Information Sheet

November 2007 Improper Medicare FFS Payments Report

What is an improper payment?

An improper payment is any payment made by a Medicare claims processing contractor that should not have been made or was made in the wrong amount. This includes claims that are incorrectly submitted, contain unnecessary services or supplies, or are not supported by medical record documentation. Although fraudulent claims are considered improper payments, not all improper payments are fraudulent. The Medicare FFS Payments error rate is not a measure of fraud.

What was the reporting period for this report?

For Medicare Administrative Contractors (MAC), Carriers, Durable Medical Equipment Regional Carriers (DMERC), and Fiscal Intermediaries (FI), the report included claims submitted between April 1, 2006 and March 31, 2007. For Quality Improvement Organizations (QIO), the report included inpatient PPS hospital discharges between January 1, 2006 and December 31, 2006.

Will these rates be updated to reflect late documentation?

No. All documentation that arrived before the cut off date for this report has been included. CMS discontinued the production of quarterly updates to the reports in November 2005.

Are Medicare Administrative Contractors (MAC) included in this report?

Yes. Several MACs were processing claims during the sampling period for this report. Additional MACs will appear in future reports as they are transitioned into the program. CMS expects all MACs to show in the 2009 Improper Medicare FFS Payments report.

What caused the error rate to decrease from 2006 to 2007?

There were several small improvements in the areas of incorrect coding and medically unnecessary services. A larger factor in the reduction was the improvement of insufficient documentation errors. Over the past 2 years, CMS has implemented several corrective actions that had a positive effect on the insufficient documentation problem. For example, the CERT program implemented a process to distribute an insufficient documentation report to all MACs, Carriers, DMERCs, and FIs 60 days prior to the due date of an improper payment report. The contractors were encouraged to contact providers to obtain missing information that is needed for CERT review of claims. In addition, the CERT Documentation Contractor contacted third party providers to request documentation when the billing provider indicated that a portion of the medical record was possessed by a third party. More information on the reduction of insufficient documentation and other errors can be found in the full report at www.cms.hhs.gov/CERT.

Why are DME errors increasing?

DME suppliers submitted about three quarters of the claims with no documentation errors. For most of the DMERC claims scored as no documentation errors, the DME supplier was unreachable after their claims were sampled for the CERT program. The increase of DME errors is attributable, at least in part, to the continued efforts of CMS and contractors finding and disabling or revoking provider numbers for providers not in compliance with CMS policies.

How will CMS reduce no documentation errors?

CMS is implementing a Durable Medical Equipment Accreditation program to ensure the legitimacy of the DME suppliers that bill Medicare and to ensure those suppliers meet all the requirements for participation in the Medicare program. Based on findings in this report and observations from other monitoring activities, CMS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments. During this report period, CMS issued regulations that clarify and strengthen provider enrollment requirements and standards and increased efforts to deactivate or, when necessary, revoke billing privileges for providers and suppliers that are inactive or do not meet program requirements.

What educational efforts is CMS undertaking to help lower the error rate?
CMS requires all CERT participating contractors to review and validate the CERT results for their jurisdiction, and determine the education needed to reduce errors. Contractors have implemented educational programs that entail both broad-based efforts and more focused communication with specific providers or provider groups concerning specific billing problems. These efforts include the use of a wide array of CMS-developed educational products (http://www.cms.hhs.gov/MLNProducts) on coverage, payment and billing. In addition to these products, to assist providers in understanding Medicare program requirements, CMS offers national and local provider forums, national and local websites, and dedicated provider contact centers answering millions of provider calls annually.

Why can't some of the improper payment calculations be compared across reports?
In previous reports the CERT program and the HPMP calculated improper payment estimates in a slightly different manner. Unlike HPMP, the CERT program did not exclude coinsurance and deductibles from the payment data used to calculate projected improper payments. This issue specifically effected contractor, service type, and provider type estimates. In earlier reports, the national improper payment estimates excluded coinsurance and deductibles, while other CERT only estimates included them. For consistency and accuracy, the CERT program switched to excluding coinsurance and deductibles in all of its calculations beginning with the 2005 report. This change does not impact comparisons of the current paid claims error rate to previous reports. The exclusion of coinsurance and deductibles effects all of the payment totals used in CERT calculations equally; therefore, the paid claims error rate is unaffected by this change.

What factors may influence future error rates?
The two largest factors that may influence future error rates will be the transition of the current Medicare claims processing contractors to new Medicare Administrative Contractors (MAC) and ongoing efforts to strengthen our provider enrollment processes. CMS expects there may be fluctuations in error rates as new contractors come up to speed in their new MAC jurisdictions. The effect of the MAC transitions will begin to subside in the 2011 report and beyond. Further, we expect future rates to fluctuate as well with the continued implementation of initiatives, such as the DME accreditation program and three, separate demonstration projects to revalidate provider enrollment. These efforts by CMS and its contractors to find and revoke provider numbers for providers not in compliance with CMS policies result in “no documentation” errors. CERT is unable to locate these providers for medical record documentation because these providers have lost billing privileges and no longer participate with the Medicare program.