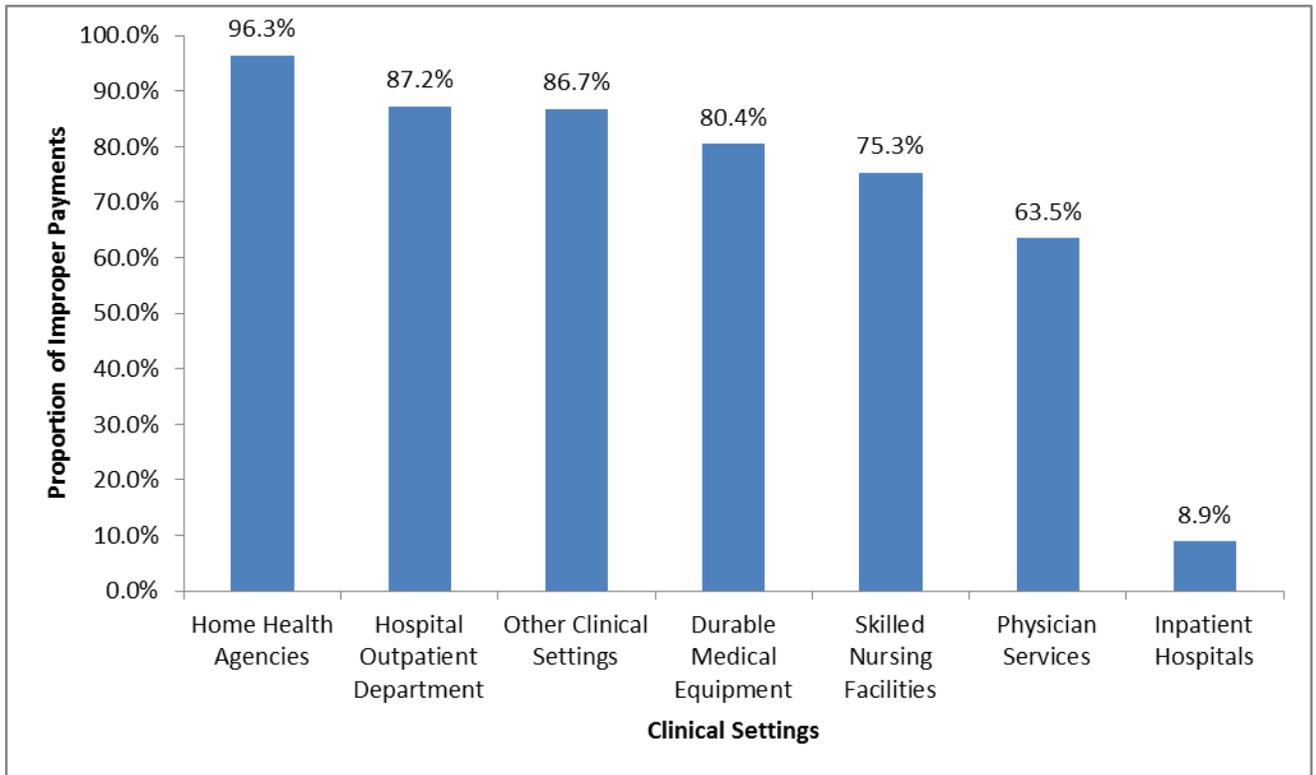


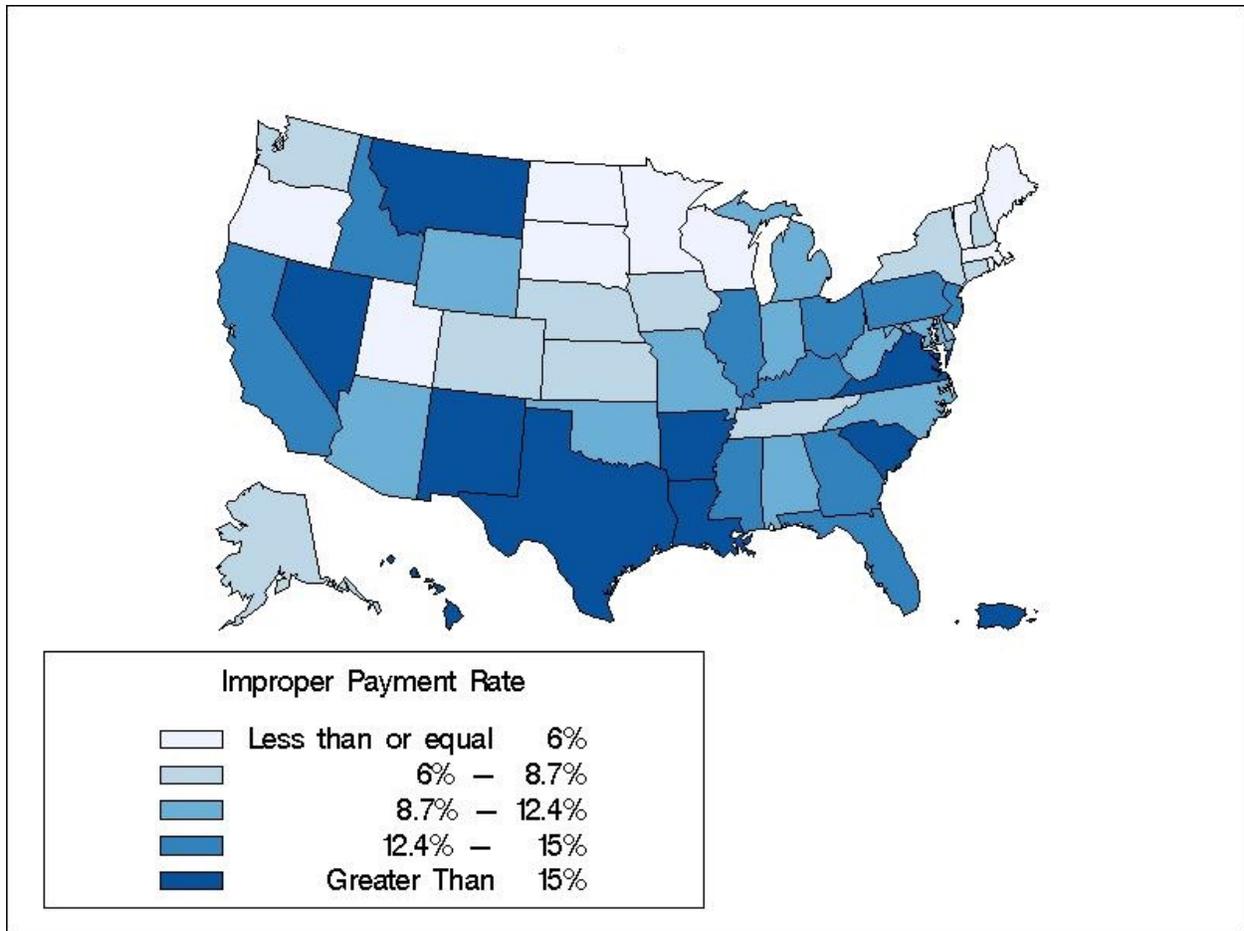
Table 8: Projected Improper Payments, Overpayments and Underpayments by Top 10 States
(Dollars in Millions)³¹

State	Overall		Overpayments		Underpayments	
	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate	Improper Payment Amount	Improper Payment Rate
CA	\$4,790.9	13.6%	\$4,662.1	13.2%	\$128.8	0.4%
TX	\$4,383.2	17.5%	\$4,284.1	17.1%	\$99.1	0.4%
FL	\$3,417.2	12.9%	\$3,331.2	12.6%	\$86.1	0.3%
PA	\$2,215.0	12.9%	\$2,179.0	12.7%	\$36.0	0.2%
IL	\$1,949.9	13.1%	\$1,906.5	12.8%	\$43.5	0.3%
OH	\$1,595.4	12.4%	\$1,489.5	11.5%	\$105.9	0.8%
NJ	\$1,587.8	12.7%	\$1,537.2	12.3%	\$50.6	0.4%
NY	\$1,501.6	6.3%	\$1,387.4	5.9%	\$114.2	0.5%
NC	\$1,445.0	11.8%	\$1,400.4	11.5%	\$44.6	0.4%
GA	\$1,390.9	13.6%	\$1,372.2	13.5%	\$18.7	0.2%
Overall	\$41,826.2	11.2%	\$40,586.4	10.9%	\$1,239.7	0.3%

³¹ 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 Trends³²

Figure 2: 2016 Improper Payment Rates by State



³² Cut points 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 IPPS, DMEPOS, and Part B

Figure 3: 2016 Improper Payment Amounts by State (Dollars in Millions)

