Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS DID NOT ALWAYS CORRECTLY MAKE CLINIC VISIT PAYMENTS TO HOSPITALS FOR CALENDAR YEAR 2012

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

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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EXECUTIVE SUMMARY

CMS made an estimated $4.6 million in incorrect outpatient payments for calendar year 2012 to hospitals for established patients' clinic visits.

WHY WE DID THIS REVIEW

Medicare payments to hospitals for evaluation and management (E/M) outpatient clinic visits (clinic visits) vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a 3-year period. The Centers for Medicare & Medicaid Services (CMS) found in its improper payment reviews for 2008 through 2011 that E/M services were frequently miscoded. In addition, in 2009, two health care entities paid more than $10 million to settle allegations that they fraudulently billed Medicare for E/M services (OEI 04-10-00180). In a 2014 report, we found that CMS made $7.5 million in incorrect outpatient payments to hospitals for clinic visits for calendar years (CYs) 2010 and 2011 (A-04-12-06154).

The objective of our audit was to determine whether CMS correctly made selected outpatient payments to hospitals for established patients' clinic visits for CY 2012 (audit period).

BACKGROUND

Title XVIII of the Social Security Act established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program and contracts with Medicare Administrative Contractors (MACs) to process and pay hospital claims.

Section 4523 of the Balanced Budget Act of 1997 (BBA) mandated CMS to implement a Medicare outpatient prospective payment system (OPPS) for hospital outpatient services. Sections 201 and 202 of the Balanced Budget Refinement Act of 1999 further modified section 4523 of the BBA. OPPS became effective for services furnished on or after August 1, 2000. Under OPPS, CMS uses Healthcare Common Procedure Coding System (HCPCS) codes to identify outpatient services. When billing for services, hospitals should select the HCPCS codes that best represent the services furnished.

Physicians provide E/M services to assess and manage patients' health. These services may be provided at a physician's office or in an outpatient or other ambulatory facility. Hospitals provide three types of outpatient E/M services: clinic visits, emergency department visits, and critical care services. The Medicare payment for clinic visits depends on the complexity of the visit and whether the patient is identified as "new" or "established" at the particular hospital.

To identify whether a patient is new or established, hospitals must determine whether the patient already has a hospital medical record. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient at the hospital. The same patient could be "new" to the physician but "established" at the hospital (73 Fed. Reg. 68502, 68677 (Nov. 18, 2008)).

WHAT WE FOUND

CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. Of the 110 randomly sampled line items for which CMS made Medicare payments to hospitals for clinic visits (HCPCS codes 99203 to 99205) for our audit period, 1 was correct. In addition, we treated 16 line items as non-errors (correct) because, for 10 line items, hospitals refunded incorrect payments totaling $276 prior to our fieldwork; for 2 line items, hospitals were under investigation; and for 4 line items, the claims were under review by another entity. CMS overpaid the remaining 93 line items by a total of $2,661. (The inconsistency between the incorrect payment total of $2,661 and the $2,660 total for incorrect payments in the bullets below is the result of rounding.) The hospitals had not refunded these overpayments by the beginning of our audit:

- For 72 line items, hospitals incorrectly used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $2,046.

- For 21 line items, in addition to incorrectly using new patient HCPCS codes for established patients, hospitals did not use correct HCPCS codes to describe the levels of services furnished, resulting in incorrect payments totaling $614.

The hospitals attributed the incorrect payments to staff making clerical and programing errors, not verifying whether the patient was registered as an inpatient or outpatient of the hospital within the past 3 years, not following hospital procedures, not fully understanding Medicare billing requirements for clinic visits, and relying on the code that the treating physician billed for that visit.

Also, CMS does not have edits in place to identify Medicare payments for patients who were already registered at a facility.

On the basis of our sample results, we estimated that CMS made incorrect payments to hospitals totaling $4,558,590 for CY 2012.

WHAT WE RECOMMEND

We recommend that CMS work with its MACs to:

- recover the $2,661 in incorrect payments identified in our sample and

- resolve the remaining 188,367 line items and recover the remaining overpayments totaling $4,555,929 to the extent feasible and allowed under the law.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS concurred with our first recommendation and stated that it would instruct contractors to recover the $2,661 in incorrect payments to the extent allowed under the law.

