Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE MADE HUNDREDS OF THOUSANDS OF DOLLARS IN OVERPAYMENTS FOR CHRONIC CARE MANAGEMENT SERVICES

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

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for Audit Services

November 2019
A-07-17-05101

Office of Inspector General

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Report in Brief
Date: November 2019
Report No. A-07-17-05101

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

Medicare Made Hundreds of Thousands of Dollars in Overpayments for Chronic Care Management Services

Why OIG Did This Audit

Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established a policy for Medicare to pay under the Medicare Physician Fee Schedule (PFS) for chronic care management (CCM) services rendered to beneficiaries whose medical conditions meet certain criteria. Before that effective date, physicians did not have the ability to bill separately for typical non-face-to-face care management services provided to these beneficiaries. CCM payments are at a higher risk for overpayments compared with payments for more established Medicare services. CCM services are a relatively new category of Medicare-covered services and have multiple restrictions on when and how they can be billed.

Our objective was to determine whether physician and outpatient payments made by CMS for CCM services provided during calendar years (CYs) 2015 and 2016 complied with Federal requirements.

How OIG Did This Audit

We reviewed the Federal requirements for CCM services and CMS's internal controls specific to claims containing CCM services in effect for CYs 2015 and 2016. We reviewed all paid claims for CCM services for CYs 2015 and 2016 (totaling $103.5 million in physicians and outpatient facility claims) to determine whether CMS's controls prevented overpayments by denying unallowable payments.

What OIG Found

Physician and outpatient payments made by CMS for CCM services provided during CYs 2015 and 2016 did not always comply with Federal requirements, resulting in $640,452 in overpayments associated with 20,165 claims. We identified 14,078 claims that resulted in $436,877 in overpayments for instances in which providers or facilities billed CCM services more than once for the same beneficiaries for the same service period. We identified an additional 6,087 claims that resulted in $203,575 in overpayments for instances in which the same physician billed for both CCM services and overlapping care management services for the same beneficiaries. For these 20,165 claims, beneficiaries were overcharged a total of up to $173,495 in cost sharing.

Further, we identified 37,124 claims totaling $1.2 million in potential overpayments for instances in which a CCM service was billed by an outpatient facility but a corresponding claim was not submitted by a physician. We are setting aside these potential overpayments for review and determination by CMS. Additionally, for these 37,124 claims, beneficiaries may have been overcharged a total of up to $373,726 in cost sharing.

These errors occurred because CMS did not have adequate controls in place, including claim system edits, to identify and prevent overpayments.

What OIG Recommends

We recommend that CMS recoup $640,452 from providers and instruct providers to refund overcharges totaling up to $173,495 to beneficiaries; review the 37,124 outpatient claims totaling $1.2 million in potential overpayments to determine whether the outpatient facilities met the requirement to bill for CCM services and recoup any overpayments from outpatient facilities and instruct the outpatient facilities to refund corresponding overcharges to beneficiaries; and implement claim processing controls, including system edits, to prevent and detect overpayments for CCM services.

CMS concurred with all of our recommendations and described corrective actions that it planned to take for the recovery of overpayments, the refund of amounts overcharged to beneficiaries, and the evaluation of the potential overpayments we identified. CMS also provided technical comments on our draft report, which we addressed as appropriate.

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INTRODUCTION

WHY WE DID THIS AUDIT

Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established a policy for Medicare to pay under the Medicare Physician Fee Schedule (PFS) for chronic care management (CCM) services rendered to beneficiaries whose medical conditions meet certain criteria. Before that effective date, physicians did not have the ability to bill separately for non-face-to-face care management services provided to these beneficiaries. CCM payments are at higher risk for overpayments compared with payments for more established Medicare services. This is because CCM services are still a relatively new category of Medicare-covered services and have multiple restrictions on when and how they can be billed. The relatively recent categorization of these services also means that sufficient monitoring may not be in place to ensure compliance with applicable requirements.

OBJECTIVE

Our objective was to determine whether physician and outpatient payments made by CMS for CCM 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. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by healthcare providers, including hospitals, physicians, and suppliers.

Payment Methodology

Under the provisions of section 1848 of the Act, CMS is required to establish a fee schedule for physicians' services based on national uniform relative value units that account for 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.

