Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INCORRECT PLACE-OF-SERVICE CLAIMS RESULTED IN POTENTIAL MEDICARE OVERPAYMENTS COSTING MILLIONS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Daniel R. Levinson
Inspector General

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A-01-13-00506

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Physicians did not always correctly code the place of service on physician claims. As a result, Medicare contractors made potential overpayments totaling approximately $33.4 million for services provided from January 2010 through September 2012.

WHY WE DID THIS REVIEW

Previous nationwide Office of Inspector General reviews found that Medicare Part B contractors overpaid physicians approximately $62.7 million during calendar years (CYs) 2005 through 2009 for physician services that were performed at "facility locations" but billed as if the services were performed at "nonfacility locations." Medicare Part B payment for physician services can be made to the physician or the physician's employer, which may be a hospital or other facility. In this report, the term "physicians" includes hospitals and other facilities authorized to bill and receive Part B payment for services rendered by physicians. These services may be provided in facility locations, such as hospital outpatient locations and ambulatory surgical centers (ASCs), or in nonfacility locations, such as physician's offices and independent clinics.

Through the results of our prior reviews, we estimate average overpayments of more than $10 million per year. These reviews used computer matching and validation procedures, and the sample results identified a pattern of (1) place-of-service coding errors by physicians and (2) insufficient efforts by Medicare contractors to identify and recover the resulting overpayments.

The objective of this review was to determine whether physicians correctly coded nonfacility places of service on Part B claims submitted to, and paid by, Medicare contractors nationwide for physician services provided from January 1, 2010, through September 30, 2012.

BACKGROUND

Medicare Part B pays for services that physicians provide to program beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. The Medicare Physician Fee Schedule (fee schedule) determines physician payments. The fee schedule includes three major categories of costs required to provide physician services: practice expense, physician work, and malpractice insurance.

Physicians are required to identify the place of service correctly on the claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare correctly reimburses the physician for the overhead portion of the service. To account for the overhead expense of providing physician services at facility locations, Medicare provides a separate payment to facilities. Claim form instructions specifically state that each physician is responsible for becoming familiar with Medicare coverage and billing requirements. The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare contractors to process and pay claims submitted by physicians, clinical laboratories, suppliers, and ASCs.

We based our nationwide review on a computer match that included 1,238,987 nonfacility-coded physician services valued at $112,586,094 that were provided from January 2010 through September 2012 (our audit period) and that corresponded to facility claims for the same types of services provided to the same beneficiaries on the same day. Physicians may have furnished these services to hospital outpatients or ASC patients.

WHAT WE FOUND

Physicians did not always correctly code nonfacility places of service on Part B claims submitted to, and paid by, Medicare contractors nationwide. We determined that Medicare contractors potentially overpaid physicians approximately $33.4 million for incorrectly coded services provided from January 2010 through September 2012. Physicians performed these services in facility locations, but physicians incorrectly coded the services as performed in nonfacility locations.

The $33.4 million consisted of:

- $7.3 million in potential overpayments for incorrect nonfacility place-of-service billing for services performed in ASCs;

- $7.1 million in incorrect nonfacility place-of-service billing for services performed in hospital outpatient locations (87 physicians agreed that some claims had been coded incorrectly and agreed to refund the overpayments);

- $800,000 in potential overpayments for the services of 33 judgmentally selected physicians who stated they were not responsible for the incorrect billing, who did not agree that some claims had been coded incorrectly, or who did not respond to our inquiries; and

- $18.2 million in potential overpayments for the services of the remaining unselected hospital outpatient location-based claims.

We attribute the overpayments to internal control weaknesses at the physician billing level and to insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service billing errors.