CMS partially concurred with our second recommendation regarding the recovery of overpayments of the remaining 188,367 line items. CMS stated that, although it takes recovery of overpayments seriously, efforts to correct and recoup improper payments should also serve to educate and improve providers' current billing practices. CMS also stated that, effective January 1, 2014, it replaced the 10 HCPCS codes (99201–99205 and 99211–99215) with a single HCPCS code (G0463), which results in a payment for hospital outpatient clinic visits under the OPPS, and that this payment methodology is different from the methodology cited in this audit report. CMS requested that we furnish the necessary data on these 188,367 line items. Additionally, CMS stated that the average overpayment is $24, yet it will cost CMS an average of $90 per claim to review.

We acknowledge that the payment methodology has changed, but do not believe it is relevant to the payments during our audit period. Additionally, we do not consider medical review of these line items to be necessary. However, we also recognize that CMS must take into account the cost associated with recoupment activities, and we encourage CMS to recover these overpayments in accordance with its policies and procedures.

We provided CMS detailed information regarding the 188,367 line items.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare payments to hospitals for evaluation and management (E/M) outpatient clinic visits (clinic visits) vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a 3-year period. The Centers for Medicare & Medicaid Services (CMS) found in its improper payment reviews for 2008 through 2011[1] that E/M services were frequently miscoded. In addition, in 2009, two health care entities paid more than $10 million to settle allegations that they fraudulently billed Medicare for E/M services.[2] In a 2014 report, we found that CMS made $7.5 million in incorrect outpatient payments to hospitals for clinic visits for calendar years (CYs) 2010 and 2011.[3]

OBJECTIVE

Our objective was to determine whether CMS correctly made selected outpatient payments to hospitals for established patients' clinic visits for CY 2012 (audit period).

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program and contracts with Medicare Administrative Contractors (MACs) to, among other things, process and pay hospital claims.

Hospital Outpatient Prospective Payment System

Section 4523 of the Balanced Budget Act of 1997 (BBA)[4] mandated CMS to implement a Medicare outpatient prospective payment system (OPPS) for hospital outpatient services. Sections 201 and 202 of the Balanced Budget Refinement Act of 1999[5] further modified section 4523 of the BBA. OPPS became effective for services furnished on or after August 1, 2000. Under OPPS, CMS uses Healthcare Common Procedure Coding System (HCPCS) codes to identify outpatient services. To determine the rate per service, CMS assigns these HCPCS

[1] CMS performed these reviews under the Comprehensive Error Rate Testing program. The objectives of the improper payment reviews were to evaluate claims to determine whether the items and services were covered, correctly coded, and medically necessary.

[2] *Coding Trends of Medicare Evaluation and Management Services* (OEI 04-10-00180, issued May 8, 2012).

[3] *CMS Did Not Always Correctly Make Clinic Visit Payments to Hospitals* (A-04-12-06154, issued March 12, 2014).

[4] P.L. No. 105-33.

[5] P.L. No. 106-113.

codes to an ambulatory payment classification (APC). Services in each APC are similar clinically and in terms of the resources they require.

Hospitals are required to submit accurate claims for outpatient services. Each Medicare claim should contain details regarding each provided service (called a line item in this report). When billing for services, hospitals should select the HCPCS codes that best represent the services furnished.

Outpatient Evaluation and Management Services

Physicians provide E/M services to assess and manage patients' health. These services may be provided at a physician's office or in an outpatient or other ambulatory facility. Hospitals provide three types of outpatient E/M services: clinic visits,[6] emergency department visits, and critical care services. The Medicare payment for clinic visits depends on the complexity of the visit and whether the patient is identified as "new" or "established" at the particular hospital. A hospital should bill a clinic visit with a *new patient* using one of five HCPCS codes, from 99201 (the lowest complexity level code (Level 1)) to 99205 (the highest complexity level code (Level 5)). Likewise, a hospital should bill a clinic visit with an *established patient* using one of five different HCPCS codes, from 99211 (the lowest complexity level code (Level 1)) to 99215 (the highest complexity level code (Level 5)). (See examples in the table on the next page.)

To identify whether a patient is new or established, hospitals must determine whether the patient already has a hospital medical record. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient at the hospital. The same patient could be "new" to the physician but "established" at the hospital (73 Fed. Reg. 68502, 68677 (Nov. 18, 2008)). The table on the next page compares the October 2012 Addendum B[7] Medicare clinic visit OPPS payment rates for new and established patients using different complexity level HCPCS codes.

