DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date FEB 17 2000

From June Gibbs Brown
Inspector General

Subject Improper Fiscal Year 1999 Medicare Fee-for-Service Payments (A-17-99-01999)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached, as you requested, is our final report on the results of our review of Fiscal Year (FY) 1999 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. Based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1999 totaled $13.5 billion, or about 7.97 percent of the $169.5 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse.

We believe that since we developed the first error rate for FY 1996, HCFA has demonstrated continued vigilance in monitoring Medicare payments and developing appropriate corrective action plans. In addition, our audit results clearly show that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly. For both FYs 1998 and 1999, we estimated that over 90 percent of fee-for-service payments met Medicare reimbursement requirements. We remain concerned, however, about continuing problems with provider documentation. Documentation errors increased by an estimated $3.4 billion over last year's estimate, largely as a result of errors by home health agencies, durable medical equipment suppliers, and physicians. Our recommendations address the need for HCFA to sustain its efforts in reducing improper payments.

We have incorporated HCFA's comments on the draft report where appropriate. We appreciate the cooperation and assistance provided by you and your staff.

If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPROPER FISCAL YEAR 1999 MEDICARE FEE-FOR-SERVICE PAYMENTS

JUNE GIBBS BROWN
Inspector General

FEBRUARY 2000
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This final report presents the results of our review of Fiscal Year (FY) 1999 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. This is the fourth year that the Office of Inspector General (OIG) has estimated these improper payments. As part of our analysis, we have profiled all 4 years' results and identified specific trends where appropriate.

Our review of 5,223 claims valued at $5.4 million disclosed that 1,034 did not comply with Medicare laws and regulations. Based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1999 totaled $13.5 billion, or about 7.97 percent of the $169.5 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (92 percent) of these improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

While this year's estimate is higher than last year's, we cannot conclude that the current error rate is statistically different. This year's estimate is about $1 billion more than the FY 1998 estimate of $12.6 billion, $6.8 billion less than the FY 1997 estimate of $20.3 billion, and $9.7 billion less than the FY 1996 estimate of $23.2 billion. The increase this year may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

We believe that since we developed the first error rate for FY 1996, HCFA has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, our audit results clearly show that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly. In this regard, for both FYs 1998 and 1999, over 90 percent of the Medicare fee-for-service payments were estimated to be correct. This is a very positive reflection, in our opinion, on the due diligence of the health care provider community to comply with Medicare reimbursement requirements.

We note, however, that documentation errors increased by $3.4 billion over last year's estimate. This increase was largely attributable to three provider groups: home health agencies, durable medical equipment (DME) suppliers, and physicians.

BACKGROUND

The Medicare program (Title XVIII of the Social Security Act) was established by the Social Security Amendments of 1965 to cover the health care needs of people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. In FY 1999, about 39.5 million beneficiaries were enrolled in the program, and HCFA incurred about $206 billion nationwide in Medicare benefit payments. Fee-for-service payments accounted for about $169.5 billion of this total.

Medicare consists of two programs, each with its own enrollment, coverage, and financing:

- Hospital insurance, also known as Medicare Part A, is usually provided automatically to people aged 65 and over and to most disabled people. It covers services rendered by participating hospitals (including prospective payment system (PPS) hospitals), skilled nursing facilities, home health agencies, and hospice providers.

- Supplementary medical insurance, also known as Medicare Part B, is available to nearly all people aged 65 and over and the disabled entitled to Part A. This optional insurance is subject to monthly premium payments by beneficiaries. Medicare Part B covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by Medicare Part A.

The HCFA pays the following types of contractors to process fee-for-service claims:

- Fiscal intermediaries (FI) process Part A payments for hospitals, skilled nursing facilities (SNF), home health agencies (HHA), rural health clinics, hospices, end stage renal disease facilities, and other institutional providers.

- Carriers process Part B payments for physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers.

- Durable medical equipment regional carriers (DMERC) process claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies under Medicare Part B except those for items incident to physician services in rural health clinics or included in payments to such providers as hospitals, SNFs, and HHAs.

To ensure the quality of care provided to Medicare beneficiaries, HCFA also contracts with peer review organizations (PRO) to conduct a wide variety of quality improvement programs. For example, PRO medical review personnel assess medical record documentation to determine whether the services rendered were medically necessary, appropriate, and met professionally recognized standards of care.

AUDIT OBJECTIVE

Our primary objective was to determine whether Medicare fee-for-service benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR). Specifically, we determined whether services were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

AUDIT SCOPE AND METHODOLOGY

Statistical Selection Method. To accomplish our objective, we used a multistage, stratified sample design. In the first stage, our sample frame consisted of 176 contractor quarters. Twelve contractor quarters were selected based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used FY 1998 Medicare fee-for-service benefit payments as the selection weighting factors (size of each contractor quarter). The 12 contractor quarters included 8 contractors, of which 3 were FIs; 2 were both FIs and carriers; and 3 were FIs, carriers, and DMERCs.

