



October 7, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Centers for Medicare & Medicaid Services' Use of Medicare Fee-for-Service Error Rate Data To Identify and Focus on Error-Prone Providers (A-05-08-00080)

The attached final report provides the results of our review of the Centers for Medicare & Medicaid Services' use of Medicare fee-for-service error rate data to identify and focus on error-prone providers.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through email at Joe.Green@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-05-08-00080 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CENTERS FOR MEDICARE
& MEDICAID SERVICES' USE
OF MEDICARE FEE-FOR-SERVICE
ERROR RATE DATA TO IDENTIFY
AND FOCUS ON ERROR-PRONE
PROVIDERS**



Daniel R. Levinson
Inspector General

October 2010
A-05-08-00080

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), administers the Medicare program. CMS contracts with payment contractors to process and pay claims submitted by health care providers on behalf of Medicare beneficiaries. CMS also contracts with quality improvement organizations, recovery audit contractors (RAC), and program safeguard contractors (PSC) to, among other things, safeguard the Medicare program from improper payments.

In fiscal year (FY) 2008, Medicare benefit payments totaled about \$445 billion, including \$310 billion in fee-for-service (FFS) payments. Medicare payments are projected to more than double to \$914 billion by 2018. The Office of Inspector General has identified the integrity of Medicare payments as one of the top management challenges facing the Department.

The Improper Payments Information Act of 2002, P.L. No. 107-300, requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimate of improper payments. In addition, for any program or activity with estimated improper payments exceeding \$10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments.

During our 4-year audit period (FYs 2005 through 2008), CMS used two programs to estimate improper Medicare FFS payments: the Hospital Payment Monitoring Program (HPMP) and the Comprehensive Error Rate Testing (CERT) program. When aggregated, the programs produced an overall improper payment estimate and a paid claim error rate. The reported estimates of improper Medicare FFS payments decreased from \$23.8 billion (a 14.2-percent error rate) in FY 1996, the first year that an error rate was developed, to \$10.4 billion (a 3.6-percent error rate) in FY 2008. We refer to providers that had at least one error in each of the 4 years of our audit period as "error-prone providers."

OBJECTIVE

Our objective was to determine whether CMS and its contractors used historical HPMP and CERT error rate data to identify and focus on error-prone providers.

SUMMARY OF RESULTS

CMS and its contractors did not use historical HPMP and CERT error rate data to identify and focus on error-prone providers. Although payment contractors developed corrective actions based on the HPMP and CERT error rate data, they typically did not focus on error-prone providers for review and corrective action.

Using the reported error rate data for FYs 2005 through 2008, we identified 740 error-prone providers. Specifically, an analysis of the HPMP error rate data disclosed that 554 providers

(21 percent of all HPMP providers with at least 1 claim sampled in each of the 4 years) accounted for 59 percent of the dollars in error for those providers. A similar analysis of the CERT error rate data for the same period disclosed that 186 providers (1.81 percent of all CERT providers with at least 1 claim sampled in each of the 4 years) accounted for 25 percent of the dollars in error for those providers. Focusing on error-prone providers for corrective action and repayment of improper payments could improve the effectiveness of CMS's efforts to reduce improper payments.

RECOMMENDATIONS

We recommend that CMS:

- use available error rate data to identify error-prone providers;
- require error-prone providers to identify the root causes of claim errors and to develop and implement corrective action plans;
- monitor provider-specific corrective action plans; and
- share error rate data with its contractors (QIOs, RACs, and PSCs) to assist in identifying improper payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations but pointed out that it had used error rate data to target providers during the audit period. Additionally, CMS stated that its goal is to reduce improper payments by 50 percent by 2012 and that our recommendations will help achieve that goal.

