

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PAYMENTS FOR  
TRANSITIONAL CARE MANAGEMENT  
SERVICES GENERALLY COMPLIED  
WITH FEDERAL REQUIREMENTS, BUT  
SOME OVERPAYMENTS WERE MADE**

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# *Office of Inspector General*

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## Report in Brief

Date: July 2021

Report No. A-07-17-05100

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Effective January 1, 2013, the Centers for Medicare & Medicaid Services (CMS) established a separate fee schedule for payments under the Medicare Physician Fee Schedule (PFS) for transitional care management (TCM) services rendered to beneficiaries whose medical conditions meet Medicare requirements. Medicare payments made under this PFS are at a higher risk of overpayments because TCM services are still a relatively new category of Medicare-covered services and because there are multiple restrictions on when and how those services can be billed.

Our objective was to determine whether payments made to physicians and qualifying nonphysician-practitioners (collectively referred to as “physicians” for this report) for TCM services provided during calendar years (CYs) 2015 and 2016 complied with Federal requirements.

### How OIG Did This Audit

Our audit covered almost 1.8 million TCM claims submitted by physicians totaling \$249.5 million in payments made in CYs 2015 and 2016. We reviewed Federal requirements for TCM services and CMS’s internal controls specific to claims containing TCM services.

## Medicare Payments for Transitional Care Management Services Generally Complied With Federal Requirements, but Some Overpayments Were Made

### What OIG Found

Payments made to physicians for TCM services provided during CYs 2015 and 2016 generally complied with Federal requirements, but we identified almost \$1.7 million in overpayments associated with 13,577 claims (that were outside the reopening and recovery period) for instances in which multiple physicians billed for TCM services for a beneficiary’s same 30-day TCM service period and for instances in which a physician billed on different dates for TCM and restricted overlapping care management services provided during the same 30-day TCM service period for the same beneficiary. These overpayments represented only 0.006 percent of the total TCM payments made in our audit period. We also identified 853 claims that were outside the reopening and recovery period, and that totaled at least \$74,275 in unallowable services, for instances in which a physician submitted claims on the same date for TCM and restricted overlapping care management services that were rendered for the same beneficiary during a single 30-day TCM service period. We were not able to determine which of these claims were overpayments. CMS did not have controls in place, to include claim system edits, to prevent and detect multiple TCM services provided to beneficiaries and to identify instances of overlapping care management.

### What OIG Recommends and CMS Comments

We recommend that CMS: (1) notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (2) implement claims processing controls, including system edits, to prevent and detect overpayments for TCM services.

CMS concurred with both of our recommendations and described corrective actions that it had taken or planned to take. CMS stated that it would analyze our findings to identify appropriate providers and suppliers to notify of potential overpayments. CMS also referred to payment policies that it has changed since our audit period and said it would evaluate opportunities to implement claims processing controls to prevent and detect overpayments for TCM services, as well as the feasibility and cost effectiveness of system edits.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Effective January 1, 2013, the Centers for Medicare & Medicaid Services (CMS) established a separate fee schedule for payments under the Medicare Physician Fee Schedule (PFS) for transitional care management (TCM) services rendered to beneficiaries whose medical conditions meet Medicare requirements. Medicare payments made under this PFS are at a higher risk of overpayments because TCM services are still a relatively new category of Medicare-covered services and because there are multiple restrictions on when and how those services can be billed.

### OBJECTIVE

Our objective was to determine whether payments made to physicians and qualifying nonphysician-practitioners (NPPs) (collectively referred to as “physicians” for this report) for TCM services provided during calendar years (CYs) 2015 and 2016 complied with Federal requirements.

### BACKGROUND

Under the provisions of Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

Under the provisions of section 1848 of the Act, CMS is required to establish a fee schedule for physicians’ services based on the relative resources used in furnishing a service to a beneficiary. Under its Federal rulemaking authority, CMS established the Medicare PFS and publishes changes and revisions to the PFS annually, in the form of a Final Rule, in the Federal Register.

#### **Medicare Administrative Contractors**

CMS relies on Medicare administrative contractors (MACs) to process and pay Medicare claims, including claims for inpatient services, outpatient services, physician services, and medical equipment and supplies. MACs are responsible for processing claims, which includes identifying and correcting underpayments and overpayments from physicians, hospitals, and other health care professionals, and submitting payments to those providers according to Medicare rules and regulations.