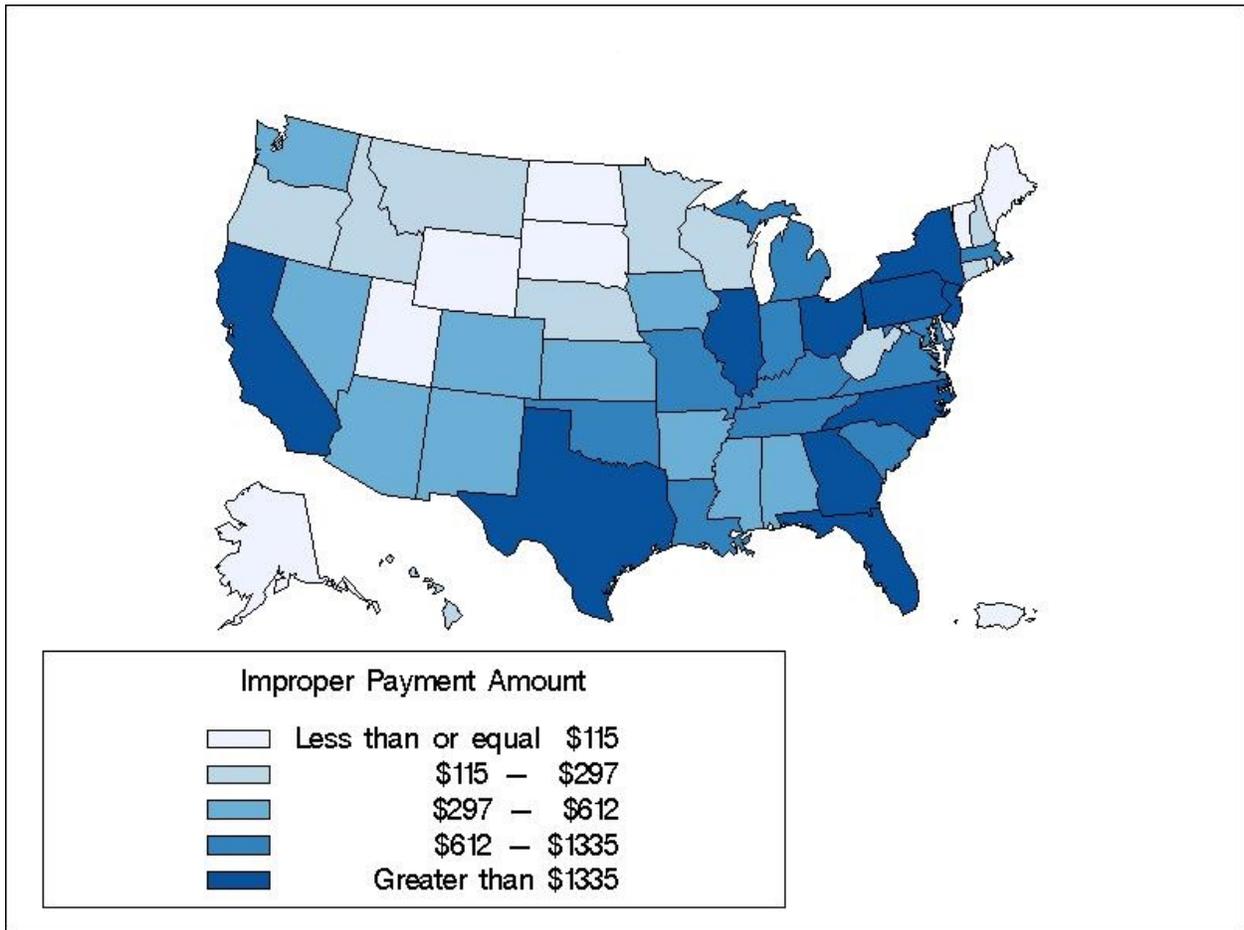
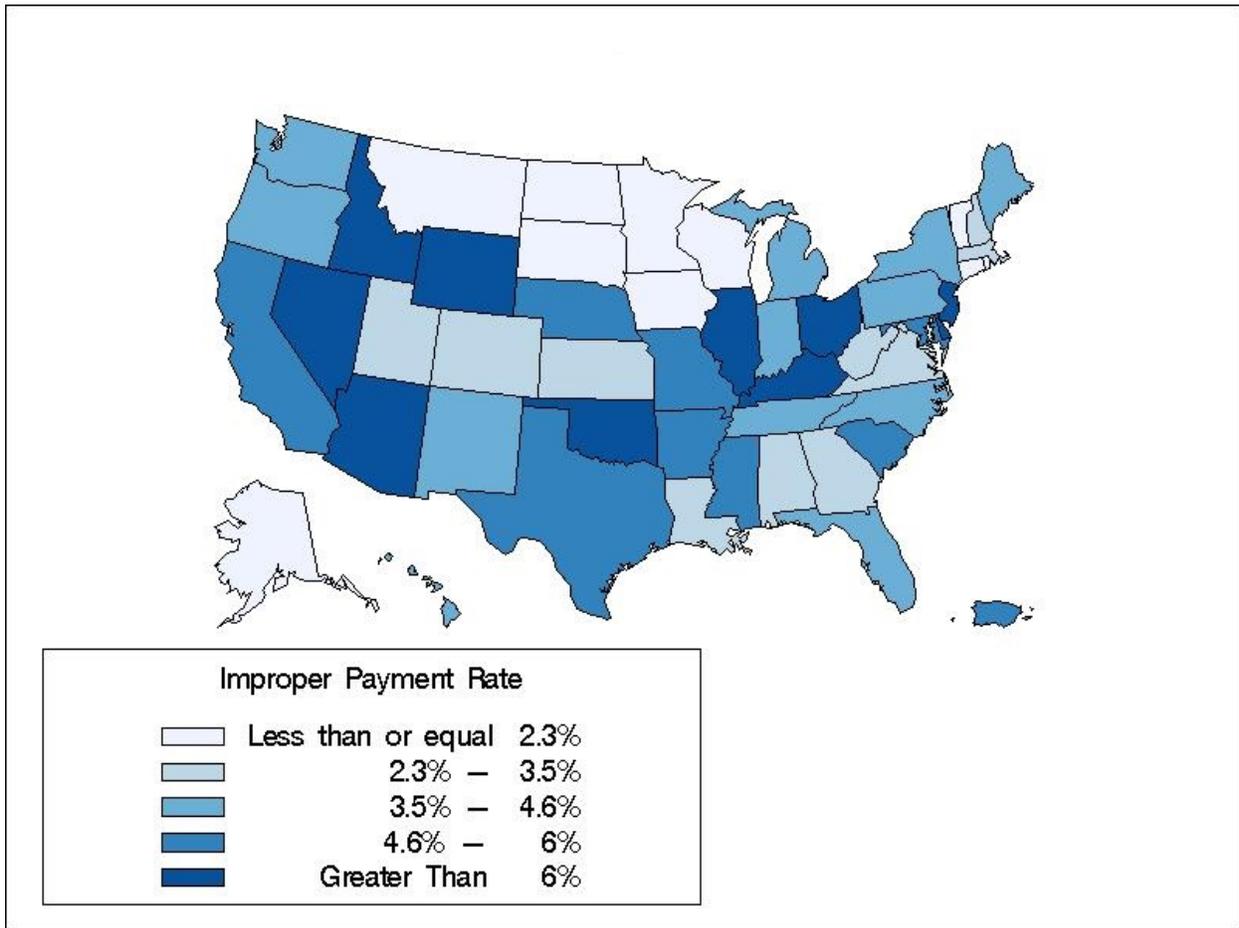