This report focuses on two different types of settings under which Medicare makes payments to healthcare providers. The first type of setting is a physician's office. The second type are outpatient departments, which include off-campus provider-based departments that are subsidiary to and under the operational control of the hospitals that own them and are integrated into those hospitals for accounting purposes. For this report, the term "outpatient

facilities" refers to on-campus and off-campus provider-based hospital outpatient departments, including clinics and emergency rooms (42 CFR § 414.32(a)(1)).[1]

The differences between these two types of settings are reflected in the PFS, which consists of three main components: the physician's work, the practice expense, and the malpractice insurance expense. Physicians are paid under this fee schedule regardless of setting, and two of the three components—the physician's work and the malpractice insurance expense—remain constant irrespective of setting. However, for some types of services, the practice expense component is reduced when these services are rendered in certain facilities, including a hospital (42 CFR § 414.22(b)).[2] This is done because it is assumed that the practice expense component reflects the operating costs of the physician's office—costs that are subsumed in the facility payment when services are rendered in an outpatient facility.

Accordingly, when a physician renders healthcare services in an outpatient setting, he or she bills for those services using the PFS and must indicate on the Medicare claim that the service was rendered at an outpatient facility. In turn, the outpatient facility where the physician rendered the service can submit a corresponding claim under the outpatient prospective payment system (OPPS), which CMS implemented effective for healthcare services rendered on or after August 1, 2000. Therefore, when a physician renders a service in an outpatient facility there are generally two claims: one claim submitted by the physician under the PFS and one submitted by the outpatient facility under the OPPS.[3]

Under the OPPS, Medicare pays the facility for hospital outpatient services on a rate per service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[4] All services and items within an APC group are comparable clinically and require comparable resources.

Beneficiaries are required to participate in cost sharing for CCM services provided under Medicare Part B (78 Fed. Reg. 74230, 74424 (Dec. 10, 2013)).

[1] The regulation was removed effective January 1, 2017 (81 Fed. Reg. 80170, 80554 (Nov. 15, 2016)), which was after our audit period. Current regulations setting forth requirements for provider-based status can be found at 42 CFR § 413.65.

[2] The practice expense component reflects the costs of maintaining a physician's office practice: rental of office space, purchase of supplies and equipment, staff salaries and benefits, and similar types of costs.

[3] CCM services provided at critical access hospitals constitute an exception to this general rule. Critical access hospitals can bill the facility and professional service on the same claim.

[4] HCPCS codes are used throughout the healthcare industry to standardize coding for medical procedures, services, products, and supplies.

Chronic Care Management

CCM involves the provision of at least 20 minutes per month of non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions expected to last at least 12 months, or until the death of the beneficiary, that place the beneficiary at significant risk of death, acute exacerbation or decompensation, or functional decline. Effective January 1, 2015, Medicare began allowing physicians and nonphysician practitioners (NPPs) to bill for CCM under the Medicare PFS using Current Procedural Terminology (CPT)[5] code 99490. For this report, we refer to physicians and NPPs together as "physicians."

Federal guidelines (the CMS Final Rule for the 2015 PFS) state that CCM services are provided by a physician on a per calendar month basis.[6] When CCM services are not provided personally by the physician, they may be provided by clinical staff at the direction of the physician.[7]

A physician may bill for CCM services only once per month for a beneficiary, and only one physician and one facility may bill for CCM services each month for a beneficiary. In addition, some of the CCM scope of service/billing requirements and certified electronic health record (EHR) requirements include that:

- the clinical staff furnished at least 20 minutes of care management services under the direction of the physician during the calendar month,
- the physician obtained beneficiary consent to provide CCM services and bill Medicare for those services,
- the physician meets all scope-of-service elements[8] contained in the PFS, and
- the physician uses a certified EHR system.[9]

[5] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2017 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.**

[6] 79 Fed. Reg. 67548, 67651, 67716 (Nov. 13, 2014). See also CMS's *Frequently Asked Questions about Billing Medicare for CCM Services* (Mar. 17, 2016).

[7] "Clinical staff" refers to clinical staff employed by either the physician's practice or the outpatient facility.

[8] "Scope-of-service elements" refer to specific standards set forth in the PFS that a physician must meet to be qualified to bill for CCM services (79 Fed. Reg. 67548, 67728 (Nov. 13, 2014)).

[9] EHR technology is approved by a certifying body authorized by the National Coordinator for Health Information Technology.

Physicians may submit a claim to CMS for payment of CCM services once the minimum 20-minute time threshold has been met; however, physicians should continue to provide the CCM services after the minimum threshold has been met.