WHAT WE RECOMMEND

We recommend that CMS direct its Medicare contractors to:

- initiate, in accordance with CMS policies, the immediate recovery of $7.3 million in potential overpayments from physicians who incorrectly coded physician services performed in ASCs;

- monitor the recoveries from the 87 physicians who expressed their intent to refund approximately $7.1 million in potential overpayments for incorrectly coded physician services performed in hospital outpatient locations;

- recover, in accordance with CMS policies, the additional $19 million in potential overpayments related to the services that may have been performed in hospital outpatient locations that we identified through our computer match;

- continue to educate physicians and billing personnel on the importance of internal controls to ensure the correct place-of-service coding for physician services; and

- expand and strengthen efforts to perform coordinated data matches of nonfacility-coded physician services and facility claims to identify physician services that are at a high risk for place-of-service miscoding and recover overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS concurred with our recommendations and described corrective actions it has taken. Regarding our second and third recommendations, CMS requested that we provide the data necessary to monitor recoveries. We plan on providing those data to CMS.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous nationwide Office of Inspector General reviews found that Medicare Part B contractors overpaid physicians approximately $62.7 million, during calendar years (CYs) 2005 through 2009, for physician services that were performed at "facility locations," but billed as if the services were performed at "nonfacility locations." Medicare Part B payment for physician services can be made to the physician or the physician's employer, which may be a hospital or other facility. In this report, the term "physicians" includes hospitals and other facilities authorized to bill and receive Part B payment for services rendered by physicians. These services may be provided in facility locations, such as hospital outpatient locations and ambulatory surgical centers (ASCs), or in nonfacility locations, such as physician's offices and independent clinics.[1]

Through the results of our prior reviews, we estimate average overpayments of more than $10 million per year. These reviews used computer matching and validation procedures, and the sample results identified a pattern of (1) place-of-service coding errors by physicians and (2) insufficient efforts by Medicare contractors to identify and recover the resulting overpayments.

OBJECTIVE

Our objective was to determine whether physicians correctly coded nonfacility places of service on Part B claims submitted to, and paid by, Medicare contractors nationwide for physician services provided from January 1, 2010, through September 30, 2012.

BACKGROUND

Medicare Part B Payments for Physician Services

Medicare Part B pays for services that physicians provide to program beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. The Medicare Physician Fee Schedule (fee schedule) determines physician payments. The fee schedule payments are based on three major categories of physician costs: practice expense, physician work, and malpractice insurance.

Medicare Reimbursement for Practice Expense

Practice expense includes the overhead costs involved in providing a service. To account for the increased practice expense that physicians generally incur by performing services in their offices and other nonfacility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations. When a physician provides services at a facility location,

[1] Hospital outpatient locations include, but are not limited to, departments of surgery, wound care, and radiology and other clinics where physicians perform examination services on registered hospital outpatients.

Medicare reimburses the physician for the services and makes a separate payment to the facility to cover the facility's overhead expense. Physicians are required to identify the place of service correctly on the claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare correctly reimburses the physician for the overhead portion of the service. Claim form instructions specifically state that each physician is responsible for becoming familiar with Medicare coverage and billing requirements.

Medicare Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare contractors to process and pay claims submitted by physicians, clinical laboratories, suppliers, and ASCs.[2] Additional responsibilities of these contractors include data analysis, provider education, medical review, and other functions related to program integrity.

Prior Office of Inspector General Reports

Our previous reviews, of audit periods 2001 through 2009, found that Medicare contractors overpaid physicians who did not correctly identify the places of service on their billings (Appendix A). In those reports, we recommended that CMS continue to educate physicians regarding proper billing, recover identified overpayments, and analyze postpayment data to detect and recover overpayments for improperly billed claims. CMS generally concurred with our recommendations.

HOW WE CONDUCTED THIS REVIEW

Our review covered 1,238,987 nonfacility-coded physician services totaling $112,586,094 that were provided from January 2010 through September 2012 (our audit period). We identified these claims by matching hospital outpatient and ASC claims to nonfacility claims for the same types of services provided to the same beneficiaries on the same day. Physicians may have furnished these services to hospital outpatients or ASC patients.