[6] We reviewed only HCPCS codes 99203, 99204, and 99205 related to clinic visits. HCPCS codes 99201 and 99202 are paid the same whether new or established.

[7] Addendum B gives a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates that are in effect at the beginning of each quarter. The quarterly update of Addendum B reflects the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals. Updates of Addendum B are posted quarterly to the OPPS Web site.

Table: Medicare Clinic Visits Outpatient Prospective Payment System Payment Rates

Description	Clinic Visit HCPCS[8] Codes	Payment Amount
Outpatient visit, new (problem focused)	99201	$53.84
Outpatient visit, new (expanded problem focused)	99202	72.18
Outpatient visit, new (detailed)	99203	95.20
Outpatient visit, new (comprehensive, moderate)	99204	130.53
Outpatient visit, new (comprehensive, high)	99205	176.66
Outpatient visit, established (minimal)	99211	53.84
Outpatient visit, established (problem focused)	99212	72.18
Outpatient visit, established (expanded)	99213	72.18
Outpatient visit, established (detailed)	99214	95.20
Outpatient visit, established (comprehensive high)	99215	130.53

HOW WE CONDUCTED THIS REVIEW

Our audit covered $19,273,921 in Medicare payments to hospitals for clinic visits with dates of service during CY 2012. We limited our review to HCPCS codes 99203 to 99205 on outpatient claims (referred to as line items in this report). We eliminated HCPCS codes 99201 and 99202 because the payment amounts for new and established patients are identical. We randomly selected 110 line items totaling $11,626 for review.

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.

[8] Effective January 1, 2014, CMS replaced these 10 HCPCS codes with a single HCPCS code, G0463. This single HCPCS code describes any and all hospital outpatient clinic visits and eliminates the need to recognize a distinction between new and established patient clinic visits (78 Fed. Reg. 74826, 75042, 75043 (Dec. 10, 2013)).

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the Federal requirements.

FINDINGS

CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. Of the 110 randomly sampled line items for which CMS made Medicare payments to hospitals for clinic visits (HCPCS codes 99203 to 99205) for our audit period, 1 was correct. In addition, we treated 16 line items as non-errors (correct) because, for 10 line items, hospitals refunded incorrect payments totaling $276 prior to our fieldwork; for 2 line items, hospitals were under investigation; and for 4 line items, the claims were under review by another entity. CMS overpaid the remaining 93 line items by a total of $2,661.[9] The hospitals had not refunded these overpayments by the beginning of our audit:

- For 72 line items, hospitals incorrectly used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $2,046.

- For 21 line items, in addition to incorrectly using new patient HCPCS codes for established patients, hospitals did not use correct HCPCS codes to describe the levels of services furnished, resulting in incorrect payments totaling $614.

The hospitals attributed the incorrect payments to staff making clerical and programing errors, not verifying whether the patient was registered as an inpatient or outpatient of the hospital within the past 3 years, not following hospital procedures, not fully understanding Medicare billing requirements for clinic visits, and relying on the code that the treating physician billed for that visit.

Also, CMS does not have edits in place to identify Medicare payments for patients who were already registered at a facility.

On the basis of our sample results, we estimated that CMS made incorrect payments to hospitals totaling $4,558,590 for CY 2012.

HOSPITALS DID NOT USE CORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS

Federal regulations required hospitals to report the correct HCPCS codes, depending on whether the hospital had registered the patient within the preceding 3 years: codes 99201 to 99205 for new patients and codes 99211 to 99215 for established patients (73 Fed. Reg. 68502, 68676,

[9] The inconsistency between the incorrect payment total of $2,661 and the sum of the total for incorrect payment for 72 line items ($2,046) and the incorrect payment for the 21 line items ($614) is the result of rounding.

68679 (Nov. 18, 2008)).[10] A Medicare claim submitted for payments contains details regarding each provided service.

For 72 line items, hospitals used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $2,046. Appendix E contains the incorrect line item detail for the 72 line items.