Overlapping Care Management Services

CCM services include care management services that are also an integral part of transitional care management services (CPT codes 99495 and 99496), home healthcare supervision (HCPCS code G0181), hospice care supervision (HCPCS code G0182), and certain end-stage renal disease (ESRD) services (CPT codes 90951 through 90970). Therefore, these codes include overlapping care management services, and no physician may bill for CCM during the same month for which he or she bills for these other services.

HOW WE CONDUCTED THIS AUDIT

We reviewed the Federal requirements for CCM services and CMS's internal controls specific to claims containing CCM services in effect for CYs 2015 and 2016. We reviewed all paid claims for CCM services for CYs 2015 and 2016[10] to determine whether CMS's controls prevented overpayments by denying unallowable payments. To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments and overlapping services. Our audit included 3,171,303 CCM claims submitted by billing physicians totaling $100,604,601 in payments and 80,966 CCM claims submitted by outpatient facilities totaling $2,856,635 in payments.[11]

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.

FINDINGS

Physician and outpatient payments made by CMS for CCM services provided during CYs 2015 and 2016 did not always comply with Federal requirements, resulting in $640,452 in overpayments associated with 20,165 claims.

[10] Delays in obtaining all of the necessary data from CMS caused us to confine our audit period to this timeframe.

[11] We identified 15,504 claims totaling $497,225 for CCM services that had a service period during the same month as Transitional Care Management (TCM) services that were billed for the same beneficiary by the same provider. We are separately reviewing these claims in another audit (A-07-17-05100). See also footnote 13 later in this report.

Specifically, we identified 14,078 claims that resulted in $436,877 in overpayments for instances in which physicians or facilities billed CCM services more than once for the same beneficiaries for the same service period. In some cases, the same CCM services were billed by a single physician or facility; in other cases, the same CCM services were billed by more than one physician or facility.

We identified an additional 6,087 claims that resulted in $203,575 in overpayments for instances in which the same physician billed for both CCM services and overlapping care management services for the same beneficiaries.

For these 20,165 claims, beneficiaries were overcharged a total of up to $173,495 in cost sharing. Further, we identified 37,124 claims totaling $1,162,562 in potential overpayments for instances in which a CCM service was billed by an outpatient facility but a corresponding claim was not submitted by a physician. We are setting aside these potential overpayments for review and determination by CMS. Additionally, for these 37,124 claims, beneficiaries may have been overcharged a total of up to $373,726 in cost sharing.

Table 1 below summarizes these findings and breaks out, for each finding, the amount of payments made by CMS and the amount of payments made by beneficiaries:

Table 1: Claims Questioned and Claims Set Aside

Claims Questioned			
	Number of Claims	**Medicare Payments**	**Beneficiary Cost-Sharing**
Multiple claims by single provider	10,171	$313,485	$90,068
Multiple claims by more than one provider	3,907	123,392	31,505
Subtotal of Multiple Claims	**14,078**	**436,877**	**121,573**
Overlapping care management claims	6,087	203,575	51,922
Total of Questioned Claims	**20,165**	**$640,452**	**$173,495**
Claims Set Aside			
Outpatient claims without corresponding physician claims	37,124	$1,162,562	$373,726

Note: Numbers do not add to totals due to rounding.

The errors we identified occurred because CMS did not have adequate controls in place, including claim system edits, to identify and prevent overpayments. CMS officials told us that prior to our audit, CMS had developed potential CCM-specific claim system edits; these officials added that CMS has no current plans to implement them.

PAYMENTS FOR CHRONIC CARE MANAGEMENT SERVICES WITH MULTIPLE CLAIMS

CMS requirements provide that physicians may bill for only one claim for CCM services for an individual beneficiary for each calendar month ("service period") (79 Fed. Reg. 67548, 67651 (Nov. 13, 2014)). In addition, only one physician and one facility may bill for CCM services provided to a beneficiary during a service period (78 Fed. Reg. 74230, 74423 (Dec. 10, 2013)). CMS's overall claim processing guidance states that Medicare contractors must establish controls to detect and prevent payments for the same service. Additionally, if a claim (for the same service period for the same beneficiary) is received after a claim has been paid, this guidance instructs Medicare contractors not to pay the subsequent claims (Medicare Claims Processing Manual, ch. 1, §§ 30.3.9 and 120).