The second stage of our sample design consisted of a random sample of 50 beneficiaries from each of the 12 contractor quarters sorted into 4 strata by total payments for services. The random sample of 600 beneficiaries produced 5,223 claims valued at $5.4 million for review. To ensure the completeness of the claim data, we reconciled Medicare contractor claim data to the HCFA 1522 Monthly Financial Reports for the 12 contractor quarters selected. The HCFA used these reports in preparing the FY 1999 financial statements.

We used a variable appraisal program to estimate the dollar value of improper payments in the total population. The population represented $169.5 billion in fee-for-service payments.

Audit Procedures. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. We contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response

from our initial letter, we made numerous follow-up contacts by letter and, in most instances, by telephone calls. At selected providers, we also made onsite visits to collect requested documentation.

Medical review personnel from HCFA's Medicare contractors and PROs assessed the medical records to determine whether the services billed were reasonable, adequately documented, medically necessary, and coded in accordance with Medicare reimbursement rules and regulations. We coordinated these reviews to ensure their consistency and accuracy. Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare Secondary Payer); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

In addition, we reviewed HCFA's corrective action plan addressing recommendations cited in our previous years' reports. We made this review in accordance with generally accepted government auditing standards and in conjunction with the audit of HCFA's FY 1999 financial statements. The Chief Financial Officers Act of 1990 requires Federal agencies to improve systems of financial management, accounting, and internal controls to ensure that they issue reliable financial information. Also, the Government Management Reform Act of 1994 requires full-scope audits of the financial statements of Federal agencies, including the Department of Health and Human Services.

RESULTS OF REVIEW

Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 5,223 fee-for-service claims processed for payment during FY 1999, we found that 1,034 claims did not comply with Medicare laws and regulations. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claim adjudication process.

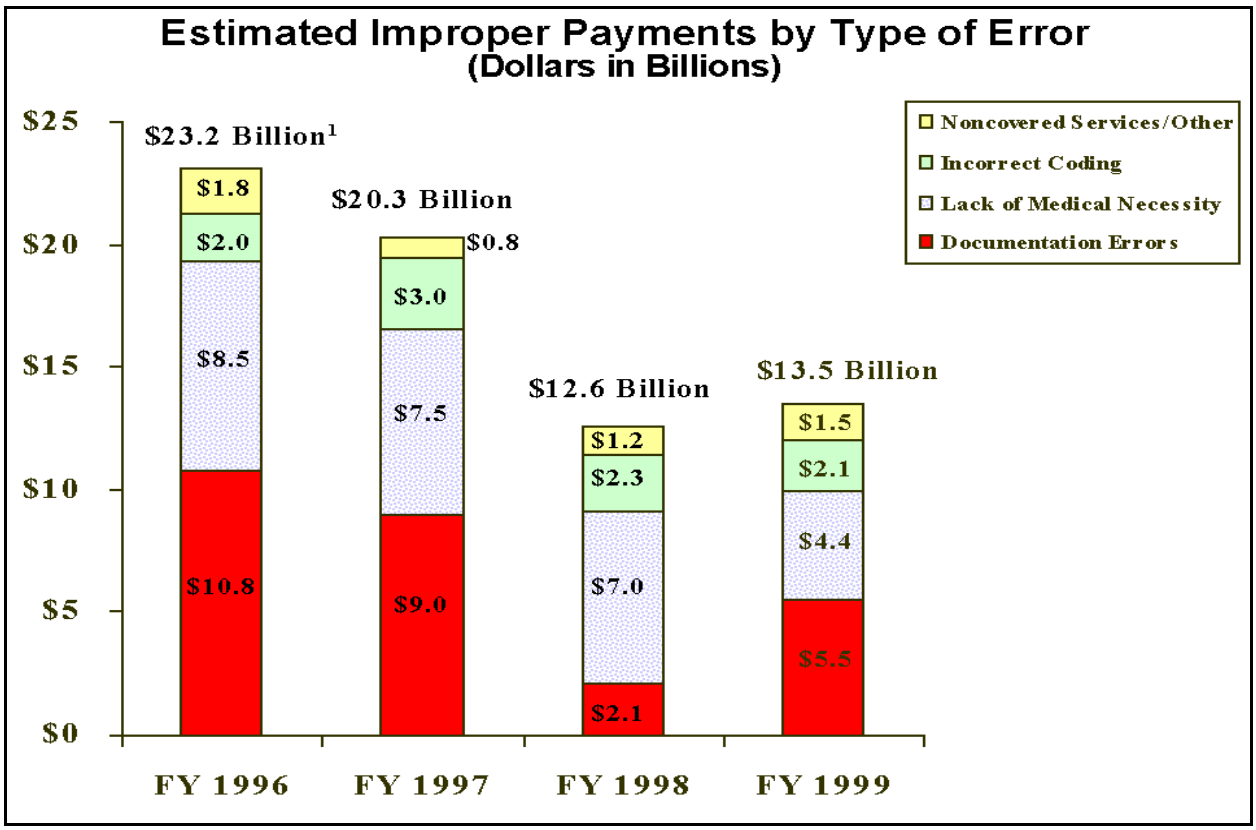
Based on our statistical sample, the point estimate of improper Medicare benefit payments made during FY 1999 was $13.5 billion, or about 7.97 percent of the $169.5 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is $9.1 billion to $17.9 billion, or about 5.4 percent to 10.6 percent, respectively. This year's point estimate is about $1 billion more than last year's point estimate of