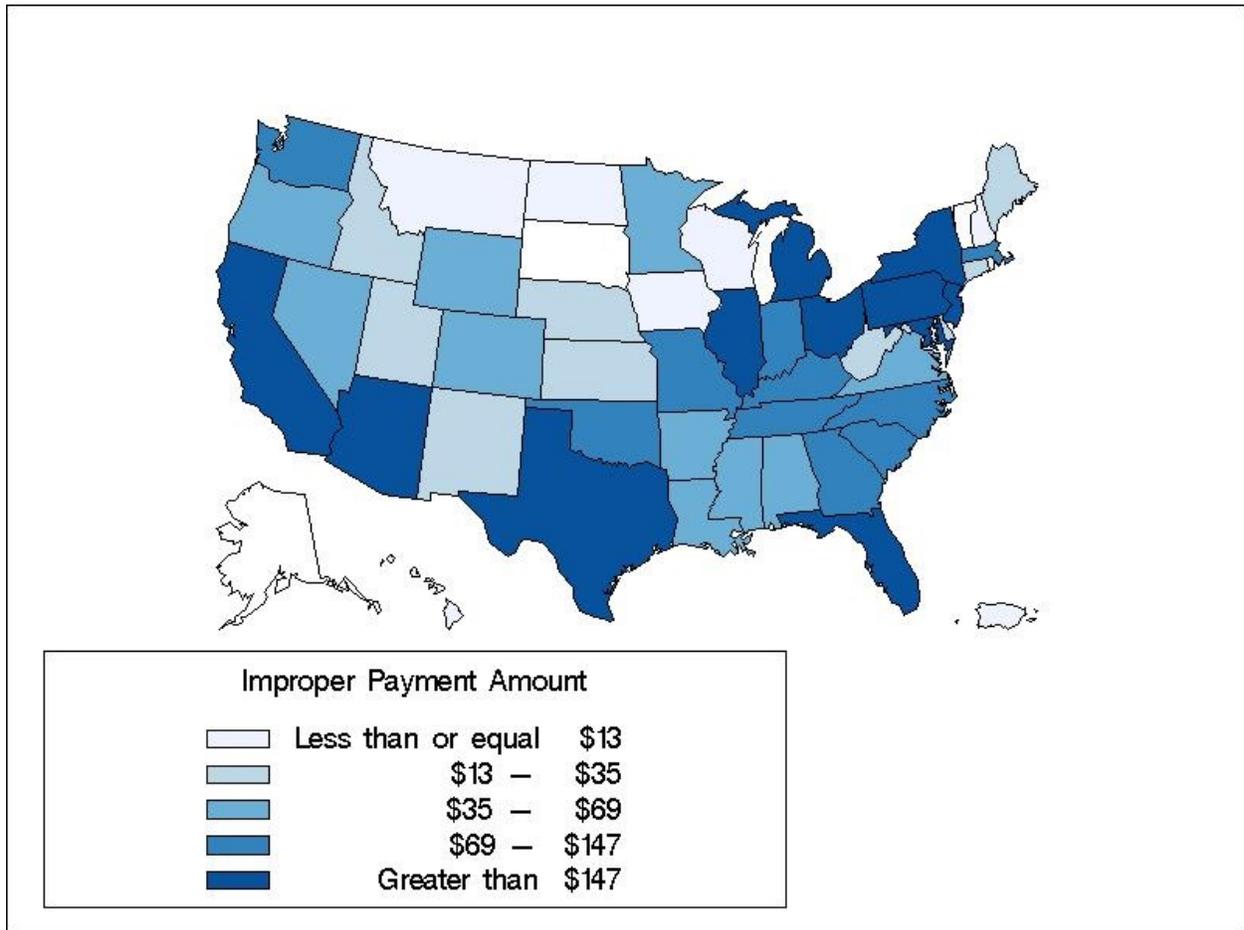