Supplemental guidance provided by CMS states that outpatient facilities may bill for CCM services through the OPPS when the staff furnishes the services at the direction of a physician. In addition, an outpatient facility may bill for CCM services rendered to a beneficiary only when a physician has met all requirements to bill for CCM services under the PFS.[12]

We identified 14,078 claims totaling $436,877 in overpayments for instances in which providers billed CCM services more than once for the same beneficiaries in the same service period. Specifically:

- an individual provider submitted more than 1 claim for CCM services rendered in a single service period to a single beneficiary (10,171 claims totaling $313,485) and

- 2 or more providers submitted a claim for CCM services rendered in the same service period to the same beneficiary (3,907 claims totaling $123,392).

In addition to the $436,877 in overpayments made by CMS, providers charged beneficiaries more in coinsurance and deductibles for these CCM services than they should have. For these 14,078 claims, beneficiaries were overcharged a total of $121,573 ($90,068 + $31,505) in cost-sharing provisions.

Table 2 below depicts an example of a provider submitting two claims for CCM services rendered to the same beneficiary in the same service period. In this case, Provider 1 submitted two different claims to CMS for July 2015 CCM services for Beneficiary A.

Table 2: Example of One Provider Submitting Two Claims for Same Month for Same Beneficiary

Beneficiary	Provider	Service Period	Date of Submission	Payment	Beneficiary Cost-Sharing Responsibility	Status
Beneficiary A	Provider 1	July 2015	July 17, 2015	32.07	8.18	First Payment
Beneficiary A	Provider 1	July 2015	August 27, 2015	32.07	8.18	Overpayment

[12] CMS's *Frequently Asked Questions about Billing Medicare for CCM Services* (Mar. 17, 2016).

The second payment that CMS made, in the amount of $32.07, was an overpayment. In addition, Beneficiary A should not have had the $8.18 cost-sharing responsibility for the second claim.

Table 3 below depicts an example of two providers submitting claims for CCM services rendered to the same beneficiary in the same service period. In this case, both Provider 2 and Provider 3 submitted claims for February 2016 CCM services for Beneficiary B.

Table 3: Example of Two Providers Submitting Claims for Same Month for Same Beneficiary

Beneficiary	Provider	Service Period	Date of Submission	Payment	Beneficiary Cost-Sharing Responsibility	Status
Beneficiary B	Provider 2	February 2016	February 18, 2016	28.03	7.15	First Payment
Beneficiary B	Provider 3	February 2016	March 2, 2016	33.47	8.54	Overpayment

CMS's second payment (to Provider 3 in the amount of $33.47) was an overpayment. In addition, Beneficiary B should not have had the $8.54 cost-sharing responsibility to Provider 3.

These errors occurred because CMS did not have adequate controls in place to identify and prevent overpayments that resulted when providers billed for the same CCM services for the same beneficiaries. CMS officials told us that prior to our audit, CMS had developed potential CCM-specific claim system edits; these officials added that CMS has no current plans to implement them.

PAYMENTS FOR CHRONIC CARE MANAGEMENT SERVICES THAT OVERLAPPED WITH OTHER CARE MANAGEMENT SERVICES

The CMS Final Rule for the 2014 PFS states that a physician cannot bill for CCM services rendered during the same service period in which the same physician billed for care management services that overlap with those CCM services. These care management services that overlap with CCM services include TCM services (CPT codes 99495 and 99496), home healthcare supervision (HCPCS code G0181), hospice care supervision (HCPCS code G0182), and certain ESRD services (CPT codes 90951 through 90970) (78 Fed. Reg. 74230, 74423 (Dec. 10, 2013)). CMS reiterates this guidance in Medicare Learning Network Fact Sheet ICN 909188, Dec. 2016.

We identified 6,087 claims totaling $203,575 in overpayments for instances in which the same physician billed for CCM services and overlapping care management services for the same

beneficiary.[13] CCM services may not be claimed during the same service period as overlapping care management services.[14]

In addition to the $203,575 in overpayments made by CMS, physicians charged beneficiaries more in coinsurance and deductibles for these CCM services than they should have. Our analysis of the 6,087 claims identified $51,922 that beneficiaries were overcharged through Medicare cost-sharing provisions.

Table 4 below depicts an example of a provider submitting claims for both CCM services and an overlapping service (home healthcare supervision (CPT code G0181)) rendered to Beneficiary C for March 2016.