$12.6 billion. It is also $6.8 billion less than the FY 1997 point estimate of $20.3 billion and $9.7 billion less than the FY 1996 point estimate of $23.2 billion.

Although this year's point estimate is $1 billion higher than last year's, we cannot conclude that the increase is statistically significant. The increase may be due to sampling variability, which means that this year's results could differ from last year's simply because selecting different claims with different dollar values will inevitably produce a different estimate of improper payments. It is also important to note that the FY 1998 $12.6 billion point estimate falls within the FY 1999 estimated range of improper payments at the 95 percent confidence level ($9.1 billion to $17.9 billion). Likewise, the FY 1999 $13.5 billion point estimate falls within the FY 1998 estimated range of improper payments at the 95 percent confidence level ($7.8 billion to $17.4 billion).

Our 4-year analysis shows that there has been sustained progress in reducing improper payments since FY 1996, the first year the error rate was developed. However, our analysis also demonstrates that documentation and medical necessity have been and continue to be pervasive problems. These two error categories accounted for over 70 percent of the total improper payments over the 4 years.

The following chart, along with appendix 1, demonstrates the trends in improper payments by the major categories of errors we have identified: (1) documentation errors, (2) lack of medical necessity, (3) incorrect coding, and (4) noncovered services and miscellaneous errors.



[1]*Does not add to total due to rounding.*

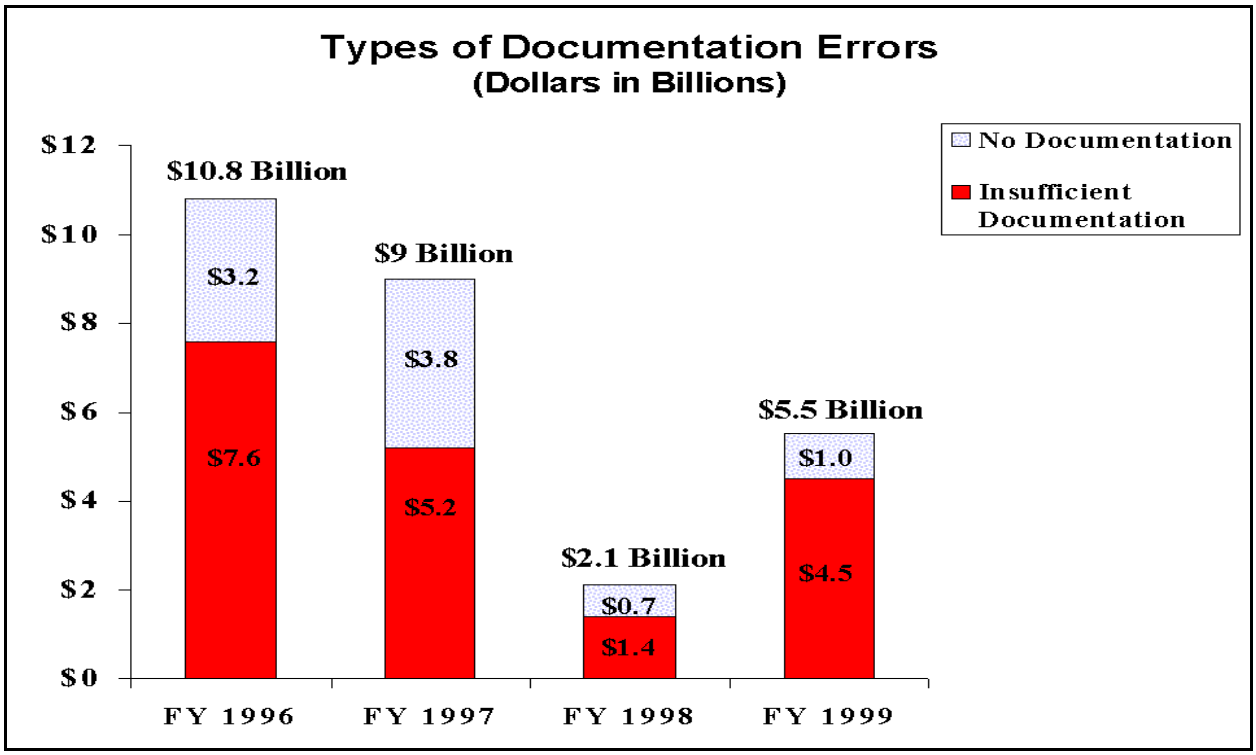
Details on the various error categories, including the types of health care providers that accounted for the errors, are discussed below. (Also see appendix 2.)