Figure 4: Part A (Hospital IPPS) Improper Payment Rates by State³³



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

Figure 5: Part A (Hospital IPPS) Improper Payment Amounts by State (Dollars in Millions)³⁴



³⁴ The improper payment amounts in this figure are unadjusted for the impact of Part A to B rebilling.

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

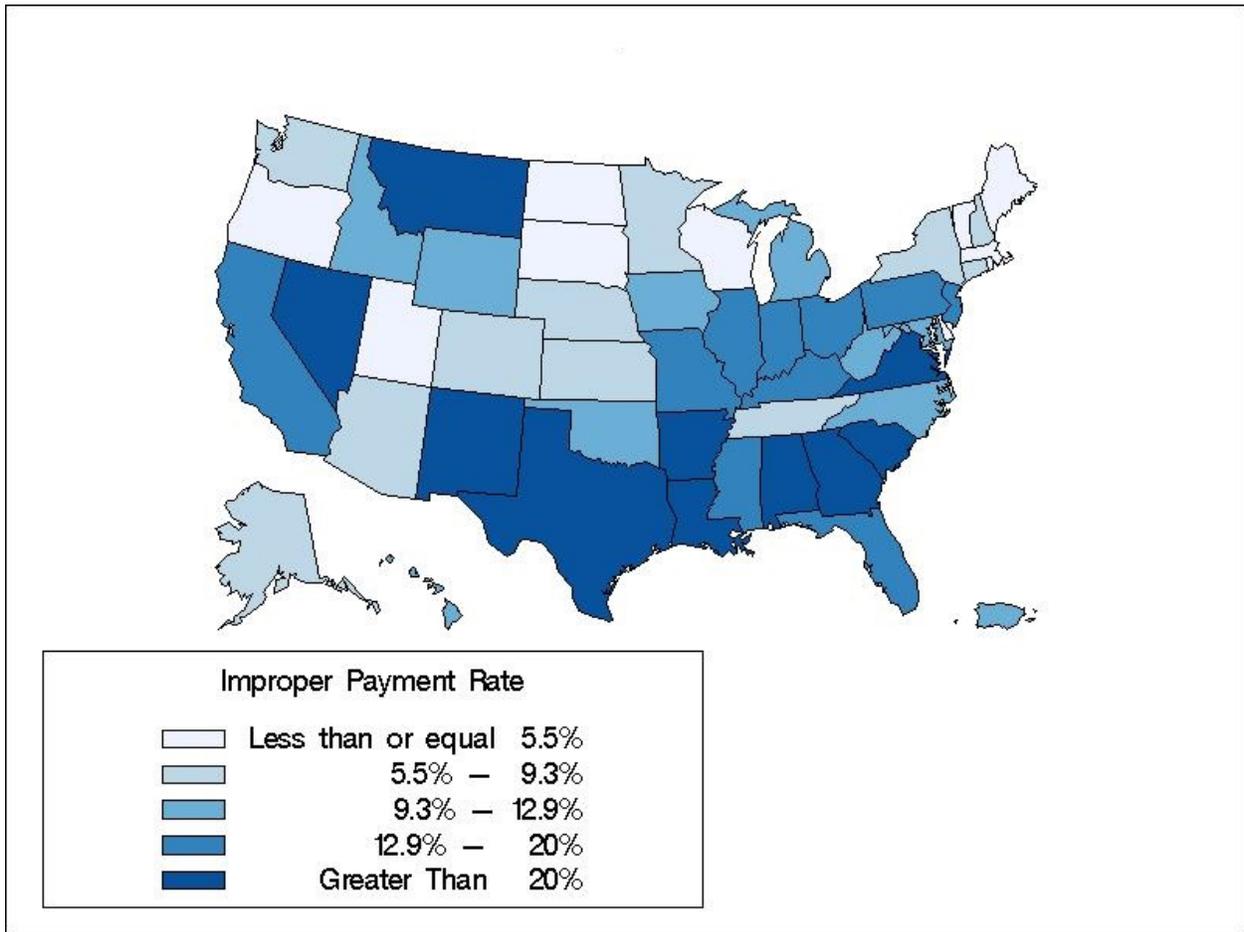


Figure 7: Part A (Excluding Hospital IPPS) Improper Payment Amounts by State (Dollars in Millions)