Table 4: Example of One Provider Submitting Claims for CCM Services and Overlapping Services for Same Month for Same Beneficiary

Beneficiary	Provider	Service Period	Date of Submission	Type of Service	Payment	Beneficiary Cost-Sharing Responsibility	Status
Beneficiary C	Provider 4	March 2016	March 2, 2016	Home Healthcare Supervision	84.93	21.66	First Payment
Beneficiary C	Provider 4	March 2016	March 31, 2016	CCM	31.86	8.13	Overpayment

According to the PFS, home healthcare supervision is a service for which a physician should not submit a claim (or bill) if that physician has submitted a claim for CCM services rendered to the same beneficiary for the same service period. However, because a claim for home healthcare services was submitted and included overlapping services, the payment that CMS made for CCM services, in the amount of $31.86, was an overpayment. Furthermore, Beneficiary C should not have had the $8.13 cost-sharing responsibility for the CCM services.

These errors occurred because CMS did not have adequate controls in place to identify and prevent payments for CCM services that were rendered by the same providers for the same beneficiaries during the same service period as the overlapping care management services. CMS officials told us that prior to our audit, CMS had developed potential CCM-specific claim system edits; these officials added that CMS has no current plans to implement them.

[13] We initially identified 21,595 claims totaling $700,800 in CCM payments ($178,634 beneficiaries' portion). However, providers claimed $497,225 ($126,677 beneficiaries' portion) for CCM services that overlapped or may have overlapped with TCM services; that is, providers billed TCM and CCM services for the same beneficiary for the same service period. In these instances, the Medicare National Correct Coding Initiative procedure-to-procedure edits state that the CCM services should be paid and the TCM services should be denied. Accordingly, we are addressing this issue in a separate audit of TCM claims (A-07-17-05100). See also "How We Conducted This Review" and footnote 11 earlier in this report.

[14] These overlapping care management services included TCM services (CPT codes 99495 and 99496), home healthcare and hospice care supervision (HCPCS codes G0181 and G0182), and ESRD services (CPT codes 90951 through 90970).

POTENTIAL OVERPAYMENTS TO OUTPATIENT FACILITIES FOR CHRONIC CARE MANAGEMENT SERVICES THAT DID NOT HAVE A CORRESPONDING PHYSICIAN CLAIM

CMS defines CCM as a physician-provided or physician-directed service; therefore, CMS will pay the outpatient facility for CCM services only when the facility provides these services at the direction of a physician. There is no requirement that CCM services billed by outpatient facility have a corresponding claim billed by a physician; however, because CCM is a physician-directed service, it is reasonable to expect that in most cases a physician would submit a claim for the same service. However, there are reasons a billing physician would not submit a claim, including (1) the physician chose not to do so, (2) the physician did not meet all CCM requirements, (3) the physician did not know that he or she could submit claims for CCM services, (4) the outpatient facility's clinical staff did not render the required CCM services, or (5) the facility's clinical staff was not under the direction of a physician.

Of the 80,966 CCM claims submitted by outpatient facilities with a total of $2,856,635 in associated payments, 37,124 claims (approximately 47 percent) did not have a corresponding claim for CCM services submitted by a physician for the same beneficiary for the same service period, an indicator that both the physician and the facility may not have met CCM requirements. The $1,162,562 that CMS paid for these 37,124 claims were potential overpayments. We are setting aside these potential overpayments for review by CMS to determine whether the physicians and outpatient facilities met all the requirements to bill for CCM services.

In addition to the $1,162,562 in potential overpayments made by CMS, providers potentially charged beneficiaries more in coinsurance and deductibles for these CCM services than they should have. Our analysis of the 37,124 claims identified up to $373,726 that beneficiaries were potentially overcharged through Medicare cost-sharing provisions.

EFFECT OF INADEQUATE CONTROLS

These errors occurred because CMS did not have adequate controls in place, to include claim system edits, to identify and prevent overpayments. CMS officials told us that CMS had developed CCM-specific controls prior to our audit; these officials added that CMS has no current plans to implement them. These officials also said that CMS has monitored the volume of claims for CCM services and added that CMS has not detected substantial rates of overpayments.

As a result of these errors, for CYs 2015 and 2016, providers billed for and received overpayments totaling $640,452, and beneficiaries were overcharged a total of up to $173,495 through Medicare cost-sharing provisions. We are setting aside an additional $1,162,562 in potential overpayments made by CMS, as well as up to an additional $373,726 that beneficiaries may have been overcharged, for review and determination by CMS.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- recoup $640,452 from providers, and instruct providers to refund overcharges totaling up to $173,495 to beneficiaries, consisting of:

    - $436,877 in overpayments to providers that billed for the same CCM services for the same beneficiaries and up to $121,573 in overcharges to these beneficiaries and

    - $203,575 in overpayments to providers that billed for both CCM services and overlapping care management services for the same beneficiaries and up to $51,922 in overcharges to these beneficiaries;

- review the 37,124 outpatient claims totaling $1,162,562 in potential overpayments to determine whether the outpatient facilities met the requirement to bill for CCM services and

    - recoup any overpayments from outpatient facilities and

    - instruct the outpatient facilities to refund corresponding overcharges to beneficiaries; and

- implement claim processing controls, including system edits, to prevent and detect overpayments for CCM services.