Documentation Errors

Documentation errors rose by $3.4 billion since FY 1998 but remained below the previous years' levels.

Documentation errors represented the most pervasive problems in our sample every year except FY 1998, when they dropped dramatically. This year, however, we saw an apparent increase — from $2.1 billion to $5.5 billion.

The overall category of documentation errors includes two components: (1) insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. As illustrated below, both components increased this year.



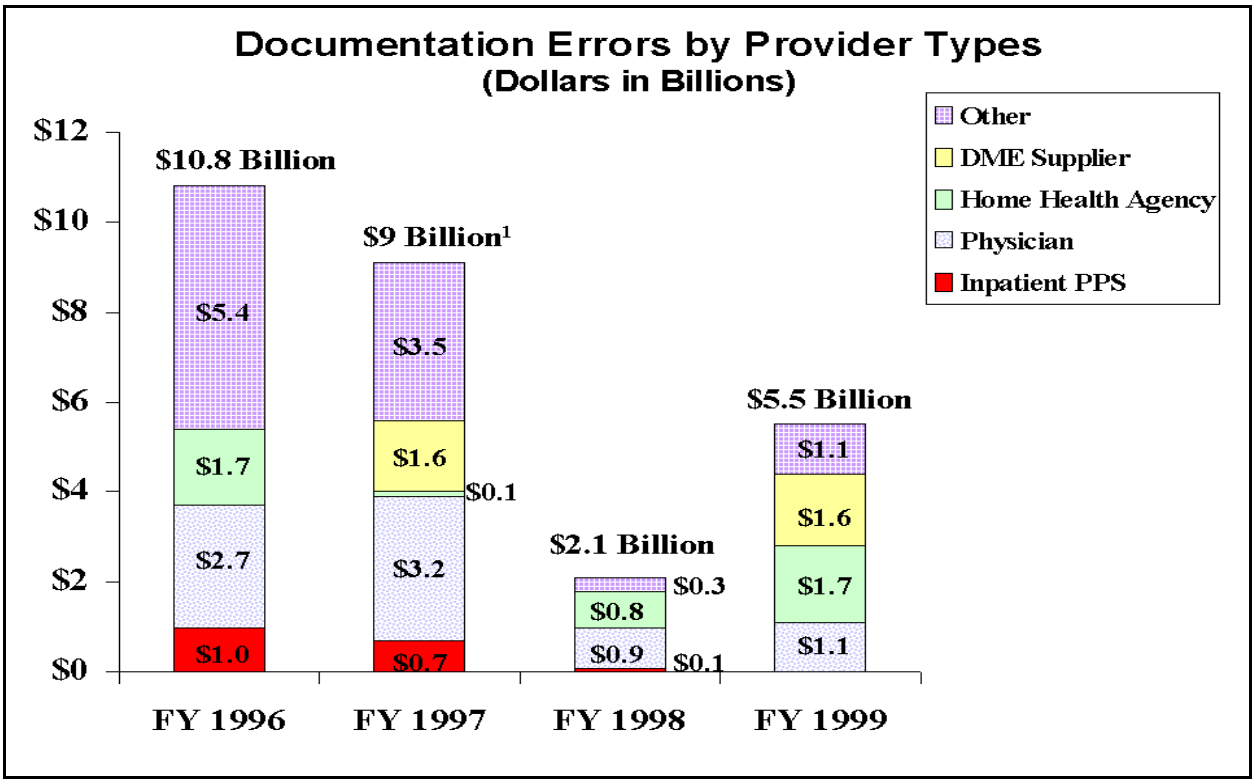
Like other insurers, Medicare makes payments based on a standard claim form. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If sampled providers failed to provide documentation or submitted insufficient documentation, the contractors or OIG staff requested supporting medical records at least three times — and in most instances four or as many as five times — before determining the payment to be improper. Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries, the extent of services

performed, or their medical necessity. It should be noted that HCFA upheld 99 percent of the overpayments identified in last year's sample and recovered about 87 percent; the remaining 13 percent has not been collected due to an ongoing investigation.

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health, history (including past and present illnesses), examinations, tests, treatments, and outcomes. Medical records chronologically document the care of the patient and are an important element contributing to high-quality care. The records facilitate:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor the patient's health care over time,
- communication and continuity of care among physicians and other health care professionals involved in the patient's care, and
- appropriate utilization review and quality-of-care evaluation.

