CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 738	**Date: August 18, 2017**
	Change Request 10210

SUBJECT: Provider Error Rate Formula

I. SUMMARY OF CHANGES: The Medicare Administrative Contractors (MACs) shall include claims denied due to no response to additional documentation requests (ADRs) when calculating the provider error rate.

EFFECTIVE DATE: September 19, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 19, 2017
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.7/3.7.1.1/Provider Error Rate

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: If the MAC identifies a provider-specific problem, the provider error rate is an important consideration in deciding how to address the problem. For instance, a provider with a low error rate with no history of patterns of errors may require a fairly minor corrective action plan such as education with recoupment of overpayment. Other factors such as the total dollar value of the problem and the past history of the provider also deserve consideration. The MAC assesses the nature of the problem as minor, moderate or major and uses available tools such as data analysis and evaluation of other information to validate the problem.

B. Policy: The MACs shall include claims denied due to no response to ADRs when calculating the provider error rate.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10210.1	The MACs shall include claims denied due to no response to ADRs when calculating the provider error rate.	X	X	X	X					
10210.2	The MACs shall use the following formula for prepayment review to calculate the provider's service specific error rate: <u>Total Dollar amount of allowable** charges for services billed in error as determined by MR***</u> Total Dollar amount of allowable** charges for services subject to a medical review documentation request	X	X	X	X					
10210.3	For postpayment review, the MACs shall use the following formula to calculate the provider's service	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	specific error rate: <u>Total Dollar amount of services paid in error as determined by MR***</u> Total Dollar amount of services subject to a medical review documentation request									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Martin, 410-786-4266 or jennifer.martin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

3.7.1.1 - Provider Error Rate

(Rev.738; Issued: 08-18-17; Effective Date: 09-19-17; Implementation Date: 09-19-17)

This section applies to MACs.

If the MAC identifies a provider-specific problem, the provider error rate is an important consideration in deciding how to address the problem. For instance, a provider with a low error rate with no history of patterns of errors may require a fairly minor corrective action plan such as education with recoupment of overpayment. Other factors such as the total dollar value of the problem and the past history of the provider also deserve consideration. The MAC assesses the nature of the problem as minor, moderate or *major* and uses available tools such as data analysis and evaluation of other information to validate the problem.

A. Provider Error Rate Formula

The MACs shall include claims denied due to no response to ADRs when calculating the provider error rate.

The MACs shall use the following formula for prepayment review to calculate the provider's service specific error rate:

Total Dollar amount of allowable** charges for services billed in error as determined by MR***
Total Dollar amount of allowable** charges for services *subject to a medical review documentation request*

For postpayment review, *the MACs shall* use the following formula to calculate the provider's service specific error rate:

Total Dollar amount of services paid in error as determined by MR***
Total Dollar amount of services *subject to a medical review documentation request*

**If allowable charges are not available, submitted charges may be used until system changes are made.

***Net out (subtract) the dollar amount of charges under billed