From our computer match of nonfacility-coded physician services to hospital outpatient services, we judgmentally selected 120 physicians whose claims matched with a high number of physician claim line items that were billed with nonfacility place-of-service codes and/or contained higher paying services we identified as vulnerable to overpayments through our prior reviews.[3] Accordingly, we considered these physicians to be at high risk for potential

[2] Historically, Medicare carriers processed Part B claims and Medicare fiscal intermediaries processed Part A claims. As required by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has transferred the functions of carriers and fiscal intermediaries to Medicare administrative contractors (MACs). During our audit period, most, but not all, of the MACs were fully operational; accordingly, for jurisdictions where the MACs were not fully operational, the carriers and fiscal intermediaries continued to process claims. In this report, the term "Medicare contractor" means the carrier, fiscal intermediary, or MAC, whichever is applicable.

[3] Our judgmental sample of 120 includes 37 physicians and 83 hospitals responsible for billing the services of many additional physicians.

overpayments. We requested that these physicians perform internal reviews to determine whether place-of-service coding was correct for services provided during our audit period.

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 objectives.

Appendix B contains the details of our scope and methodology.

FINDINGS

Physicians did not always correctly code nonfacility places of service on Part B claims submitted to, and paid by, Medicare contractors nationwide. We determined that Medicare contractors potentially overpaid physicians approximately $33.4 million for incorrectly coded services provided from January 2010 through September 2012. Physicians performed these services in facility locations, but physicians incorrectly coded the services as performed in nonfacility locations.

The $33.4 million consisted of:

- $7.3 million in potential overpayments for incorrect nonfacility place-of-service billing for services performed in ASCs;

- $7.1 million in incorrect nonfacility place-of-service billing for services performed in hospital outpatient locations (87 physicians agreed that some claims had been coded incorrectly and agreed to refund the overpayments);

- $800,000 in potential overpayments for the services of 33 judgmentally selected physicians who stated they were not responsible for the incorrect billing, who did not agree that some claims had been coded incorrectly, or who did not respond to our inquiries; and

- $18.2 million in potential overpayments for the services of the remaining unselected hospital outpatient location-based claims.

The overpayments occurred because of internal control weaknesses at the physician billing level and because of insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service billing errors.

MEDICARE REQUIREMENTS FOR PHYSICIAN SERVICES

Medicare pays for physician services under the Social Security Act (the Act).[4] The Act requires that the fee schedule base the payments on national uniform relative value units (RVUs) according to the categories of costs used in furnishing a service.

Medicare payment for physician services is based on the lower of the actual charge or the fee schedule amount. CMS publishes yearly updates to the fee schedule in the Federal Register. For 2010 through 2012, nearly all physician services with payments that varied depending on place of service resulted in a higher payment when they were billed with a nonfacility place-of-service code.

Federal requirements state: "The nonfacility PE [practice expense] RVUs apply to services performed in a physician's office, a patient's home, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC" (42 CFR § 414.22(b)(5)(i)(B)). The facility PE RVUs apply to services "furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center" (42 CFR § 414.22(b)(5)(i)(A)).[5]

The *Medicare Claims Processing Manual* (the Manual) provides definitions for assigning the place-of-service codes designated with facility and nonfacility payment rates for fee schedule services (Pub. No. 100-04, chapter 26, § 10.5).

PAYMENTS FOR INCORRECT PLACE-OF-SERVICE CODES

Physicians did not always correctly code nonfacility places of service on Part B physician claims submitted to, and paid by, Medicare contractors from January 2010 through September 2012. As a result, Medicare contractors potentially overpaid physicians approximately $33.4 million for physician services provided in facility locations.

Physician Services Performed in Ambulatory Surgical Centers Billed in Error

From our computer match of nonfacility-coded physician services to ASC claims, we determined that Medicare contractors potentially overpaid physicians $7.3 million for billing more than 100,000 services using the incorrect place-of-service code. (See Appendix C.[6])

[4] Section 1848(a)(1) of the Act, 42 U.S.C., § 1395w-4(a)(1).