CMS's comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Medicare Program

The U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), administers the Medicare program. In fiscal year (FY) 2008, CMS made Medicare payments totaling about \$445 billion, including \$310 billion in fee-for-service (FFS) payments, on behalf of approximately 45 million Medicare beneficiaries. The *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* projects that by 2018, Medicare payments will more than double to \$914 billion and the number of beneficiaries will increase to about 59 million.

Estimating Improper Medicare Payments

The Improper Payments Information Act of 2002 (the Act), P.L. No. 107-300, requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimate of improper payments. In addition, for any program or activity with estimated improper payments exceeding \$10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments.

For FYs 1996 through 2002, prior to the Act, the Office of Inspector General (OIG) estimated and reported improper Medicare FFS payments and national error rates. In November 2003, CMS assumed this responsibility and OIG began providing oversight of the error rate process.¹ During our 4-year audit period (FYs 2005 through 2008), CMS used two programs to estimate improper Medicare FFS payments: the Hospital Payment Monitoring Program (HPMP) and the Comprehensive Error Rate Testing (CERT) program. When aggregated, the programs produced an overall improper payment estimate and a paid claim error rate.

- Under the HPMP, CMS contracted with quality improvement organizations (QIO)² to test an annual sample of paid claims to determine an improper payment estimate for inpatient acute-care hospital claims. An HPMP error was a claim that did not meet Medicare payment rules. Payments to inpatient acute-care hospitals accounted for approximately 40 percent of the total FFS payments during our audit period.
- Under the CERT program, CMS contracted with AdvanceMed, a program safeguard contractor (PSC), to test an annual sample of paid claims to determine an improper payment estimate for all claims other than inpatient acute-care hospital claims. A CERT error was a line of service on a claim that did not meet Medicare payment rules. Payments to providers other than inpatient acute-care hospitals and to suppliers of

¹ Recent OIG reports related to the error rate process include A-01-07-00508, issued August 22, 2008; A-01-09-00500, issued May 12, 2009; and A-01-09-00511, issued September 29, 2009.

² As of April 1, 2008, the QIOs' responsibility for the HPMP was transferred to the CERT contractors.

medical equipment³ accounted for approximately 60 percent of the total FFS payments during our audit period.

Each year CMS samples a large number of paid claims. For FY 2008, for example, the HPMP sample contained 39,841 claims and the CERT sample contained 123,746 claims.

Reported Estimates of Improper Payments

The reported estimates of improper Medicare FFS payments decreased from \$23.8 billion (a 14.2-percent error rate) in FY 1996 to \$10.4 billion (a 3.6-percent error rate) in FY 2008, as shown in Table 1.

Table 1: Reported Estimates of Improper Payments and Error Rates

FY	Improper Payments in Billions⁴	Error Rate
1996	\$23.8	14.2%
1997	20.9	11.8%
1998	14.9	8.4%
1999	14.5	8.6%
2000	16.4	9.4%
2001	16.8	8.8%
2002	17.1	8.0%
2003	12.7	6.4%
2004	21.7	10.1%
2005	12.1	5.2%
2006	10.8	4.4%
2007	10.8	3.9%
2008	10.4	3.6%

As a result, at least in part, of changes in the CERT medical review process, the estimate of improper Medicare FFS payments increased to \$24.1 billion (a 7.8-percent error rate) in FY 2009. (See the Appendix for more information on the FY 2009 CERT program changes.)

Medicare Contractors

Payment Contractors

CMS’s payment contractors process and pay claims submitted by health care providers on behalf of Medicare beneficiaries. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, established Medicare administrative contractors (MAC) as

³ This report refers to providers and suppliers of medical equipment as “providers.”

⁴ The reported estimates of improper payments represent the absolute value of overpayments plus the absolute value of underpayments.

payment contractors. Until 2012, when the transition to MACs is required to be completed, CMS's payment contractors also include carriers, durable medical equipment regional carriers, and fiscal intermediaries.

Claims processed and paid by payment contractors contain minimal information, such as provider identification numbers and codes identifying the types of services provided to Medicare beneficiaries. Beneficiaries' medical records, which are maintained at the provider level, usually do not accompany the claims submitted to payment contractors.