Specific functions of claims processing include: receiving, verifying, and logging claims and adjustments received; performing internal claims edits; performing claim validation edits;

completing claims development and adjudications; maintaining pricing and user files; and generating reports.

## **Transitional Care Management**

TCM services focus on beneficiaries whose medical or psychosocial conditions require physicians to make moderate- or high-complexity medical decisions during transitions in care from: (1) an inpatient hospital setting to (2) the beneficiary's community setting.<sup>1</sup> TCM generally consists of one face-to-face visit within specified timeframes following a discharge, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional. This report centers on TCM services billed under the Medicare PFS using two Current Procedural Terminology (CPT) codes: 99495 and 99496.<sup>2</sup> Only one physician can bill for TCM services provided to a beneficiary during a single 30-day TCM service period, and physicians who bill for TCM services are restricted from billing for a specified set of overlapping care management services. TCM's goal, as designed by CMS, is to keep beneficiaries healthier, preventing unnecessary relapses and readmissions to inpatient hospital settings.

Physicians of any specialty may furnish TCM services. TCM services may also be furnished by the following types of NPPs who are legally authorized and qualified to provide the services in the State in which those services are furnished:

- certified nurse-midwives,
- clinical nurse specialists,
- nurse practitioners, and
- physicians' assistants.

CMS program guidance states that the principal required elements of TCM services billed using CPT code 99495 include:

- communication (direct contact, telephonic, or electronic) with the beneficiary, caregiver, or both, within 2 business days of discharge, and

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<sup>1</sup> For this report, the term "inpatient hospital setting" includes the following types of settings: inpatient acute care hospital, inpatient psychiatric hospital, long-term-care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient observation or partial hospitalization, and partial hospitalization at a community mental health center. By a "beneficiary's community setting," we refer to home, domiciliary, rest home, or assisted living.

<sup>2</sup> **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**



- medical decisionmaking of at least moderate complexity during the face-to-face visit within 14 calendar days of discharge (*CMS Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014*).<sup>3, 4</sup>

CMS program guidance states that the principal required elements of TCM services billed using CPT code 99496 include:

- communication (direct contact, telephonic, or electronic) with the beneficiary, caregiver, or both within 2 business days of discharge, and
- medical decisionmaking of high complexity during the face-to-face visit within 7 calendar days of discharge (*CMS Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014*) (footnote 4).<sup>5</sup>

Effective January 1, 2013, CPT codes 99495 and 99496 are required for reporting physician TCM services.<sup>6</sup>

### **Prohibition Against Billing of Multiple Transitional Care Management Services**

Medicare requirements specify that billing for TCM services should occur at the end of a 30-day TCM service period that commences with the day of discharge. Adopting any policy other than billing at the end of the 30-day service period would make it difficult to monitor the requirement that the CPT code(s) for TCM services be billed only once in the 30-day TCM service period.<sup>7</sup>

Effective January 1, 2016, CMS requires that the date of service reported on a claim for TCM services be the date of the face-to-face visit.<sup>8</sup>

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<sup>3</sup> Moderate decisionmaking involves: multiple diagnoses or management options that must be considered; a moderate amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and a moderate risk of significant complications, morbidity, and/or mortality.

<sup>4</sup> See also the CY 2014 Final Rule at 78 Fed. Reg. 74230, 74403 (Dec. 10, 2013).

<sup>5</sup> Highly complex decisionmaking involves: an extensive number of diagnoses or management options that must be considered; an extensive amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and a high risk of significant complications, morbidity, and/or mortality.

<sup>6</sup> 77 Fed. Reg. 68987 (Nov. 16, 2012).

<sup>7</sup> 77 Fed. Reg. 68987 (Nov. 16, 2012).

<sup>8</sup> 80 Fed. Reg. 70886, 70921 (Nov. 16, 2015).