[5] CMS revised 42 CFR § 414.22(b)(5)(i) during our audit period, but the revisions had no impact on our review. See 73 Fed. Reg. 69726, 69935 (Nov. 19, 2008) (containing the version of 42 CFR § 414.22(b)(5)(i) in this report, which was in effect from 2009 through 2011). For the current version of 42 CFR § 414.22(b)(5)(i), which was in effect during last 9 months of our audit period, see 76 Fed. Reg. 73026, 73471 (Nov. 28, 2011) (effective Jan. 1, 2012).

[6] We forwarded our entire computer match of nonfacility-coded physician services to ASC claims to CMS in October 2013 for overpayment recovery.

An Example of a Physician Overpayment for a Service Performed at an Ambulatory Surgical Center

A Medicare contractor paid a physician $2,240 for performing a microwave therapy procedure coded as though it had been performed in the physician's office. Our analysis showed that the physician had actually performed this procedure in an ASC and that a Medicare contractor had reimbursed the ASC for the overhead portion of the service. If the claim had been coded correctly, the physician would have received a payment of $522, which would not have included overhead costs. Therefore, Medicare overpaid the physician $1,718.

Physician Services Performed in Hospital Outpatient Locations Billed in Error

The results from our computer match of nonfacility-coded physician services to hospital outpatient services determined that Medicare contractors potentially overpaid physicians $26.1 million for billing more than 1.1 million services using the incorrect place-of-service code. (See Appendix C.) To validate the results of our computer match, we judgmentally selected 120 physicians for review.

The 26.1 million in potential overpayments consisted of:

- $7.1 million in incorrect nonfacility place-of-service billing for services performed in hospital outpatient locations (87 physicians agreed that some claims had been coded incorrectly and agreed to refund the overpayments[7]);

- $800,000 in potential overpayments for the services of 33 judgmentally selected physicians who stated they were not responsible for the incorrect billing, did not agree that some claims had been coded incorrectly, or did not respond to our inquiries; and

- $18.2 million in potential overpayments for the services of the remaining unselected hospital outpatient location-based claims.

An Example of a Physician Overpayment for a Service Performed at a Hospital Outpatient Location

A Medicare contractor paid a physician $10,664 for performing an angioplasty procedure coded as though it had been performed in the physician's office. Our analysis showed that the physician had actually performed this procedure in a hospital outpatient location and that a Medicare contractor had reimbursed the hospital for the overhead portion of the service. If the claim had been coded correctly, the physician would have received a payment of $613, which would not have included overhead costs. Therefore, Medicare overpaid the physician $10,051.

[7] These physicians also stated that they intended to refund $1.2 million in additional overpayments for dates of service outside our audit period.

CAUSES OF OVERPAYMENTS

Internal Control Weaknesses at the Provider Billing Locations

Many physicians had not implemented internal controls to prevent billing with incorrect place-of-service codes. Physicians and their billing personnel or agents told us that they had coded the place of service incorrectly for one or more of the following reasons, which are consistent with a lack of adequate controls:

- Billing personnel were confused about the precise definition of a "physician's office" or other nonfacility location or were simply following established practices in applying the nonfacility codes.

- Some billing personnel were unaware that an incorrect place-of-service code could result in an increased Medicare payment.

- Billing personnel made isolated data entry errors.

- Undetected flaws in the design or implementation of some billing systems caused all claims to be submitted with a nonfacility location as the place of service.

Insufficient Postpayment Reviews at Medicare Contractors

In our prior reviews, we recommended that CMS establish postpayment reviews through coordinated data matches of nonfacility-coded physician services and facility claims to identify and recover place-of-service overpayments. CMS concurred with this recommendation and stated that it would recover overpayments in a manner consistent with the agency's policies and procedures. To address the recommendations from our 2011 nationwide report for 2009 dates of service, CMS commissioned in 2012 a place-of-service overpayment voluntary refund demonstration project, administered by one Medicare contractor. This limited scope project identified an expected overpayment recovery of $394,041 and demonstrated that additional projects of this type are needed to address a continual pattern of place-of-service coding errors that resulted in average overpayments of more than $10 million per year.