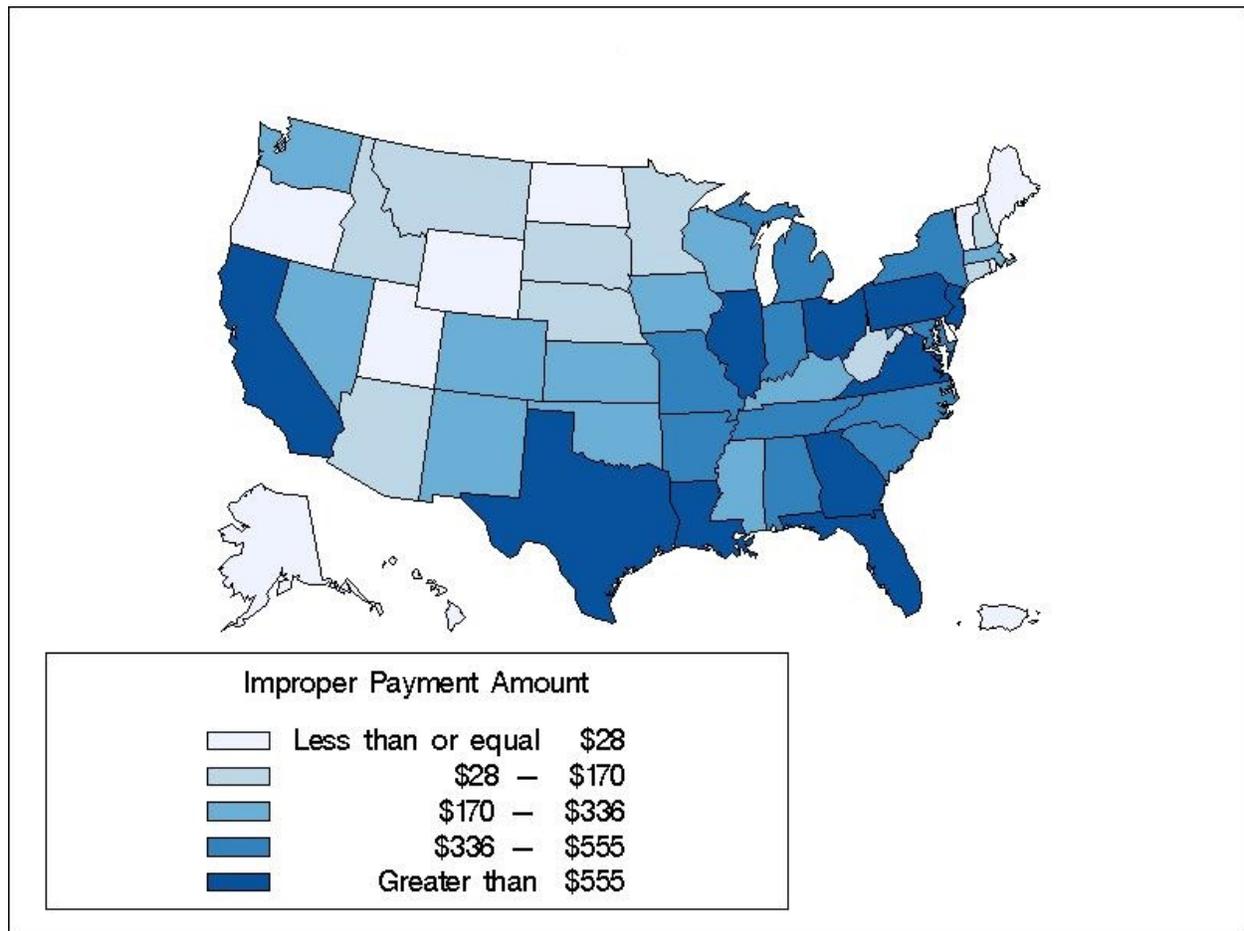


Figure 8: Part B Improper Payment Rates by State

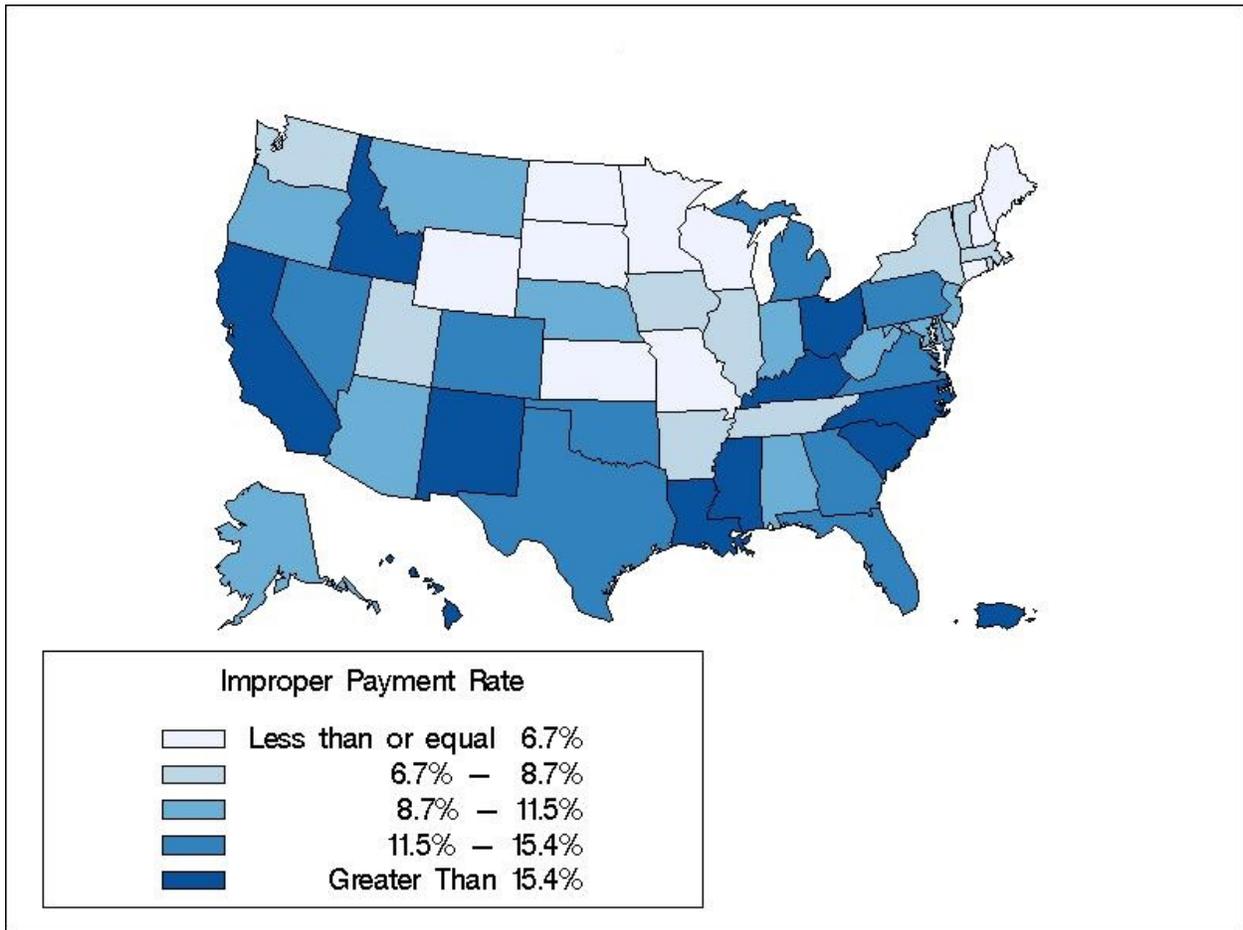


Figure 9: Part B Improper Payment Amounts by State (Dollars in Millions)

