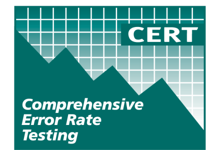
Information Sheet

November 2006 Improper Medicare FFS Payments Report



What was the reporting period for this report?
For Carriers, Durable Medical Equipment Regional Carriers (DMERC), and Fiscal Intermediaries (FI), the report included claims submitted between April 1, 2005 and March 31, 2006. For Quality Improvement Organizations (QIO), the report included inpatient PPS hospital discharges between January 1, 2005 and December 31, 2005.

Why did CMS move the claim submitted dates of the report?
CMS Reduced the lag time between the end of a reporting period and the production of the Comprehensive Error Rate Testing (CERT) report for that period, thereby providing Carriers/DMERCs/FIs with more timely error rates. CMS accelerated the sampling and review process, reducing the interval between the last sampled claim for a report and the report publication from 11 months to 8 months. The Hospital Payment Monitoring Program (HPMP) also accelerated the time between the sampling period to the report publication; from 18 months to 11 months.

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?
No. The MACs were not processing claims during the sampling period for this report. MACs will start appearing in the report as they are transitioned into the program. CMS expects the first MACs to show in the 2007 Improper Medicare FFS Payments report.

What caused the error rate to decrease from 2005 to 2006?
The main factor in the improvement of the error rate was the reduction in 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 Carriers, DMERCs, and FIs 60 days prior to the due date of an improper payment report. Carriers/DMERCs/FIs 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.hh.gov/CERT.

What educational efforts is CMS undertaking to help lower the error rate?
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 (the Medicare Learning Network products can be viewed at 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 over 56M provider calls annually. CMS requires the Carriers/DMERCs/FIs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce errors.

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.