HOSPITALS DID NOT USE CORRECT CODES REPRESENTING SERVICES FURNISHED

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. For 21 line items, hospitals, in addition to incorrectly reporting the clinic visit for an established patient, did not use the correct HCPCS code that represented the level of service furnished, resulting in inappropriate payments totaling $614.[11]

- For 14 line items, hospitals identified that they had incorrectly used new patient HCPCS codes for established patients and used higher complexity level HCPCS codes to describe the services, resulting in incorrect payments totaling $640. Appendix F contains the incorrect line item detail for the 14 line items.

- For seven line items, hospitals identified that they had incorrectly used new patient HCPCS codes for established patients and used lower complexity level HCPCS codes to describe the services, resulting in incorrect underpayments totaling $25.[12] Appendix G contains the incorrect line item detail for the seven line items.

CAUSES OF INCORRECT PAYMENTS FOR CLINIC VISITS

The hospitals attributed the incorrect payments to staff:

- making clerical and programing errors,

- not verifying whether the patient was registered as an inpatient or outpatient of the hospital within the past 3 years,

- not following hospital procedures,

[10] CMS continued these definitions of new and established patients in CYs 2010, 2011, and 2012 (74 Fed. Reg. 60316, 60547 (Nov. 20, 2009), 75 Fed. Reg. 71800, 71986 (Nov. 24, 2010), and 76 Fed. Reg. 74122, 74341 (Nov. 30, 2011)).

[11] The inconsistency between the incorrect payment of $614 and the sum of the total for the incorrect payment for the 14 line items ($640) and the incorrect underpayments for the 7 line items ($25) is the result of rounding.

[12] Six of the seven line items resulted in no incorrect payments because the payment for the higher level of complexity equaled the difference between the HCPCS code rate for new and established patients.

- not fully understanding Medicare billing requirements for clinic visits, and

- relying on the code that the treating physician billed for that visit.

Also, CMS does not have edits in place to identify Medicare payments for patients who were already registered at a facility.

ESTIMATE OF INCORRECT PAYMENTS FOR CLINIC VISITS

On the basis of our sample results, we estimated that CMS made incorrect payments to hospitals for clinic visits totaling $4,558,590 for CY 2012.

RECOMMENDATIONS

We recommend that CMS work with its MACs to:

- recover the $2,661 in incorrect payments identified in our sample and

- resolve the remaining 188,367 line items and recover the remaining overpayments totaling $4,555,929 to the extent feasible and allowed under the law.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS COMMENTS

In written comments on our draft report, CMS concurred with our first recommendation and stated that it would instruct contractors to recover the $2,661 in incorrect payments to the extent allowed under the law.

CMS partially concurred with our second recommendation and stated that it will analyze the remaining 188,367 line items and medically review a sample of providers associated with those line items. However, CMS stated that it will not review all of the providers or line items for two reasons. First, CMS stated that it believes that efforts to correct and recoup improper payments should also serve to educate and improve providers' current billing practices. CMS noted that the line items reviewed were paid in CY 2012, and that effective January 1, 2014, it replaced the 10 HCPCS codes (99201–99205 and 99211–99215) with a single HCPCS code (G0463). CMS stated that this change results in a payment for hospital outpatient clinic visits under the OPPS, and that this payment methodology is different from the methodology during our audit period. Secondly, CMS stated that the average overpayment for the 188,367 line items is $24, yet it will cost CMS an average of $90 per claim to review.

CMS requested that we furnish the necessary data on the 188,367 line items.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree that the current payment methodology is different from the payment methodology during our audit period. However, we do not believe it is relevant to the payments during the audit period. We maintain that we identified valid overpayments and that they should be recovered.

Regarding CMS's statement that the cost of medical review exceeds the average overpayment per line item, we do not consider medical review of the 188,367 line items necessary. We questioned the payments in our audit solely on the basis of administrative criteria regarding whether the patient had been previously treated in the hospital, not on medical necessity. We relied on the hospitals to determine the level of the services for any recoded line items and are encouraging CMS to employ the same protocol to avoid the expense of medical review. However, we recognize that CMS must take into account the cost associated with recoupment activities, and we encourage CMS to recover these overpayments in accordance with its policies and procedures.

We provided CMS the necessary data on the 188,367 line items.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 188,477 line items with payments to hospitals totaling $19,273,921 for clinic visits from January 1, 2012, through December 31, 2012. We randomly selected 110 line items totaling $11,626 for review.