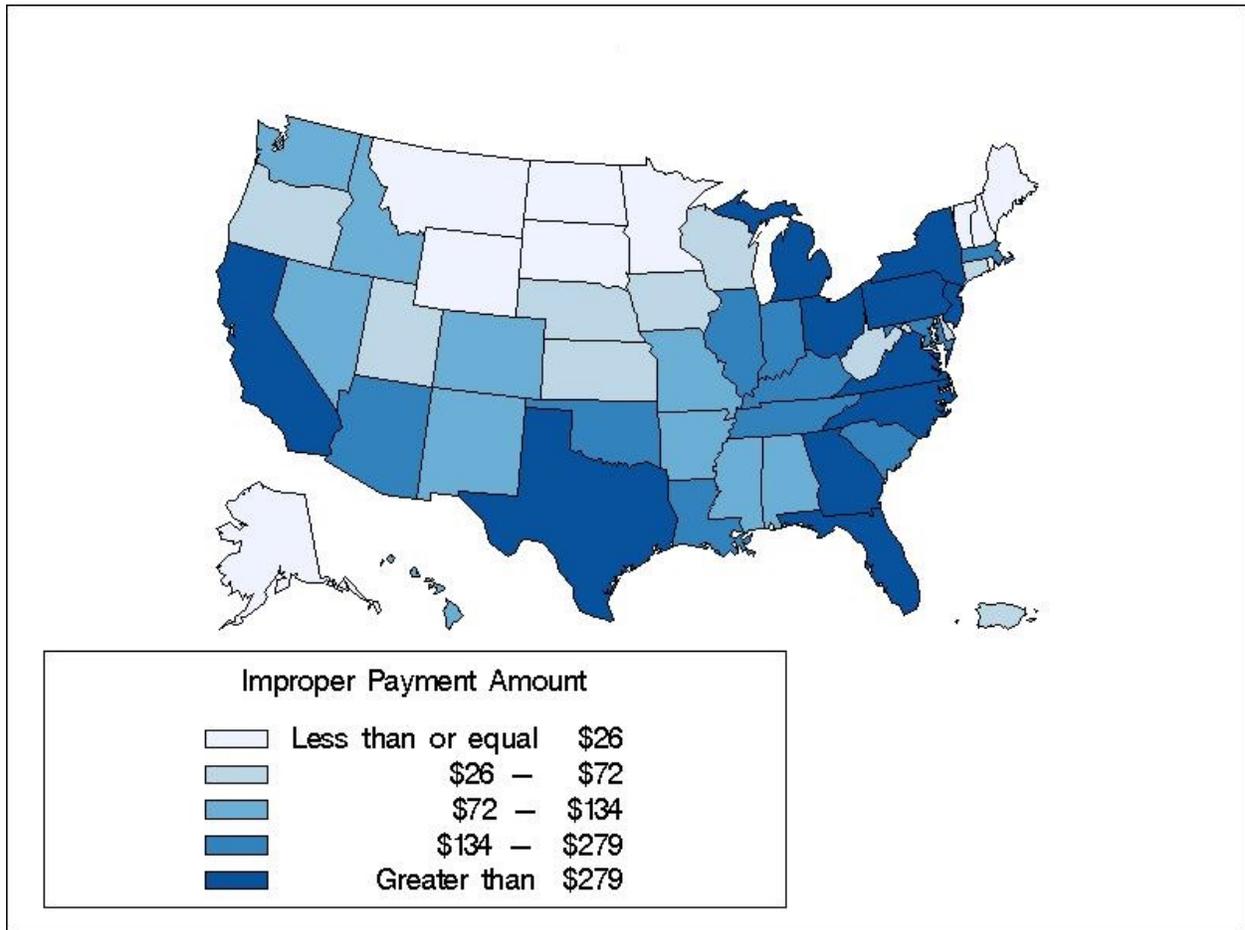


Figure 10: DMEPOS Improper Payment Rates by State

