

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE MADE MILLIONS OF
DOLLARS IN OVERPAYMENTS FOR
END-STAGE RENAL DISEASE
MONTHLY CAPITATION PAYMENTS**

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



Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: May 2021

Report No. A-07-19-05117

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



Why OIG Did This Audit

Recovery Audit Contractors (RACs) assist the Centers for Medicare & Medicaid Services (CMS) by performing audits of monthly capitation payments (MCPs) for end-stage renal disease (ESRD) patients receiving four or more visits per month; these audits have identified claims with improper payments. An MCP is a monthly payment made to physicians for dialysis-related physician services provided to Medicare ESRD patients. Only one physician may receive an MCP for all ESRD-related services provided to a Medicare beneficiary during a calendar month. The RAC audits found that this was not always the case: some of these audits identified claims that were improperly paid, because they reflected more than one MCP for ESRD-related services provided to the same beneficiary for the same calendar month.

Our objective was to determine whether CMS made Medicare MCPs to physicians for monthly ESRD-related services provided in calendar years (CYs) 2016 through 2018 in accordance with Federal requirements.

How OIG Did This Audit

Our audit covered \$12.2 million in Medicare MCPs to physicians for 53,608 claims for monthly ESRD-related services with dates of service in CY 2016, CY 2017, or CY 2018 that we identified as at risk for noncompliance with Federal requirements.

Medicare Made Millions of Dollars in Overpayments for End-Stage Renal Disease Monthly Capitation Payments

What OIG Found

CMS did not always make Medicare MCPs to physicians for monthly ESRD-related services provided in CYs 2016 through 2018 in accordance with Federal requirements. Specifically, 23,695 claims were for services for which physicians reported monthly ESRD-related billing codes more than once for the same beneficiary for the same month. These claims consisted of 21,763 claims that resulted in \$4 million in overpayments for instances in which different physicians reported codes for services and 1,932 claims that resulted in \$291,813 in overpayments for instances in which the same physician reported codes for services. Beneficiaries were responsible for up to \$1.1 million in cost sharing related to these 23,695 claims. We are setting aside potential overpayments related to an additional 1,598 claims totaling \$289,169 and \$74,563 in beneficiary cost sharing for CMS's review and determination. CMS did not have adequate claims processing controls in place, to include system edits, to identify and prevent these overpayments.

What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to: (1) recover the \$4 million for claims that are within the reopening period; (2) recover the \$291,813 for claims that are within the reopening period; (3) instruct the physicians to refund the \$1.1 million in beneficiary cost-sharing amounts; (4) review the 1,598 claims for potentially duplicate claims, determine which should have been denied, and take followup actions; (5) based on the results of this audit, notify physicians so that they can exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule and identify any returned overpayments as according with this recommendation; and (6) implement improved claims processing controls, including improved system edits, to prevent and detect overpayments.

CMS did not concur with our first recommendation (because, it said, some physicians may not be liable for overpayments because they could be found to be without fault under the provisions of the Social Security Act) but concurred with all of our other recommendations and described actions taken or planned. We revised our first recommendation for this final report by deleting the reference to physicians that had been in the draft report's first recommendation. This revision conforms to CMS provisions that the Medicare contractors make determinations regarding the recovery of overpayments. The actions that CMS described, when fully executed, should resolve the other recommendations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	1
Medicare Monthly Capitation Payments for End-Stage Renal Disease-Related Services.....	2
Medicare Claims Processing System.....	4
The 60-Day Rule and 6-Year Lookback Period.....	4
How We Conducted This Audit.....	5
FINDINGS.....	5
Federal Requirements.....	6
Different Physicians Reported Current Procedural Terminology Codes for the Same Beneficiary for the Same Month.....	7
The Same Physicians Reported Current Procedural Terminology Codes More Than Once for the Same Beneficiary for the Same Month.....	7
Beneficiary Cost-Sharing Responsibility Associated With Overpayments Made for Duplicate Services.....	8
Different Physicians Submitted Potentially Duplicate Claims on the Same Day to Different Medicare Contractors.....	8
Inadequate Claims Processing Controls To Include System Edits.....	9
Effect of Payment Errors.....	9
RECOMMENDATIONS.....	9
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	10
APPENDICES	
A: Audit Scope and Methodology.....	12
B: CMS Comments.....	14

INTRODUCTION

WHY WE DID THIS AUDIT

Recovery Audit Contractors (RACs) assist the Centers for Medicare & Medicaid Services (CMS) by performing audits of claims submitted by physicians and other qualified health care professionals (collectively referred to as “physicians” for this report). RAC audits identified improper monthly capitation payments (MCPs) made to physicians managing Medicare end-stage renal disease (ESRD) patients in a dialysis center (center-based ESRD patients).¹ For this report, we refer to dialysis-related services provided to these patients as “ESRD-related services.” Specifically, RAC audits identified instances in which more than one physician was paid an MCP during a calendar month for claims for ESRD-related services that were provided to center-based ESRD patients during four or more visits per month at the dialysis center. Medicare requirements specify that only one MCP may be reported (i.e., through submission of a bill) per month for services performed that are related to the patient’s ESRD. The physician who provides the complete assessment, establishes the patient’s plan of care, and provides the ongoing management is the physician who submits the bill for the monthly service.² The RAC audits found that this was not always the case: some of these audits identified claims that were improperly paid, because they reflected more than one MCP being submitted for ESRD-related services provided to the same beneficiary for the same calendar month. Additionally, through data matching, we determined that the risk for overpayments was not limited to MCPs for ESRD-related services in cases when center-based ESRD patients received services during four or more visits per month.