We did not review the overall internal control structure of the hospitals or the Medicare program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether CMS correctly paid selected Medicare outpatient payments made to hospitals for clinic visits at the new patient rate. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file (NCH), but we did not assess the completeness of the file.

We did not review the medical necessity of any of the services rendered.

We conducted our audit fieldwork from November 2013 to April 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- gained an understanding of CMS's internal controls over identifying, preventing, and correcting improper payments;
- using the NCH, extracted 5,179,905 outpatient line items totaling $391,397,512 containing the new patient HCPCS codes for clinic visits (99201 through 99205) and 54,102,403 inpatient claims paid for CYs 2009 through 2012;
- identified 188,477 outpatient line items totaling $19,273,921 containing the new patient HCPCS codes (99203 through 99205) for clinic visits for the audit period that had another inpatient or outpatient line item for the same patient and for which the hospital had received payment within the prior 3-year period—HCPCS codes 99201 and 99202 were excluded because the payment amounts for new and established patients are identical;
- randomly selected for review 110 line items totaling $11,626;
- sent letters to the 86 hospitals related to the sampled line items, requesting documentation to determine whether CMS paid the sampled items correctly;
- reviewed documentation provided by hospitals to support:

    - whether, for the sampled line items' dates of service, the patient was a new or established patient,
    - the correct coding that represents services furnished, and
    - the reason(s) the error occurred;
- for each sampled line item's dates of service, obtained information from CMS's Common Working File to support:
    - that a prior registration occurred within 3 years,
    - an adjustment to the sampled line item, and
    - the accuracy of the paid amount and completeness test;
- calculated the difference between the originally paid amount of the line item at the new patient HCPCS code rate and the correct payment amount at the established patient HCPCS code rate; and
- performed a statistical estimate of the incorrect payment amount using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software program.

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: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of outpatient line item payments that Medicare made to hospitals using the new patient HCPCS codes 99201 through 99205 and inpatient claims[13] paid for CYs 2009 through 2012.

SAMPLING FRAME

From a database of 5,179,905 outpatient line item payments extracted from CMS's NCH, we removed 4,991,428 line items (zero paid line items, line items paid to nonhospitals or hospitals not using OPPS, line items with HCPCS codes 99201 and 99202,[14] line items with a date of service during CYs 2009 through 2011, and other extraneous line items) totaling $372,123,591 to refine our sampling frame.

After we removed these line items, the sampling frame consisted of 188,477 outpatient line items totaling $19,273,921 for Medicare clinic visits matched to other outpatient line items or inpatient claims for the same patient and hospital paid within 3 years of the matching outpatient line item.

SAMPLE UNIT

The sample unit was an individual Medicare paid line item for a registered, established patient billed as a new patient for the date of service reviewed.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 110 line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

[13] We used inpatient claims only as evidence of a prior hospital registration. We did not calculate the total paid amount for these claims.

[14] The payment amounts for new and established patients are identical for HCPCS codes 99201 and 99202.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sampling frame from 1 through 188,477. After generating 110 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of incorrect payments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Number of Line Items	Value	Sample Size	Value of Sample	Number of Incorrect Line Items	Value of Incorrect Line Items
188,477	$19,273,921	110	$11,626	93[15]	$2,661

Estimated Value of Incorrect Line Items
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount
Point estimate	$4,558,590
Lower limit	4,050,791
Upper limit	5,066,390

[15] Of the 93 incorrect line items, 6 resulted in no incorrect payments because the payment for the higher level of complexity equaled the difference between the HCPCS code rate for new and established patients. As a result, we used only 87 of the incorrect line items to estimate the value of the incorrect line items.

APPENDIX D: FEDERAL REQUIREMENTS

Federal regulations require hospitals to report the HCPCS[16] codes that describe new and established clinic visits (76 Fed. Reg. 74122, 74340 (Nov. 30, 2011)). Furthermore, as published in 73 Fed. Reg. 68677 (Nov. 18, 2008):

> [T]he meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital. The same patient could be "new" to the physician but an ''established'' patient to the hospital.

CMS continued this definition of a new or established patient into CYs 2010, 2011, and 2012 (74 Fed. Reg. 60316, 60547 (Nov. 20, 2009), 75 Fed. Reg. 71800, 71986 (Nov. 24, 2010), and 76 Fed. Reg. 74122, 74341 (Nov. 30, 2011)).