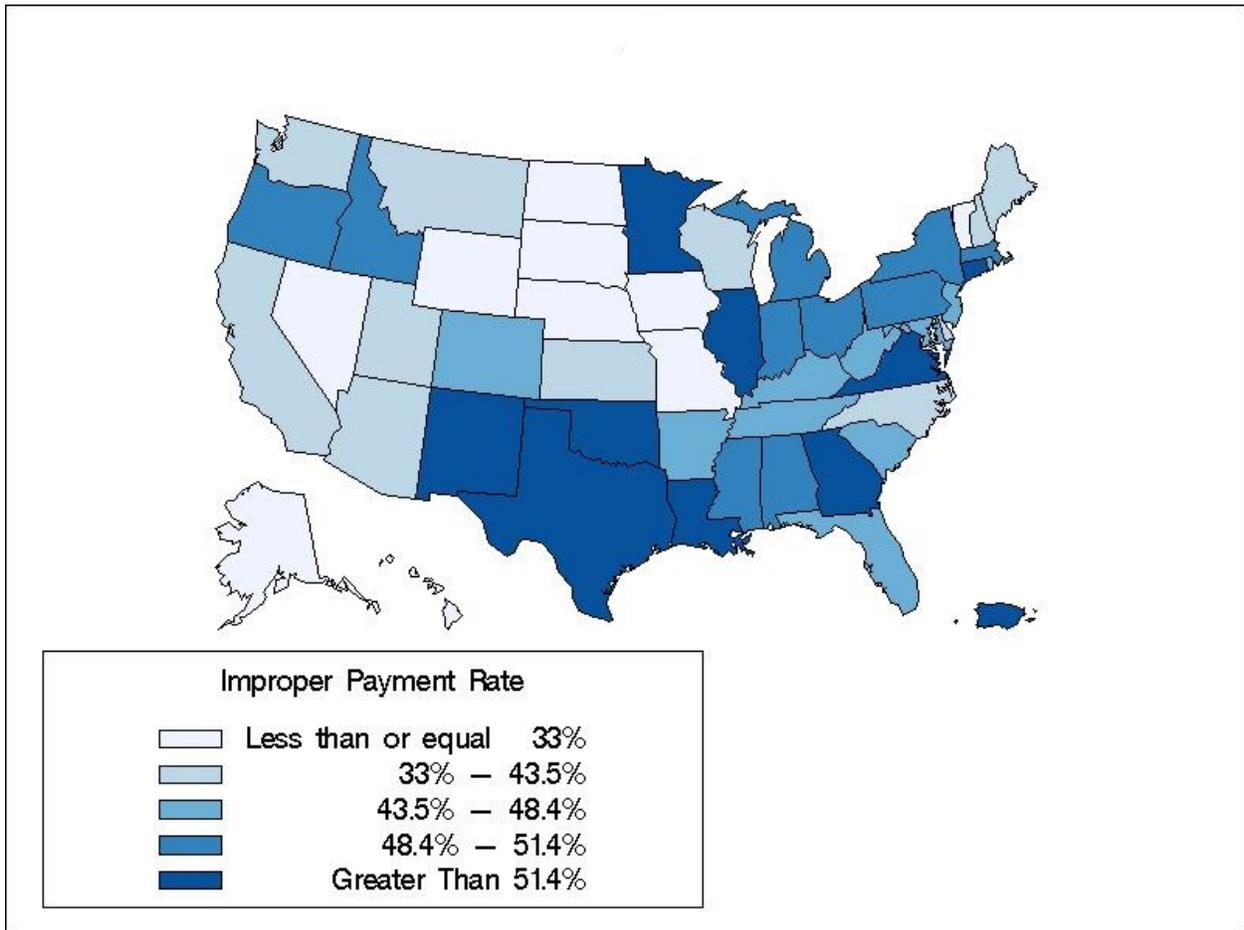


Figure 11: DMEPOS Improper Payment Amounts by State (Dollars in Millions)