RECOMMENDATIONS

We recommend that CMS direct its Medicare contractors to:

- initiate, in accordance with CMS policies, the immediate recovery of $7.3 million in potential overpayments from physicians who incorrectly coded physician services performed in ASCs;

- monitor the recoveries from the 87 physicians who expressed their intent to refund approximately $7.1 million in potential overpayments for incorrectly coded physician services performed in hospital outpatient locations;

- recover, in accordance with CMS policies, the additional $19 million in potential overpayments related to the services that may have been performed in hospital outpatient locations that we identified through our computer match;

- continue to educate physicians and billing personnel on the importance of internal controls to ensure the correct place-of-service coding for physician services; and

- expand and strengthen efforts to perform coordinated data matches of nonfacility-coded physician services and facility claims to identify physician services that are at a high risk for place-of-service miscoding and recover overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our recommendations. Regarding our second and third recommendations, CMS requested that we provide the data necessary to monitor the recoveries. We plan on providing CMS with the requested data.

CMS also described several corrective actions it has taken to respond to previous and current recommendations. Some of the corrective actions follow:

- In response to a prior Office of Inspector General recommendation[8] to strengthen the education process and emphasize the importance of correct place-of-service coding, CMS clarified policy and issued educational materials on correct place-of-service coding in April 2013, after the audit period of this review.

- In response to our recommendation in this report to recover $7.3 million in potential overpayments for physician services performed in ASCs, CMS said that it has recovered $1.75 million of the 2010 overpayments in accordance with its policies and procedures and that it would begin reporting on the recovery of 2011 and 2012 overpayments in June 2015.

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

OTHER MATTERS

Effective July 2013, CMS implemented Common Working File prepayment and postpayment edits to detect and prevent certain overpayments resulting from incorrect physician claims billed with nonfacility place-of-service codes. However, these edits are limited in scope and, unless modified, would not detect and prevent the types of incorrectly billed physician claims identified by this review.

[8] This recommendation appeared in the four reports listed in the "Nationwide Audits" section of Appendix A.

APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date	Value of Identified Overpayments
Nationwide Audits		
Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006 (A-01-08-00528)	June 2009	$20,169,812
Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007 (A-01-09-00503)	July 2010	13,766,568
Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2008 (A-01-10-00513)	September 2011	19,270,689
Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009 (A-01-10-00516)	September 2011	9,501,422
Nationwide Review Overpayment Subtotal		**$62,708,491**
Specific Provider and Contractor Audits		
Review of Payments Made by National Heritage Insurance Company for Ambulatory Surgical Procedures for Calendar Year 2001 (A-01-02-00524)	July 2003	$250,329
Review of Place of Service Coding For Physician Services-Wisconsin Physicians Service Insurance Corporation, Madison, Wisconsin (A-05-04-00025)	October 2004	742,510
Review of Place of Service Coding for Physician Services-TrailBlazer Health Enterprises, LLC, for the Period January 1, 2001 Through December 31, 2002 (A-06-04-00046)	January 2005	1,051,477
Review of Place of Service Coding for Physician Services (A-02-04-01010)	January 2005	1,467,318
Review of Place of Service Coding for Physician Services Processed by National Heritage Insurance Company During Calendar Years 2002 and 2003 (A-01-06-00502)	December 2006	4,254,613