Quality Improvement Organizations

Pursuant to section 1862(g) of the Social Security Act, CMS contracts with a QIO in each State "for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services" QIOs review medical care, help beneficiaries with complaints about the quality of care, implement improvements in the quality of care, conduct quality-of-care reviews of providers referred by CMS, and refer potential cases of fraud or abuse to payment contractors for recovery or followup action.

Recovery Audit Contractors

Pursuant to section 302 of the Tax Relief and Health Care Act of 2006, which added section 1893(h) to the Social Security Act, CMS contracts with recovery audit contractors (RAC) to identify improper Medicare payments. RACs recommend that payment contractors recover the identified overpayments and collect, usually on a contingency fee basis, an amount based on the amount of the overpayments. Using CMS data sources, RACs develop their own proprietary databases to identify and analyze provider billing patterns warranting further examination.

Program Safeguard Contractors

The Health Insurance Portability and Accountability Act of 1996 added section 1893 to the Social Security Act to authorize CMS to contract with PSCs to promote the integrity of the Medicare program. PSCs identify and investigate cases of suspected fraud and take actions such as denying claims, suspending providers, and referring providers to payment contractors for recoupment of payment or to OIG for possible administrative and/or criminal prosecution. PSCs also profile aberrant providers based on leads received from various sources and trends developed through data analyses. In 2008, CMS began reassigning PSCs' responsibilities and jurisdictions to zone program integrity contractors.

Medicare Integrity Challenge

OIG has identified the integrity of Medicare payments as one of the top management challenges facing the Department. OIG's efforts in addressing this challenge are aimed at identifying and recommending methods to minimize inappropriate payments; holding providers accountable for fraud, waste, and abuse within the program; identifying ways to close exploited loopholes; and examining payment and pricing methods to ensure that Medicare, its beneficiaries, and taxpayers realize value for program expenditures.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether CMS and its contractors used historical HPMP and CERT error rate data to identify and focus on error-prone providers.⁵

Scope

We reviewed CMS's nationwide error rate data for FYs 2005 through 2008. Based on those data, CMS estimated that improper Medicare FFS payments totaled \$44.1 billion for the 4-year period.

We limited our review of internal controls to obtaining an understanding of the HPMP, the CERT program, and CMS's oversight activities. We did not validate the HPMP and CERT data or the medical review decisions made on sampled claims.

We performed our fieldwork at CMS in Baltimore, Maryland, and at various CMS contractor locations.

Methodology

To accomplish our objective, we:

- reviewed Federal requirements for estimating and reporting improper Medicare FFS payments;
- reviewed HPMP and CERT program policies and procedures;
- interviewed CMS officials in the HPMP and the CERT program;
- interviewed officials at CMS's contractors, including payment contractors, QIOs, RACs, and PSCs;
- reviewed and analyzed error rate data from the HPMP and the CERT program⁶ for FYs 2005 through 2008 to identify error-prone providers;
- reviewed contractually required QIO activities related to the HPMP; and
- reviewed CMS's and the payment contractors' annual Error Rate Reduction Plans.

⁵ We defined an error-prone provider as a provider that had at least one error in each of the 4 years of our audit period.

⁶ Our analysis excluded (1) zero-dollar errors in both the HPMP and the CERT program and (2) claims that contained coding errors in the CERT program (because of their low dollar value).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS OF REVIEW

CMS and its contractors did not use historical HPMP and CERT error rate data to identify and focus on error-prone providers. Although payment contractors developed corrective actions based on the HPMP and CERT error rate data, they typically did not focus on error-prone providers for review and corrective action.