As noted in the next chart, much of this year's increase in documentation errors was attributable to home health agency, DME supplier, and physician claims, which accounted for $1.7 billion, $1.6 billion, and $1.1 billion, respectively, of the total $5.5 billion in documentation errors.



[1]*Does not add to total due to rounding.*

Some examples of documentation problems follow:

- ***Home Health Agency.*** An HHA was paid $309 for five skilled nursing visits. While four of the visits were adequately supported, one visit was not documented in the medical records. As a result, the medical reviewers denied the $61 payment for this visit.

- ***Home Health Agency.*** An HHA was paid $84 for a psychiatric nurse visit to a patient. While there was documentation showing that the visit had been made, neither the patient's plan of care nor the doctor's orders authorized the HHA to provide the psychiatric nursing care. As a result, the medical reviewer denied the entire $84.

- ***DME Supplier.*** A supplier was paid $815 for an enteral feeding supply kit, a gastrostomy tube, and 380 units of enteral formula. The medical review staff concluded that the supplier's documentation was not sufficient to support the claim because the records did not include physician's progress notes, laboratory values, radiological studies ordered, or weight charts. In addition, because the delivery ticket did not provide individual beneficiary information, medical reviewers were unable to determine what products were delivered and to whom. As a result, the total payment was denied.

- ***DME Supplier.*** A supplier was paid $607 for an oxygen concentrator and related respiratory equipment with a maximum flow rate greater than 4 liters per minute. Medical review staff found major inconsistencies with oxygen amounts prescribed by the physician on the certificate of medical necessity (CMN). A hard copy of the CMN showed that the tests on the beneficiary took place while the beneficiary was exercising and that the physician ordered only 2 liters of oxygen, while an electronic version of other CMNs showed that the tests were performed when the beneficiary was at rest. The respiratory nurse's progress notes showed even more conflicts; one section indicated that the beneficiary required 4 liters of oxygen with activity, but another section showed that the beneficiary needed 3 liters with activity. A new physician's order is required when a change is necessary in oxygen liter flow. Due to the various discrepancies, medical review concluded that the claim was insufficiently documented, resulting in a payment denial of $607. We have referred this matter to the OIG's Office of Investigations for further review.

- ***DME Supplier.*** A supplier was paid $1,430 for enteral feeding supply kits and 1,378 units of enteral formula. Based on submitted documentation, the medical review staff determined that the CMN was invalid because the duration of need, the diagnosis code, and other information on the certificate had been changed. All changes on the CMN must be initialed and dated by responsible medical personnel. The medical reviewers could not determine if the physician was aware of these changes. As a result, they concluded that the entire payment should be denied based on insufficient documentation. We have referred this matter to the OIG's Office of Investigations for further review.

- ***Physician.*** A physician was paid $38 for interpreting an abdominal ultrasound. Based on the medical records, the reviewer found no evidence of an ultrasound or an interpretation of an ultrasound on this date of service. Therefore, the payment was denied.

- ***Physician.*** A physician was paid $28 for a hospital visit. However, the medical reviewer found a note in the medical records which stated, "Pt [patient] not in room." Because a patient encounter could not be verified and no other documentation substantiated the visit, the payment was denied.