## Restricted Overlapping Care Management Services

Physicians who bill for TCM services using CPT codes 99495 or 99496 are restricted from billing the following overlapping care management services:

- care plan oversight services (CPT codes 99339, 99340, and 99374 through 99380),
- prolonged evaluation and management services without direct patient contact (CPT codes 99358 and 99359),
- anticoagulant management (CPT codes 99363 and 99364),
- medical team conferences (CPT codes 99366 through 99368),
- education and training (CPT codes 98960 through 98962, 99071, and 99078),
- telephone services (CPT codes 98966 through 98968 and 99441 through 99443),
- end stage renal disease services (CPT codes 90951 through 90970),
- online medical evaluation services (CPT codes 98969 and 99444),
- preparation of special reports (CPT code 99080),
- analysis of data (CPT codes 99090 and 99091),
- complex chronic care coordination services (CPT codes 99481X through 99483X),
- medication therapy management services (CPT codes 99605 through 99607),
- home health or hospice supervision (Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182),<sup>9</sup> and
- chronic care management (CCM) and complex CCM (CPT codes 99487, 99489, and 99490).<sup>10</sup>

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<sup>9</sup> 77 Fed. Reg. 68985, 68985 and 68990 (Nov. 16, 2012). The Federal Register provisions cited here apply to all of the listed restricted CPT codes except the chronic care management (CCM) CPT code listed below. For this code, see footnote 10. HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

<sup>10</sup> 78 Fed. Reg. 74423 (Dec. 10, 2013). We separately audited CCM services in an earlier report, *Medicare Made Hundreds of Thousands of Dollars in Overpayments for Chronic Care Management Services* (A-07-17-05101; Nov. 7, 2019). Therefore, our analysis did not include the CCM claims that we reviewed in our earlier audit, which covered the same time period.

These restricted codes may not be billed for services provided during the same 30-day TCM service period because the services are overlapping of care management services, which are separately billed under different codes. According to CMS officials, in these instances the first claim submitted should be paid and the second claim submitted should be denied.

### **The 60-Day Rule and 6-Year Lookback Period**

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, physicians must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Physicians must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>11</sup>

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, physicians can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>12</sup>

### **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 1,765,091 TCM claims submitted by physicians totaling \$249,523,261 in payments made in CYs 2015 and 2016 (audit period).<sup>13</sup>

For our audit period, we reviewed the Federal requirements for TCM services and CMS's internal controls specific to claims containing TCM services. To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments.

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 A contains details of our audit scope and methodology.

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<sup>11</sup> The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>12</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

<sup>13</sup> Data from this timeframe were the most current available to us at the time of our audit.

## FINDINGS

Payments made to physicians for TCM services provided during CYs 2015 and 2016 generally complied with Federal requirements, but we identified \$1,660,677 in overpayments associated with 13,577 claims that were outside the reopening and recovery period.<sup>14</sup> These overpayments represented only 0.006 percent of the total TCM payments made in our audit period. Specifically, we identified:

- 5,941 claims totaling \$864,433 for instances in which multiple physicians billed for TCM services for a beneficiary's same 30-day TCM service period, and
- 7,636 claims totaling \$796,244 for instances in which a physician billed on different dates for TCM and restricted overlapping care management services provided during the same 30-day TCM service period for the same beneficiary.

Additionally, we identified 853 claims that were outside the reopening and recovery period, and that totaled at least \$74,275 in unallowable services, for instances in which a physician submitted claims on the same date for TCM and restricted overlapping care management services that were rendered for the same beneficiary during a single 30-day TCM service period. For the 853 claims submitted on the same date, we were not able to determine which overlapping claims were allowable and which were overpayments. Specifically, we were not able to determine which claims were submitted first. According to CMS officials, in instances of overlapping care management services, the first claim submitted should be paid and the second claim submitted should be denied.

Although payments generally complied with Federal requirements, we identified errors that occurred because CMS did not have controls in place, to include claim system edits, to prevent and detect multiple TCM services provided to beneficiaries and to identify instances of overlapping care management.

### **MULTIPLE TRANSITIONAL CARE MANAGEMENT SERVICES BILLED BY DIFFERENT PHYSICIANS FOR THE SAME 30-DAY TRANSITIONAL CARE MANAGEMENT SERVICE PERIOD**

#### **Federal Requirements**

Only one physician can bill for TCM services provided to a beneficiary during a single 30-day TCM service period.<sup>15</sup>

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<sup>14</sup> This finding does not include the overpayment amount we identified in audit report A-07-17-05101 (footnote 10).

<sup>15</sup> CMS, Final Rule for CY 2013, 77 Fed. Reg. 68990 (Nov. 16, 2012).