Using the reported error rate data for FYs 2005 through 2008, we identified 740 error-prone providers. Specifically, an analysis of the HPMP error rate data disclosed that 554 providers (21 percent of all HPMP providers with at least 1 claim sampled in each of the 4 years) accounted for 59 percent of the dollars in error for those providers.⁷ A similar analysis of the CERT error rate data for the same period disclosed that 186 providers (1.81 percent of all CERT providers with at least 1 claim sampled in each of the 4 years) accounted for 25 percent of the dollars in error for those providers. Focusing on error-prone providers for corrective action and repayment of improper payments could improve the effectiveness of CMS's efforts to reduce improper payments.

PROVIDERS NOT TARGETED FOR REVIEW

Centers for Medicare & Medicaid Services' Current Practices

CMS and its contractors did not use historical HPMP and CERT error rate data to identify and focus on error-prone providers. Although payment contractors developed corrective actions based on the HPMP and CERT error rate data, they typically did not focus on error-prone providers for review and corrective action. Furthermore, the RACs and PSCs did not focus on providers based on the HPMP and CERT error rate data because CMS did not share the error rate data with these types of contractors. In its "long reports," CMS typically reported improper payments and associated error rates by type of contractor, specific contractor, type of service, and type of provider.

Analyses of Data on Error-Prone Providers

Hospital Payment Monitoring Program Providers

HPMP data for the 3,851 providers whose claims were sampled for FY 2005, 2006, 2007, or 2008 showed that 2,673 providers had at least 1 claim sampled in each of the 4 years. Of the 2,673 providers, 554 (21 percent of all HPMP providers with at least 1 claim sampled in each of the 4 years) had at least 1 error in each of the 4 years. The 554 providers accounted for

⁷ After issuing our draft report, we revised certain numbers related to the HPMP to correct errors caused by a software conversion problem.

59 percent of the dollars in error for providers sampled by the HPMP in each of the 4 years, as shown in Table 2.

Table 2: Analysis of HPMP Error-Prone Providers

	Number of Providers	Dollar Amount of HPMP Errors
Error-prone providers	554	\$30,754,846
Providers with claims sampled for FYs 2005, 2006, 2007, and 2008	2,673	\$52,211,586
Percentage for error-prone providers	21%	59%

Table 3 presents details on 10 of the 554 HPMP error-prone providers. These 10 providers had a high amount and a high percentage of sampled dollars in error for our 4-year audit period.

Table 3: Examples of HPMP Error-Prone Providers

FYs 2004–2008			
Provider	Dollar Amount of Sampled Claims	Dollars in Error	Percentage of Dollars in Error
1	\$2,018,105	\$258,803	12.82%
2	2,088,445	214,892	10.29%
3	1,194,210	164,489	13.77%
4	1,623,167	162,893	10.04%
5	1,263,001	148,793	11.78%
6	1,060,528	131,472	12.40%
7	779,881	110,217	14.13%
8	446,775	92,135	20.62%
9	288,304	91,830	31.85%
10	614,871	91,703	14.91%

Comprehensive Error Rate Testing Program Providers

CERT data for the 134,273 providers whose claims were sampled for FY 2005, 2006, 2007, or 2008 showed that 10,296 providers had at least 1 claim sampled in each of the 4 years. Of the 10,296 providers, 186 (1.81 percent of all CERT providers with at least 1 claim sampled in each of the 4 years) were error-prone providers. The 186 providers accounted for 25 percent of the total dollars in error for providers sampled by the CERT program in each of the 4 years, as shown in Table 4 on the following page.

Table 4: Analysis of CERT Program Error-Prone Providers

	Number of Providers	Dollar Amount of CERT Errors
Error-prone providers	186	\$333,048
Providers with claims sampled for FYs 2005, 2006, 2007, and 2008	10,296	\$1,329,335
Percentage for error-prone providers	1.81%	25%

Table 5 presents details on 10 of the 186 CERT program error-prone providers. These 10 providers had a high amount and a high percentage of sampled dollars in error for our 4-year audit period.