CMS COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and described corrective actions that it planned to take. Specifically, CMS described steps it would take for the recovery of the overpayments we identified, the refund of coinsurance and deductible amounts overcharged to beneficiaries, and the evaluation of a sample of the outpatient claims whose associated potential overpayments we identified. CMS also stated, with respect to our third recommendation, that "[w]hile CMS has not observed substantial rates of chronic care management overpayments, we will evaluate opportunities to implement claims processing controls to prevent and detect overpayments" for these services.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the Federal requirements for CCM services and CMS's internal controls specific to claims containing CCM services in effect for CYs 2015 and 2016. We reviewed all paid claims for CCM services for CYs 2015 and 2016 (footnote 11) to determine whether CMS's controls prevented overpayments by denying unallowable payments. To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments and overlapping services. Our audit included 3,171,303 CCM claims submitted by billing physicians totaling $100,604,601 in payments and 80,966 CCM claims submitted by outpatient facilities totaling $2,856,635 in payments (footnotes 11 and 13).

We performed our audit work from July 2017 to May 2019.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and guidelines;
- obtained CCM claims with dates of service during CYs 2015 and 2016;
- used computer matching, data mining, and other data analysis techniques to identify overpayments for CCM services;
- interviewed CMS officials to obtain an understanding of CMS's oversight of CCM claims;
- provided CMS officials with data supporting the overpayments and potential overpayments that we identified and solicited CMS's input on these findings and their causes; and
- discussed our findings with CMS officials on March 11, 2019.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: October 4, 2019

TO: Gloria L. Jarmon
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Made Hundreds of Thousands of Dollars in Overpayments for Chronic Care Management Services (A-07-17-05101)

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.

CMS recognizes chronic care management as a critical component of primary care that contributes to better health and care for individuals. In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule for chronic care management services furnished to Medicare patients with multiple chronic conditions. CMS has monitored chronic care management utilization since 2015. In this time, CMS has not observed substantial rates of chronic care management overpayments. Similarly, the OIG's audit found that less than one percent of claims for chronic care management services did not comply with billing requirements. Additionally, early data show that, in general, chronic care management services are increasing patient and practitioner satisfaction, saving costs and enabling solo practitioners to remain in independent practice.[1]

CMS educates providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, a booklet detailing the Medicare billing requirements for chronic care management services was published in July 2019.[2]

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

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

OIG Recommendation

The OIG recommends that CMS recoup $640,452 from providers, and instruct providers to refund overcharges totaling $173,495 to beneficiaries consisting of $436,877 in overpayments to providers that billed for the same CCM services for the same beneficiaries and $121,573 in

[1] https://innovation.cms.gov/Files/reports/chronic-care-mngmt-finalevalrpt.pdf
[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

overcharges to these beneficiaries and $203,575 in overpayments to providers that billed for both CCM services an overlapping care management services for the same beneficiaries and $51,922 in overcharges to these beneficiaries.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures. As part of this process, the Medicare Administrative Contractors will instruct providers to refund any deductible or coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

OIG Recommendation

The OIG recommends that CMS review the 37,124 outpatient claims totaling $1,162,562 in potential overpayments to determine whether the outpatient facilities met the requirement to bill for CCM services and recoup any overpayments from outpatient facilities and instruct the outpatient facilities to refund corresponding overcharges to beneficiaries.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to review a sample of the outpatient claims identified by the OIG to determine whether the outpatient facilities met the requirement to bill for chronic care management services. Based on the findings of the sample review, CMS will determine the appropriate course of action. CMS will recover, as appropriate, any identified overpayments associated with the reviews consistent with agency policy and procedures.

OIG Recommendation

The OIG recommends that CMS implement claim processing controls, including system edits, to prevent and detect overpayments for CCM services.

CMS Response

CMS concurs with this recommendation. While CMS has not observed substantial rates of chronic care management overpayments, we will evaluate opportunities to implement claims processing controls to prevent and detect overpayments for chronic care management services. CMS will also evaluate the feasibility and cost effectiveness of system edits in the context of overall access to chronic care management services.