If more than one physician reports TCM services for a beneficiary, Medicare will pay only the first eligible claim submitted during the 30-day TCM service period that commences with the day of discharge.<sup>16</sup>

**Multiple Physicians Billed for Transitional Care Management Services for the Same Beneficiary for the Same 30-Day Transitional Care Management Service Period**

We identified 5,941 claims that were outside the reopening and recovery period and that totaled \$864,433 for instances in which multiple physicians billed for TCM services for a beneficiary’s same 30-day TCM service period.

Table 1 depicts an example of two physicians submitting claims for TCM services rendered to Beneficiary A in the same 30-day TCM service period. In this example, both physicians submitted claims for the same 30-day TCM service period for the same beneficiary. CMS’s second payment, in the amount of \$177, was therefore an overpayment.

**Table 1: Example of Two Physicians Submitting Claims for Transitional Care Management Services for the Same Beneficiary for the Same 30-Day Transitional Care Management Service Period**

Beneficiary	Type of Service	Date of Service	Submission Date	Physician Payment	Status
Beneficiary A	Physician 1 TCM Service	April 22, 2016	April 25, 2016	\$177	First Payment
Beneficiary A	Physician 2 TCM Service	April 25, 2016	May 13, 2016	\$177	Overpayment

**TRANSITIONAL CARE MANAGEMENT SERVICES AND RESTRICTED OVERLAPPING CARE MANAGEMENT SERVICES BILLED BY THE SAME PHYSICIAN FOR THE SAME 30-DAY TRANSITIONAL CARE MANAGEMENT SERVICE PERIOD**

**Federal Requirements**

Physicians who bill for TCM services are restricted from billing for restricted overlapping care management services (77 Fed. Reg. 68985 and 68990 (Nov. 16, 2012)). Therefore, these overlapping care management services may not be billed for services provided during the same 30-day TCM service period for the same beneficiary.

<sup>16</sup> Footnote 7. See also CMS, *FAQs about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services*. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-tcms.pdf> (accessed on Dec. 2, 2020).

According to CMS officials, in these instances the first claim submitted should be paid and the second claim submitted should be denied.

**The Same Physician Billed for Transitional Care Management and Restricted Overlapping Care Management Services for the Same Beneficiary for the Same 30-Day Transitional Care Management Service Period**

We identified 7,636 claims that were outside the reopening and recovery period and that totaled \$796,244 in overpayments for instances in which a physician billed on different dates for TCM or restricted overlapping care management services provided during the same 30-day TCM service period for the same beneficiary.

For example, Table 2 shows that Physician 3 submitted both a TCM service claim and a restricted overlapping care management services claim for Beneficiary B on different dates in April and May 2016—dates that were within the same 30-day TCM service period. The TCM service claim was submitted before the overlapping care management services claim. Therefore, the first eligible claim was the TCM claim, and the overlapping care management services claim resulted in an overpayment.

**Table 2: Example of Transitional Care Management and Restricted Overlapping Care Management Services Claims Submitted on Different Dates During a 30-Day Transitional Care Management Service Period**

<b>Beneficiary</b>	<b>Physician 3 Service</b>	<b>Date of Service</b>	<b>Submission Date</b>	<b>Physician Payment</b>	<b>Status</b>
Beneficiary B	TCM Service	April 28, 2016	April 29, 2016	\$130.98	First Claim Submitted
Beneficiary B	Restricted Overlapping Care Management Services	April 22, 2016	May 2, 2016	\$78.40 (Overpayment)	Second Claim Submitted

**TRANSITIONAL CARE MANAGEMENT AND RESTRICTED OVERLAPPING CARE MANAGEMENT SERVICES CLAIMS SUBMITTED BY THE SAME PHYSICIAN ON THE SAME DATE**

**Federal Requirements**

Physicians who bill for TCM services are restricted from billing for restricted overlapping care management services (77 Fed. Reg. 68985 and 68990 (Nov. 16, 2012)). Therefore, these restricted overlapping care management services may not be billed for services provided during the same 30-day TCM service period for the same beneficiary.

According to CMS officials, in these instances the first claim submitted should be paid and the second claim submitted should be denied.