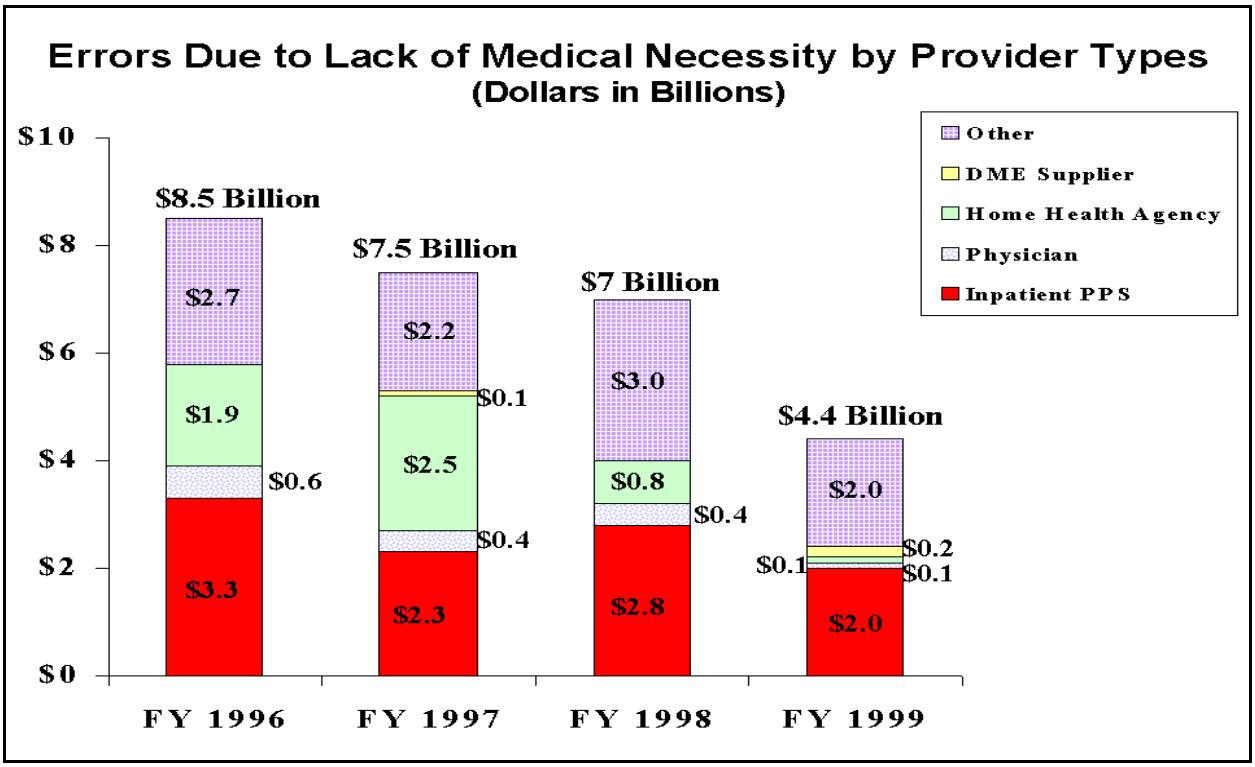
- ***Physician.*** A physician was paid $420 for nine hospital visits for a patient's evaluation and management. According to the medical reviewer, the progress notes supported only three of the nine hospital visits. Accordingly, the reviewer denied a total of $280 for the six undocumented visits.

Errors Due to Lack of Medical Necessity

Medically unnecessary services were a significant problem for the 4-year period.

This error category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. **As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the Medicare claims.

During the 4-year period, errors due to the lack of medical necessity represented a significant part of the overall error rate; they represented 37 percent of the improper payments for FY 1996, 37 percent for FY 1997, 56 percent for FY 1998, and 32 percent for FY 1999. As noted in the following chart, these types of errors in inpatient PPS claims have been consistently significant in all 4 years (FY 1996 - 39 percent of the total $8.5 billion; FY 1997 - 31 percent of the total $7.5 billion; FY 1998 - 40 percent of the total $7 billion; and FY 1999 - 45 percent of the total $4.4 billion).



Following are examples of services that were found not medically necessary:

- ***Inpatient PPS.*** A hospital was paid $3,883 to treat a patient with an episode of hypoglycemia. According to the medical reviewers, the patient's condition and the treatment given did not require admission to the acute level of care, and the patient could have been safely evaluated and treated at a less acute level. Therefore, the entire payment was denied as medically unnecessary.

- ***Inpatient PPS.*** A hospital was paid $7,642 to treat a beneficiary for dehydration. The beneficiary, who was initially treated in the emergency room, was eventually admitted to the hospital's acute care unit. The beneficiary received x-rays, blood tests, IV fluids, Tylenol, and a fever work-up but was discharged the same day. The medical reviewers concluded that the patient's condition did not require acute hospital inpatient care and that the services could have been rendered in an outpatient setting. Therefore, the entire payment was denied.

- ***Inpatient PPS.*** An acute care hospital was paid $3,596 for a 3-day patient admission. The patient was originally seen in the hospital's emergency room complaining of chest pain and was subsequently admitted as an inpatient. However, the emergency room records indicated that there was no evidence of heart damage and that the patient responded well to treatment in the emergency room. An emergency room note stated that the patient "clinically is improved and lungs are clear." In the opinion of the medical

reviewer, the patient could have continued to be treated on an outpatient basis. Accordingly, the reviewer denied the diagnosis-related group (DRG) payment due to the invalid admission.