Report Title and Number	Issue Date	Value of Identified Overpayments
Review of Place-of-Service Coding for Physician Services Processed by First Coast Service Options, Inc., During Calendar Years 2004 and 2005 (A-01-07-00518)	July 2008	$1,493,801
Verification of Midcoast Hospital's Refund of Place-of-Service Overpayments for Calendar Years 2004-2007 (A-01-10-00523)	November 2010	208,486
Verification of Central Vermont Medical Center's Refund of Place-of-Service Overpayments for Calendar Years 2007-2010 (A-01-11-00507)	May 2011	237,368
Verification of Hillcrest Baptist Medical Center's Refund of Place-of-Service Coding Overpayments for Calendar Years 2007-2009 (A-01-10-00528)	May 2011	122,053
Verification of Saint Francis Medical Center's Refund of Place-of-Service Overpayments for Calendar Years 2009-2010 (A-01-11-00512)	September 2011	267,433
Place of Service Refund Verification for Boston Medical Center for Calendars Years 2006 Through 2010 (A-01-11-00508)	November 2011	89,724
Meritus Medical Center Refunded Overpayments for Physician Claims With Place-of-Service Coding Errors for 2009 Through 2012 (A-01-12-00531)	June 2013	568,420
Specific Provider and Contractor Overpayment Subtotal		**$10,753,532**
Total Overpayments		**$73,462,023**

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide review covered 1,238,987 nonfacility-coded physician services valued at $112,586,094 that were provided from January 2010 through September 2012 and that matched hospital outpatient or ASC claims for the same types of services provided to the same beneficiaries on the same day.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the nonfacility locations or the Medicare contractors. Therefore, we limited our review of internal controls at nonfacility locations to obtaining an understanding of controls related to developing and submitting Medicare claims. We limited our review of internal controls at the Medicare contractors to the payment controls in place to prevent overpayments resulting from place-of-service billing errors.

We conducted our audit work from August 2013 through January 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- reviewed the Medicare physician fee schedule to identify the types of physician services that had variable payment levels depending on the place of service;
- used data from the National Claims History file to match physician claims for services with variable payment levels that were coded as having been performed in nonfacility locations to claims from facility locations for the same services provided to the same beneficiaries on the same dates and identified 1,238,987 physician services;
- reviewed paid claim data from the Common Working File to validate selected payment amounts and to verify the places of service identified on the claims;
- provided CMS with the ASC-based nonfacility-coded physician service claims, segregated by Medicare contractor jurisdiction, that represented $7,295,252 in potential overpayments;
- identified hospital outpatient location-based nonfacility-coded physician claims that represented $26,086,739 in potential overpayments;
- from the hospital outpatient location-based claims, judgmentally selected 120 physicians with claim payments of $22 million, on the basis of high claim numbers and/or higher paying services vulnerable to overpayments as identified through our prior reviews;

- sent the identified claims and internal control questionnaires to these 120 physicians and requested that they review the place-of-service coding associated with these claims and refund any overpayments resulting from incorrect nonfacility coding to their Medicare contractors;

- reviewed questionnaire responses and followed up with sampled physicians or their billing agents to discuss their responses and to request additional information concerning the causes of incorrect billing, overpayment determination methods, and refund intent;

- provided Medicare contractors with the claims of physicians that intend to refund overpayments;

- discussed the results of our review with CMS and Medicare contractor officials; and

- referred certain physicians with potential place-of-service coding overpayments to the Office of Counsel to the Inspector General for civil monetary penalty evaluation.

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 objectives.

APPENDIX C: RESULTS OF OUR COMPUTER MATCH

Facility Type	Total Number of Physician Services	Dollar Value of Physician Services	Dollar Value of Potential Overpayments
Hospital Outpatient Location	1,133,064	$85,810,795	$26,086,739[9]
ASC	105,923	26,775,299	7,295,252[10]
Total	**1,238,987**	**$112,586,094**	**$33,381,991**

[9] This amount ($26,086,739) includes $7,121,359 that physicians have stated that they intend to refund, plus an additional $18,965,380 (i.e., $26,086,739 - $7,121,359) identified by our computer match as potential overpayments related to services performed in hospital outpatient locations.

[10] After discussions with CMS officials, we have forwarded to CMS the ASC component of the computer match for overpayment collection.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB -4 2015

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Incorrect Place-of-Service Claims Resulted in Potential Medicare Overpayments Costing Millions" (A-01-13-00506)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG's) draft report titled "Incorrect Place-of-Service Claims Resulted in Potential Medicare Overpayments Costing Millions." CMS is committed to protecting the health of all Americans by preventing fraud, waste, and abuse in federal health care programs.