**Transitional Care Management and Restricted Overlapping Care Management Services Claims Submitted on the Same Date for Services Rendered During a Single 30-Day Transitional Care Management Service Period**

We identified 853 claims that were outside the reopening and recovery period and that totaled \$216,856 for instances in which the same physician submitted bills on the same date for TCM and restricted overlapping care management services that were rendered for the same beneficiary during a single 30-day TCM service period. We determined that for the 853 claims, the overpayment amount totaled at least \$74,275. (See Appendix A for an explanation of how we determined this minimum overpayment amount.) For the 853 claims submitted on the same date, we were not able to determine which overlapping claims were allowable and which were overpayments. Specifically, we were not able to determine which claims were submitted first. According to CMS officials, in instances of overlapping care management services, the first claim submitted should be paid and the second claim submitted should be denied.

Table 3 shows that Physician 4 submitted both a TCM service claim and a restricted overlapping care management services claim for Beneficiary C on the same date (in January 2016) within the same 30-day TCM service period. We were not able to determine which of the overlapping claims were allowable and which were overpayments. We can determine only that the overpayment amount was at least \$84.51 (the lower of the two amounts in question)—but we cannot determine which of these amounts was allowable and which was the overpayment.

**Table 3: Example of the Same Physician Submitting Claims for Transitional Care Management and Restricted Overlapping Care Management Services on the Same Date for Services Rendered During a Single 30-Day Transitional Care Management Service Period**

<b>Beneficiary</b>	<b>Physician 4 Service</b>	<b>Date of Service</b>	<b>Submission Date</b>	<b>Physician Payment</b>	<b>Status</b>
Beneficiary C	Restricted Overlapping Care Management Services	September 4, 2015	January 15, 2016	\$84.51	The overpayment was at least \$84.51
Beneficiary C	TCM Service	October 1, 2015	January 15, 2016	\$129.45	

## **NO SYSTEM EDIT TO PREVENT AND DETECT OVERPAYMENTS FOR TRANSITIONAL CARE MANAGEMENT SERVICES**

The errors discussed above occurred because CMS did not have controls in place, to include claim system edits, to identify multiple TCM services provided to beneficiaries and restricted overlapping care management services. Specifically, there was not a system edit to prevent and detect instances in which multiple physicians billed for TCM services for a beneficiary's same 30-day TCM service period or when physicians billed restricted overlapping care management services for the same beneficiary for the same 30-day TCM service period.

As a result of these errors for claims that were outside the reopening and recovery period, for CYs 2015 and 2016 physicians billed for and received overpayments totaling \$1,660,677. Physicians also received overpayments totaling at least \$74,725 for 853 claims that were submitted on the same day and for which we were not able to determine which claim was unallowable.

### **RECOMMENDATIONS**

Based on the results of this audit, we recommend that the Centers for Medicare & Medicaid Services:

- notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and
- implement claims processing controls, including system edits, to prevent and detect overpayments for TCM services.

### **CMS COMMENTS**

In written comments on our draft report, CMS concurred with both of our recommendations and described corrective actions that it had taken or planned to take. For our first recommendation, CMS stated that it would analyze our findings to identify appropriate providers and suppliers to notify of potential overpayments. CMS added that it would then instruct MACs to notify the identified providers and suppliers of our audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

CMS also referred to the CY 2020 and CY 2021 PFS final rules (issued after our audit period). CMS stated that in those final rules, it reviewed the active codes that are paid separately under the PFS and determined that these codes, when medically necessary, may complement TCM services rather than substantially overlapping or duplicating them. CMS said that it modified its



policy and now permits these codes to be billed during a 30-day TCM service period when medically necessary. Therefore, “these services no longer represent overpayments when billed appropriately.”

For our second recommendation, CMS referred to the payment policies that it has changed since our audit period and stated that it would evaluate opportunities to implement claims processing controls to prevent and detect overpayments for TCM services. CMS also stated that it would evaluate the feasibility and cost effectiveness of system edits in the context of overall access to TCM services.

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

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We reviewed the Federal requirements for TCM services in effect for CYs 2015 and 2016 (our audit period). We reviewed all paid claims for TCM services for CYs 2015 and 2016 to determine whether CMS's controls prevented overpayments by denying unallowable payments.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the control activities designed and implemented to prevent and detect overpayments. However, because our review was limited to this internal control component and underlying principles, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments from restricted overlapping care management services and duplicated TCM services. Our audit included 1,765,091 TCM claims submitted by physicians totaling \$249,523,261 in payments (footnote 13). This report centers on TCM services billed under the Medicare PFS using two CPT codes: 99495 and 99496.<sup>17</sup>

Our analysis did not include the CCM claims that we reviewed in our earlier audit (A-07-17-05101; footnote 10). In addition, we removed from our review 194 claims that matched to the Recovery Audit Contractor Data Warehouse.