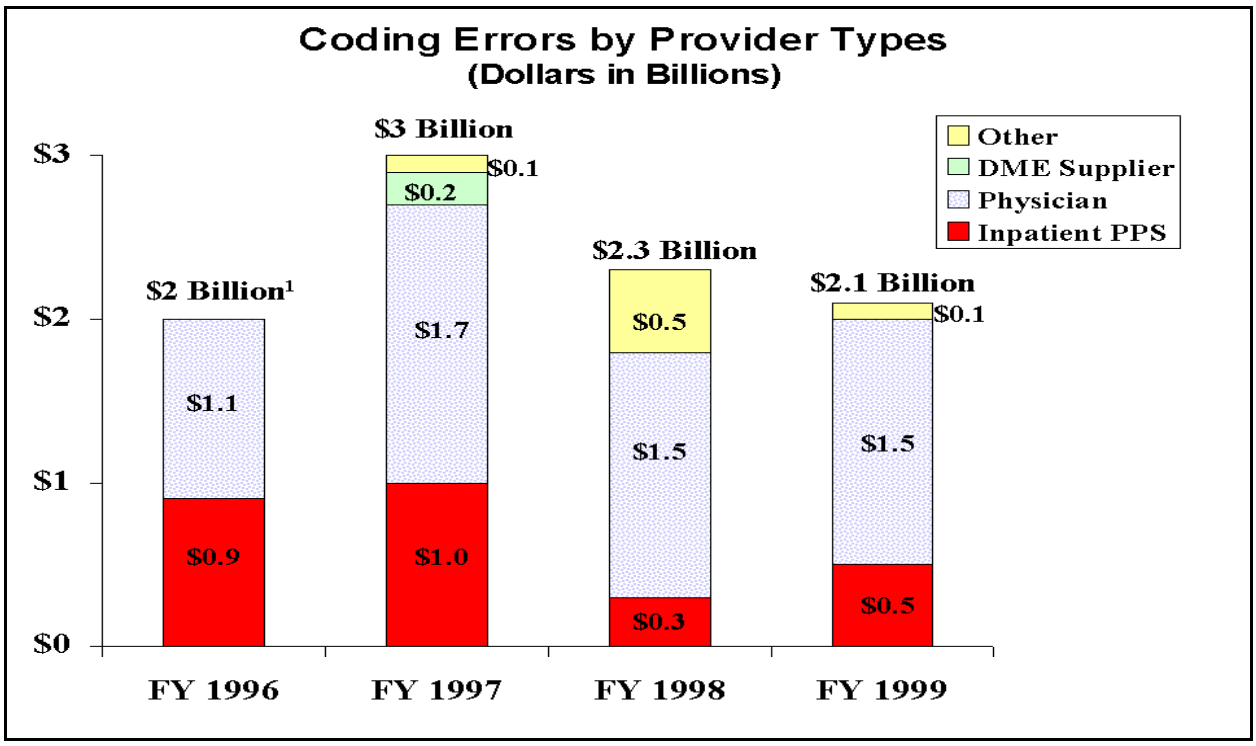
" ***Inpatient PPS.*** An acute care hospital received a DRG payment of $3,122 for a patient's 1-day admission. This patient had been hospitalized for 7 days under another admission and was discharged to home. However, when no one was at the home to receive the patient, the beneficiary was readmitted for a day under a new DRG. The medical reviewer considered the second admission to be invalid, since the patient's stay was a continuation of the original admission. The 1-day readmission was denied.

Errors Due to Incorrect Coding

Over the last 4 years, the estimated dollar amount of coding errors has remained consistently in the $2 billion to $3 billion range.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Incorrect coding is the third highest error category this year, representing $2.1 billion in improper payments. As illustrated in the following chart, physician and inpatient PPS claims accounted for 90 percent of the coding errors over the 4 years reviewed.



[1] *Includes insignificant errors by other provider types.*

Some examples of incorrect coding follow:

- ***Inpatient PPS.*** A hospital was paid $9,387 for a respiratory system surgical procedure. The medical records, however, supported a nonsurgical procedure. The medical reviewers' correction of the procedure code produced a lesser valued DRG of $2,481, resulting in denial of $6,905 of the payment.

- ***Physician.*** A physician was paid $274 for hospital visits for a patient's evaluation and management. To bill for this code, a physician must perform and document at least two of the following three key components in the medical records: a detailed interval history, a detailed examination, and medical decision-making of high complexity. According to the medical reviewer, the provider's documentation supported a problem-focused examination and straightforward medical decision-making. Because the provider should have billed a lower level of care, $143 was denied.

- ***Physician.*** A physician was paid $50 for a psychotherapy session which requires medical evaluation and management. According to the medical reviewer, the physician's records evidenced neither the time spent nor the psychotherapy services performed. However, the records supported psychiatric medication management services in an office setting, for which a lower level of service would have been appropriate. Therefore, $31 of the payment was denied.

- ***Physician.*** A physician was paid $89 for an office visit for a patient's evaluation and management. To bill for this code, the physician must perform and document at least two of the following three key components in the medical records: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. According to medical reviewers, the physician's documentation supported an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of low complexity. Because the provider should have billed a lower level of care, $51 of the payment was denied.

Noncovered Services and Other Errors

Errors due to noncovered services have consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the *Medicare Handbook*, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;

- eye and ear examinations to prescribe or to fit glasses or hearing aids;

- most prescription drugs;

- most routine foot care; and

- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray.

Following are some examples of noncovered services identified during our review:

- ***Physician.*** A physician was paid $30 for nail debridement. Medicare covers this procedure if there is evidence of diabetes in the beneficiary's medical history. However, there was no indication of diabetes in this beneficiary's history. Therefore, the service was considered routine foot care, which Medicare does not cover, and payment was denied.