In April 2013, in response to prior OIG recommendations that we strengthen our education process and reemphasize the importance of correctly coding the place of service, CMS clarified national policy for place-of-service (POS) code assignment and clarified longstanding policy on reporting the service location for a given service code.[1] At the time a POS code is developed, CMS determines whether a Medicare Physician Fee Schedule (PFS) facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the PFS rate designated for each POS code. Under the PFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. We also issued a document to provide responses to frequently asked questions about issues related to place-of-service codes.[2] These clarifications and revisions were implemented after the timeframe of the review described in this draft report had passed.

In October 2013, OIG provided the data indicating $7.3 million in potential overpayments for physician services performed in ambulatory surgical centers (ASCs) discussed in this report to

[1] Change Request 7631: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2679CP.pdf; MLN Matters Article 7631: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

[2] Frequently Asked Questions Related to Change Request 7631: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQs-CR7631-4-25-13.pdf

CMS. Since then, CMS has recovered $1.75 million in overpayments. CMS continues to work to recover the outstanding potential overpayments.

OIG's recommendations and CMS' responses to those recommendations are discussed below.

OIG Recommendation
We recommend that CMS direct its Medicare contractors to initiate, in accordance with CMS policies, the immediate recovery of $7.3 million in potential overpayments from physicians who incorrectly coded physician services performed in ASCs.

CMS Response
CMS concurs with this recommendation. In October 2013, OIG provided the data indicating potential overpayments for physician services performed in ambulatory surgical centers (ASCs) to CMS. As of December 2014, the MACs have collected approximately $1.75 million of the 2010 OIG identified overpayments in accordance with CMS' policies and procedures. The MACs will begin reporting on the recovery of the 2011 and 2012 overpayments in June 2015.

OIG Recommendation
We recommend that CMS direct its Medicare contractors to monitor the recoveries from the 87 physicians who expressed their intent to refund approximately $7.1 million in potential overpayments for incorrectly coded physician services performed in hospital outpatient locations.

CMS Response
CMS concurs with this recommendation. CMS requests that the OIG provide for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, CMS requests that current Medicare contractor-specific data be sent through a secure portal to better facilitate the transfer of information to the appropriate contractor.

OIG Recommendation
We recommend that CMS direct its Medicare contractors to recover, in accordance with CMS policies, the additional $19 million in potential overpayments related to the services that may have been performed in hospital outpatient locations that we identified through our computer match.

CMS Response
CMS concurs with this recommendation. CMS requests that the OIG provide for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, CMS requests that current Medicare contractor-specific data be sent through a secure portal to better facilitate the transfer of information to the appropriate contractor.

OIG Recommendation

We recommend that CMS direct its Medicare contractors to continue to educate physicians and billing personnel on the importance of internal controls to ensure the correct place-of-service coding for physician services.

CMS Response

CMS concurs with this recommendation. We believe that correct coding of claims is critical to efficient claim processing and accurate payments. CMS issued guidance and education on this issue in April 2013 by clarifying national policy for place-of-service code assignment and clarifying longstanding policy on reporting the service location for a given service code.[3] CMS also issued a frequently asked questions document to respond to questions about place-of-service codes.[4] CMS expects its Medicare contractors to educate physicians and billing personnel on the importance of internal controls to ensure the correct place-of-service coding for physician services.

OIG Recommendation

We recommend that CMS direct its Medicare contractors to expand and strengthen efforts to perform coordinated data matches of nonfacility-coded physician services and facility claims to identify physician services that are at a high risk for place-of-service miscoding and recover overpayments.

CMS Response

CMS concurs with this recommendation. CMS will work collaboratively across components to develop a plan for coordinating data matches of non-facility-coded physician services and facility claims to identify physician services that are at a high risk for place-of-service miscoding and recover overpayments.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

[3] Change Request 7631: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2679CP.pdf; MLN Matters Article 7631: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

[4] Frequently Asked Questions Related to Change Request 7631: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQs-CR7631-4-25-13.pdf