We performed our audit work from July 2017 to April 2021.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and guidelines;
- obtained TCM claims for services provided during our audit period, their associated overlapping care management codes data, and inpatient discharge data;
- analyzed TCM data, its associated overlapping care management codes data, and inpatient discharge data;
- interviewed CMS officials to obtain an understanding of CMS's oversight of TCM claims;

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<sup>17</sup> See footnote 2 for the CPT copyright notice.

- identified 853 claims for instances in which a physician submitted bills on the same date for TCM and restricted overlapping care management services that were rendered for the same beneficiary during a single 30-day TCM service period and, for each instance:
  - determined the lower payment amount of the 2 services in question and
  - combined the lower payment amounts from all 853 claims to arrive at the minimum overpayment amount (at least \$74,275) that we set aside for review and determination by CMS; and
- discussed the results of our audit with CMS officials on July 8, 2020.

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.



**DATE:** June 2, 2021

**TO:** Amy J. Frontz  
Deputy Inspector General for Audit Services  
Office of Inspector General

**FROM:** Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Payments for Transitional Care Management Services Generally Complied With Federal Requirements, but Some Overpayments Were Made (A-07-17-05100)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars.

Ensuring proper care management when a beneficiary transitions from care furnished by a treating physician during a hospital, skilled nursing facility, or community mental health center stay to the beneficiary's primary physician in the community not only benefits the beneficiary, but the health care system as a whole. For example, ensuring a smooth transition can improve beneficiary outcomes and can avoid adverse events such as readmissions or subsequent illnesses and an overall financial burden on the health care system. Effective January 1, 2013, under the Physician Fee Schedule, Medicare pays for two CPT codes (99495 and 99496) that are used to report transitional care management services for a patient following a discharge from a hospital, skilled nursing facility, or community mental health center stay, outpatient observation, or partial hospitalization.

In the calendar year (CY) 2013 Physician Fee Schedule final rule, CMS established a list of codes that could not be billed during the 30-day period covered by transitional care management services by the same provider reporting the transitional care management service.<sup>1</sup> This list mirrored reporting restrictions put in place by the Current Procedural Terminology (CPT) Editorial Panel for the transitional care management codes. At the time, CMS agreed with the CPT Editorial Panel that the services described by the codes could be overlapping and duplicative with transitional care management services in their definition and scope.

In a recent analysis of the services associated with the codes, and since the time of the OIG's review which covered calendar years 2015 and 2016, CMS identified that the majority of the codes on the list are either bundled, noncovered by Medicare, or invalid for Medicare payment purposes. In the CY 2020 and CY 2021 Physician Fee Schedule final rules, CMS reviewed the active codes that are paid separately under the Physician Fee Schedule and determined that these codes, when medically necessary, may complement transitional care management services rather

<sup>1</sup> <https://www.govinfo.gov/content/pkg/FR-2012-11-16/pdf/2012-26900.pdf>

than substantially overlap or duplicate them.<sup>2</sup> CMS modified its policy and now permits these codes to be billed during a 30-day transitional care management service period when medically necessary. Therefore, these services no longer represent overpayments when billed appropriately.

CMS continues to update Physician Fee Schedule payment policies to improve payment for transitional care management and appreciates OIG's review in this area.

The OIG's recommendations and CMS' responses are below.

### **OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information or potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

### **CMS Response**

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate providers and suppliers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers and suppliers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

### **OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services implement claim processing controls, including system edits, to prevent and detect overpayments for TCM services.

### **CMS Response**

CMS concurs with this recommendation. While CMS has not observed substantial rates of transitional care management overpayments, and CMS has since changed payment policies through notice and comment rulemaking to recognize that many of the codes, when medically necessary, complement transitional care management services rather than substantially overlap or duplicate them, we will evaluate opportunities to implement claims processing controls to prevent and detect overpayments for transitional care management services. CMS will also evaluate the feasibility and cost effectiveness of system edits in the context of overall access to transitional care management services.

<sup>2</sup> <https://federalregister.gov/d/2019-24086>; <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>