In addition, the Manual, Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

[16] The Federal regulation cited actually states that hospitals must report Current Procedural Terminology (CPT) codes. We substituted the term HCPCS for CPT to reduce confusion because the CPT code is included as part of every HCPCS code. For our purposes, the codes are interchangeable.

APPENDIX E: INCORRECT LINE ITEM DETAIL – HOSPITALS USED INCORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS

Sample Order[17]	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
2	99205	$128.91	99215	$95.26	$33.65
3	99204	112.36	99214	83.23	29.13
6	99203	90.52	99213	68.63	21.89
7	99203	75.92	99213	57.56	18.36
9	99203	84.50	99213	60.21	24.29
10	99203	76.83	99213	58.31	18.52
12	99203	91.94	99213	69.70	22.24
13	99203	75.92	99213	57.51	18.41
15	99203	78.08	99213	59.26	18.82
16	99204	100.18	99214	73.06	27.12
17	99204	124.11	99214	90.52	33.59
19	99204	105.64	99214	77.13	28.51
20	99203	73.06	99213	55.39	17.67
22	99205	187.20	99215	138.44	48.76
23	99204	114.13	99214	76.59	37.54
24	99204	101.22	99214	73.90	27.32
25	99203	84.99	99213	64.50	20.49
26	99204	125.93	99214	91.94	33.99
28	99204	95.22	99214	64.95	30.27
30	99203	73.32	99213	55.65	17.67
31	99203	90.52	99213	68.63	21.89
32	99204	116.53	99214	85.07	31.46
33	99204	117.14	99214	85.52	31.62
34	99203	73.85	99213	56.04	17.81
35	99205	129.21	99215	95.48	33.73
36	99205	137.47	99215	101.66	35.81
37	99204	138.30	99214	100.97	37.33
40	99205	137.77	99215	101.80	35.97
41	99204	124.11	99214	90.52	33.59
42	99203	78.08	99213	58.84	19.24

[17] We did not review 16 line items from our sample (sample numbers 14, 21, 27, 38, 39, 48, 61, 62, 71, 72, 77, 83, 92, 94, 98, and 99) or include them in any of the line item detail appendixes for one of the following reasons: they were incorrect but the hospitals had refunded the incorrect payments prior to our audit, they were from hospitals under investigation, or they were under review by another entity.

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
43	99205	$153.88	99215	$101.25	$52.63
44	99204	138.30	99214	100.97	37.33
45	99204	94.36	99214	68.89	25.47
46	99204	148.26	99214	108.13	40.13
47	99205	129.65	99215	95.80	33.85
50	99204	96.00	99214	70.02	25.98
51	99205	148.90	99215	102.96	45.94
52	99203	91.85	99213	69.70	22.15
54	99204	100.82	99214	73.94	26.88
55	99204	117.26	99214	85.52	31.74
56	99203	80.08	99213	60.78	19.30
57	99204	107.05	99214	78.15	28.90
58	99205	148.97	99215	110.17	38.80
63	99205	159.11	99215	117.57	41.54
64	99203	85.07	99213	64.50	20.57
65	99204	138.44	99214	100.97	37.47
67	99204	104.09	99214	75.86	28.23
69	99203	68.58	99213	52.00	16.58
70	99204	101.57	99214	74.15	27.42
73	99204	96.58	99214	70.44	26.14
74	99204	104.80	99214	76.51	28.29
76	99203	78.08	99213	58.84	19.24
78	99203	84.99	99213	64.50	20.49
79	99203	83.31	99213	63.17	20.14
80	99204	88.20	99214	64.39	23.81
82	99203	90.52	99213	68.63	21.89
84	99205	131.43	99215	97.12	34.31
85	99205	137.02	99215	101.33	35.69
87	99203	90.52	99213	68.63	21.89
88	99204	109.10	99214	79.58	29.52
89	99205	143.51	99215	106.14	37.37
90	99203	90.43	99213	68.63	21.80
93	99203	73.89	99213	51.65	22.24
95	99205	157.86	99215	116.64	41.22
96	99205	187.36	99215	138.44	48.92
97	99203	72.78	99213	55.18	17.60
104	99204	98.78	99214	72.04	26.74
105	99203	95.86	99213	72.75	23.11

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
106	99203	$68.34	99213	$51.86	$16.48
107	99204	98.56	99214	71.95	26.61
108	99204	102.13	99214	74.93	27.20
110	99204	103.75	99214	75.67	28.08
	Total*	**$7,743**		**$5,697**	**$2,046**

* Note: Totals are rounded.