Table 5: Examples of CERT Program Error-Prone Providers

FYs 2004–2008			
Provider	Dollar Amount of Sampled Lines	Dollars in Error	Percentage of Dollars in Error
1	\$95,801	\$23,260	24.28%
2	62,890	10,501	16.70%
3	83,697	9,777	11.68%
4	37,107	4,505	12.14%
5	22,778	3,932	17.26%
6	12,701	3,494	27.51%
7	19,296	3,284	17.02%
8	6,914	2,696	38.99%
9	12,149	2,540	20.90%
10	12,629	2,459	19.47%

Most Errors Caused by Providers

Provider actions caused most of the \$44.1 billion in improper payments that CMS reported for FYs 2005 through 2008. CMS reported four categories of errors: incorrect coding, medically unnecessary services, documentation errors,⁸ and other errors. Individual providers are responsible for ensuring that their claims are properly coded and that the care provided is medically necessary and adequately documented.

⁸ Under the HPMP, CMS included all documentation errors in the “no documentation” category. Under the CERT program, CMS used two subcategories of documentation errors (no documentation and insufficient documentation). For our analysis, we included all documentation errors in one category.

CONCLUSION

CMS did not use historical error rate data to identify and focus on error-prone providers for review and corrective action. Using the reported error rate data from the HPMP and the CERT program for FYs 2005 through 2008, we identified 740 error-prone providers. These providers accounted for a significant portion of the total dollars in error in the sampled years. Focusing on error-prone providers for corrective action and repayment of improper payments could reduce improper payments.

RECOMMENDATIONS

We recommend that CMS:

- use available error rate data to identify error-prone providers;
- require error-prone providers to identify the root causes of claim errors and to develop and implement corrective action plans;
- monitor provider-specific corrective action plans; and
- share error rate data with its contractors (QIOs, RACs, and PSCs) to assist in identifying improper payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations but pointed out that it had used error rate data to target providers during the audit period. Additionally, CMS stated that its goal is to reduce improper payments by 50 percent by 2012 and that our recommendations will help achieve that goal.

CMS's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: FISCAL YEAR 2009 COMPREHENSIVE ERROR RATE TESTING PROGRAM CHANGES

For fiscal year (FY) 2009, the Centers for Medicare & Medicaid Services (CMS) implemented changes in its Comprehensive Error Rate Testing (CERT) program. Page III-13, note 1, of the U.S. Department of Health & Human Services (HHS) *FY 2009 Agency Financial Report* explained these changes as follows:

This report shows that 7.8 percent of the dollars paid nationally did not comply with one or more Medicare coverage, coding, billing, and payment rules. The improper payment amount for the Medicare FFS [fee-for-service] program for fiscal year 2009 is projected as \$24.1 B. Based on both the recommendations contained in recent OIG [Office of Inspector General] audit reports and those of CMS' advisory medical staff, HHS modified the medical review process for the November 2009 improper payments report. HHS implemented three separate revisions to the CERT review criteria based on these recommendations. Due to these modifications, the CERT contractor was not able to meet the original goal of 120,000 reviewed claims. Approximately 99,500 claims completed the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria. The national paid claims error rate for those claims reviewed under the strictest criteria, when applied to the entire year, is 12.4 percent or \$35.4 billion (this amount was derived from statistical calculations based on the sub-sample reviewed). However, HHS consulted with the OIG concerning the limited time period covered by these claims, and determined that reporting the error rate for this subset of claims only, would not be in compliance with *Improper Payment Information Act* requirements.