- ***Outpatient.*** A hospital was paid $21 for medications to a patient that medical reviewers determined could have been self-administered. Medications furnished in an outpatient setting are covered only if they are of a type that cannot be self-administered. As a result, the medical reviewers denied the payment.

CONCLUSIONS AND RECOMMENDATIONS

Based on our FY 1999 sample, we estimate that this year's Medicare fee-for-service payment error rate is 7.97 percent, or $13.5 billion. This amount is about $1 billion more than that for FY 1998 but $9.7 billion less than that for FY 1996, when we developed the first national error rate. This reduction, we believe, demonstrates HCFA's vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, it clearly shows that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly. For both FYs 1998 and 1999, we estimated that over 90 percent of the fee-for-service payments met Medicare reimbursement requirements.

While our 4-year analysis indicates continuing progress in reducing improper payments, it also shows that documentation errors and medically unnecessary services have been and continue to be pervasive problems. These two error categories accounted for over 70 percent of the total improper payments over the 4 years. The HCFA needs to sustain its efforts to maintain progress in reducing these improper payments. We continue to recommend that HCFA:

- continue to update its systems' capabilities to keep pace with questionable billing practices;

- ensure that adequate program safeguards are in place for those Medicare contractors that transition out of the Medicare program;

- enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare payments;

- continue to direct that the Medicare contractors expand provider training to further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare for services provided;

- ensure that contractors recover the improper payments identified in our review;

- direct its PROs to identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews;

- continue to refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented; and

- continue to encourage health care providers to adopt compliance plans which promote adherence to applicable Federal program requirements and laws.

The HCFA officials agreed with our findings and recommendations, and their comments have been incorporated where appropriate.

Appendices

Estimated Improper Payments by Type of Error
(Dollars in Millions)

Type of Error	1996		1997		1998		1999		Increase (Decrease) from 1996 to 1999	
Documentation	$10,846	46.77%	$8,994	44.35%	$2,115	16.83%	$5,452	40.34%	($5,394)	-49.73%
Insufficient documentation	7,596		5,203		1,403		4,471		(3,125)	
No documentation	3,250		3,791		712		981		(2,269)	
Lack of medical necessity	8,529	36.77%	7,480	36.88%	6,981	55.56%	4,436	32.83%	(4,093)	-47.99%
Incorrect coding	1,978	8.53%	2,975	14.67%	2,256	17.96%	2,133	15.78%	155	7.84%
Noncovered/Other	1,839	7.93%	833	4.10%	1,212	9.65%	1,493	11.05%	(346)	-18.81%
Total	**$23,192**	**100.00%**	**$20,282**	**100.00%**	**$12,564**	**100.00%**	**$13,514**	**100.00%**	**($9,678)**	

APPENDIX 1

APPENDIX 2

The following table shows the types of errors and provider claims included in the $13.5 billion improper payments estimate for FY 1999. About 75 percent of these improper payments occurred within the first four provider types highlighted below:

Types of Errors (Dollars in Millions)							
Type of Provider	*Insufficient Documentation*	*Lack of Medical Necessity*	*Incorrect Coding*	*No Documentation*	*Non-Covered/ Other*	*Total*	*Percentage of Improper Payments*[1]
Inpatient PPS	$ -	$2,001	$ 485	$ -	$1,138	$ 3,624	26.82%
Physician	656	112	1,513	432	291	3,004	22.23%
DME	1,609	186	-	3	3	1,801	13.33%
HHA	1,605	87	-	71	-	1,763	13.05%
Subtotal	3,870	2,386	1,998	506	1,432	10,192	75.42%
SNF	273	448	73	103	-	897	6.64%
Outpatient	77	398	68	121	51	715	5.29%
Hospice	-	604	-	-	-	604	4.47%
End Stage Renal Disease	202	3	(1)[2]	230	-	434	3.21%
Inpatient Non-PPS	-	284	-	-	(1)[3]	283	2.09%
Laboratory	43	212	(5)[2]	16	9	275	2.03%
Transportation	6	91	-	-	2	99	0.73%
Ambulatory Surgery	-	10	-	5	-	15	0.11%
Total	$4,471	$4,436	$2,133	$981	$1,493	$13,514[4]	100.00%
Percentage of Improper Payments	33.08%	32.83%	15.78%	7.26%	11.05%	100.00%	

[1] Percentage of the overall estimate of $13.514 billion by type of claim.

[2] Negative dollars represent claims for which the medical review determined that the provider was underpaid.

[3] Negative dollars represent claims for which the number of services billed was less than the number of services provided.

[4] The range of improper payments at the 95 percent confidence level is $9.141 billion to $17.887 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all dollars equals the overall estimate of $13.514 billion.