APPENDIX F: INCORRECT LINE ITEM DETAIL – HOSPITALS USED INCORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS AND USED HIGHER COMPLEXITY LEVEL CODES TO DESCRIBE SERVICES

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
1	99204	$113.71	99213	$57.98	$55.73
4	99204	107.85	99213	59.63	48.22
5	99203	90.52	99212	68.63	21.89
8	99205	132.66	99214	71.49	61.17
29	99203	79.90	99212	55.85	24.05
59	99205	136.35	99214	73.54	62.81
60	99204	113.71	99213	57.98	55.73
66	99203	71.70	99212	54.37	17.33
68	99204	100.84	99213	55.76	45.08
75	99204	107.05	99213	59.26	47.79
81	99205	124.84	99214	67.28	57.56
91	99204	97.34	99213	53.82	43.52
103	99204	104.42	99213	57.74	46.68
109	99204	116.53	99213	64.50	52.03
	Total*	**$1,497**		**$858**	**$640**

* Note: Totals are rounded.

APPENDIX G: INCORRECT LINE ITEM DETAIL – HOSPITALS USED INCORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS AND USED LOWER COMPLEXITY LEVEL CODES TO DESCRIBE SERVICES

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
11	99203	$68.60	99215	$94.06	($25.46)
49	99204	94.03	99215	94.03	0.00
53	99204	107.85	99215	107.85	0.00
86	99204	126.06	99215	126.06	0.00
100	99204	124.11	99215	124.11	0.00
101	99203	68.75	99214	68.75	0.00
102	99203	90.52	99214	90.52	0.00
	Total*	**$680**		**$705**	**($25)**

* Note: Totals are rounded.

APPENDIX H: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 18 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "CMS Did Not Always Correctly Make Clinic Visit Payments to Hospitals During Calendar Year 2012" (A-04-13-06168)

Thank you for the opportunity to review and comment on the above OIG draft report. OIG's objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) correctly made selected outpatient payments to hospitals for established patients' clinic visits for calendar year (CY) 2012.

The OIG found that CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. Based on OIG's sample results, they estimated that CMS made incorrect payments to hospitals totaling $4,558,590 during CY 2012.

The OIG recommendations and CMS responses to those recommendations are discussed below.

OIG Recommendation 1

Recover the $2,661 in incorrect payments identified in our sample.

CMS Response:

The CMS concurs with the recommendation. CMS will instruct its contractors to recover the $2,661 in incorrect payments to the extent allowed under the law.

OIG Recommendation 2

Resolve the remaining 188,367 line items and recover the remaining overpayments totaling $4,555,929 to the extent feasible and allowed under the law.

CMS Response

The CMS partially concurs with this recommendation. CMS will medically review a sample of the providers based on analysis of the 188,367 line items; we will not review all line items or providers for the following reasons.

While CMS does take the recovery of overpayments seriously, we believe that efforts to correct and recoup improper payments should also serve to educate and result in improvements to a provider or facility's current billing practices. The claims reviewed by the OIG were paid in calendar year 2012. Effective January 1, 2014, CMS replaced Current Procedural Terminology (CPT) codes 99201-99205 and 99211-99215 with Healthcare Common Procedure Coding System (HCPCS) code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the Outpatient Prospective Payment System for outpatient hospital clinic visits. Therefore, the claims in the OIG's sample were coded differently than current practices.

The average overpayment for the 188,367 line items is $24, yet it will cost CMS an average of $90 per claim to review. Additionally, Medicare Administrative Contractors routinely target evaluation and management codes that are more problematic in their jurisdictions based on Comprehensive Error Rate Testing Program (CERT) data.

The CMS requests that the OIG furnish CMS with the claims data that includes, at a minimum, the provider number, claim line payment amount, Medicare contractor number, claim paid date, date of service, procedure code, Health Insurance Claim Number (HICN), and claim/document control number.

The CMS appreciates the OIG's efforts and insight on this report and looks forward to continually working with the OIG on issues related to our health care programs.