APPENDIX B: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

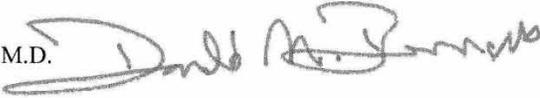
Centers for Medicare & Medicaid Services

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Administrator
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TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. 
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report "CMS' Use of Medicare Fee-for-Service Error Rate Data to Identify and Focus on Error-Prone Providers"
(A-05-08-00080)

Thank you for the opportunity to comment on the subject OIG draft report regarding the analysis of error-prone providers identified through the Comprehensive Error Rate Testing (CERT) program data. We appreciate the OIG's review of the CERT error rate data. CMS developed the CERT program to produce a national paid claims error rate for the Medicare fee-for-service (FFS) program and to comply with Improper Payment Elimination and Recovery Act (IPERA) of 2010 requirements.

Prior to 2009, the Medicare FFS improper payment estimate was derived from two programs: the CERT program and the Hospital Payment Monitoring Program (HPMP). Beginning with claims sampled for the FY 2009 report, the CERT program commenced sampling and reviewing the in-patient hospital claims previously reviewed under the HPMP.

This OIG report spans years 2005-2008 and, during that time, CMS targeted error-prone providers through the HPMP and CERT programs. For example, under the 8th Scope of Work, each Quality Improvement Organization (QIO) was required to conduct a special project which targeted specific providers in a specific payment error rate area. These projects included interventions with individual providers, the monitoring of the results of these interventions, and feedback to the participating providers. In addition, CMS shared error rate data with its contractors in several ways. For example, CMS shared with the QIOs the results of all of their case reviews for HPMP cases. CMS also provided payment error cause analyses, which included the number of claims with dollars in error by provider number, annually to each QIO for cases sampled for calculating the error rate. Lastly, in the CERT program, the CMS shared all error rate data for each claim reviewed with the Medicare Administrator Contractors to use in planning provider education efforts.

The CMS appreciates the efforts and recommendations provided by the OIG – and has used the recommendations to improve the CERT process. Based on these recommendations, CMS has taken aggressive actions to reflect a more complete accounting of Medicare's improper payments

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and provide the Agency and OIG with more complete information about errors so the Agency can better target improper payments.

An integral part of the CERT process is the analysis of error rate data and development of error rate reduction plans to reduce improper payments and maintain the fiscal integrity of the Medicare program. OIG's additional analysis demonstrates the utility of using CERT findings to identify the providers that repeatedly make billing errors allowing the agency to focus on improper payment reduction efforts as it moves forward.

The CMS goal is to reduce improper payments by 50 percent by 2012 and recommendations and support such as those provided in this report will help CMS achieve that goal.

We appreciate OIG's work in this area and look forward to working with them as we continue to enhance the CERT process. Our responses to OIG's recommendations are below.

OIG Recommendation

The OIG recommends that CMS should use available error rate data to identify error-prone providers.

CMS Response

The CMS agrees that historical error rate data is a valuable tool for identifying providers that repeatedly make the same types of billing errors. CMS will conduct analysis of historical error rate data similar to the OIG analysis beginning with FY 2009 data and share the findings with the appropriate contractors to assist in developing corrective actions.

OIG Recommendations

The OIG recommends that CMS should require error-prone providers to identify the root causes of claim errors and to develop and implement corrective action plans.

The OIG recommends that CMS should monitor provider-specific corrective action plans.

CMS Response

The CMS concurs that eliminating errors made by error-prone providers will help reduce the national paid claims error rate. There currently is no mechanism for requiring providers to develop corrective action plans. CMS will work with our Office of General Counsel to determine whether we have the statutory authority to implement such a process. There are other administrative actions that can be taken, such as probe reviews and individualized education for providers that prove to be problematic. CMS will direct its contractors to initiate appropriate administrative actions for providers determined to be error prone.

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OIG Recommendation

The OIG recommends that CMS should share error rate data with its contractors (QIOs, RACs, and PSCs) to assist in identifying improper payments.

CMS Response

The CMS concurs. CMS will share the findings of this audit with the contractors responsible for ensuring proper Medicare FFS payments. In order to do so, we will need the data gathered by your office in a format that ensures each contractor will only receive findings for providers in its jurisdiction. We look forward to working with the OIG on this initiative.