For calendar years (CYs) 2016, 2017, and 2018, CMS paid physicians approximately \$2.2 billion for MCPs for ESRD-related services; accordingly, it is important that MCPs are made in accordance with Federal requirements.

OBJECTIVE

Our objective was to determine whether CMS made Medicare MCPs to physicians for monthly ESRD-related services provided in CYs 2016 through 2018 in accordance 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

¹ An MCP is a monthly payment made to physicians for dialysis-related physician services provided to Medicare ESRD patients.

² Other physicians providing ESRD-related services to the same beneficiary for less than a full month can bill only on a per diem basis.

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 health care providers, including hospitals, physicians, and suppliers.

Medicare Monthly Capitation Payments for End-Stage Renal Disease-Related Services

Physicians managing center-based ESRD patients can be paid an MCP that covers most outpatient dialysis-related physician services provided to each Medicare beneficiary who is being treated for ESRD.^{3,4} The MCP varies based on the beneficiary's age and the number of visits during each calendar month in which the beneficiary receives ESRD-related services. Physicians report (to Medicare contractors) separate Current Procedural Terminology (CPT) codes based on the beneficiary's age and whether they provide ESRD-related services to the beneficiary on one visit per month, two to three visits per month, or four or more visits per month. A physician who provides ESRD-related services to a beneficiary during one visit per month receives Medicare payment at a lower payment rate. A physician receives Medicare payment at a relatively higher payment rate when services are provided during two to three visits per month. To receive the highest payment amount, a physician has to provide services during at least four ESRD-related services' visits per month. Physicians managing ESRD patients who dialyze at home are paid a single monthly rate based solely on the age of the beneficiary. Physicians must furnish at least one face-to-face patient visit per month for the home dialysis MCP service; however, Medicare contractors may waive the monthly face-to-face requirement on a case-by-case basis.

The CPT codes 90951 through 90962 reflect physician services for center-based ESRD patients, and CPT codes 90963 through 90966 reflect physician services for ESRD patients who dialyze at home; see Table 1 on the following page.⁵ The CPT code descriptions for these codes contain the term "per month" and are to be reported once per month. The term "month" means a calendar month. CPT codes for ESRD-related services are determined, in part, by the beneficiary's age. In submitting claims for these services, a physician must report the CPT code associated with the beneficiary's age as of the end of the month in which services are

³ 42 CFR § 414.314(a). See also CMS's *Claims Processing Manual*, chapter 8, section 140. The term "center-based" refers to services performed in one of the multiple types of facilities identified in CMS's *Medicare Claims Processing Manual* (the Manual), chapter 8, section 10.9.

⁴ This report focuses on physician services paid under the physician MCP method. However, physicians can elect to be paid under the initial method instead of the physician MCP method. The physician cannot be paid under both methods for the same service (42 CFR § 414.310(e)).

⁵ **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2016 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.**

provided.⁶ For this report, we conform to language in CMS requirements by referring to this process as “reporting” CPT codes.

Table 1: CPT Code Descriptions

Beneficiary Age	Center-Based Dialysis			Home Dialysis
	1 Visit	2 – 3 Visits	4 or More Visits	All Visits
<2 Years Old	90953	90952	90951	90963
2-11 Years Old	90956	90955	90954	90964
12-19 Years Old	90959	90958	90957	90965
20 Years Old and Older	90962	90961	90960	90966

The physician who provides the complete assessment, establishes the patient’s plan of care, and provides the ongoing management (whether for center-based ESRD patients or patients who dialyze at home) is the physician who reports the CPT codes for services during that month. The physician may use other physicians or qualified nonphysician practitioners (NPPs) to provide some of the visits during the month. The physician does not have to be present when these other physicians or NPPs provide visits. In such instances, the rules are consistent with the requirements for hospital split or shared evaluation and management visits; that is, the other physician or qualified NPP must be a partner, an employee of the same group practice, or an employee of the physician. When another physician is used to furnish some of the visits during the month, the physician who provides the complete assessment, establishes the patient’s plan of care, and provides the ongoing management should bill for the MCP service.⁷

Other physicians may, in specific circumstances, receive payments for managing patients on dialysis for less than a full month of care. Payment for ESRD-related services provided for less than a full month is made on a per diem basis. Circumstances under which physicians can receive payments for managing patients for less than a full month include home dialysis (less than a full month), transient patients, and partial-month services. Partial-month services involve cases in which there were one or more face-to-face visits without a complete assessment of the patient and the patient either (1) was hospitalized before a complete assessment was furnished (dialysis stopped due to death or the patient had a transplant) or (2) had a permanent change in his or her physician during the month.⁸

Payment for ESRD-related services (CPT codes 90951 through 90966) is made at 80 percent of the Medicare-approved amount (i.e., the lesser of the actual charge or applicable Medicare fee

⁶ The Manual, chapter 8, sections 140.1(a) and (b).

⁷ The Manual, chapter 8, section 140.1.

⁸ The Manual, chapter 8, section 140.2.

schedule amount) after the beneficiary's Part B deductible has been met. The beneficiary is responsible for the Part B deductible and the 20-percent coinsurance for physician ESRD-related services.⁹

Medicare Claims Processing System

CMS's Common Working File (CWF) is the Medicare Part A and Part B beneficiary benefits coordination and prepayment claims validation system. The CWF provides a single data source that contractors can use for prepayment review and approval of claims. The CWF verifies that: (1) the beneficiary is entitled to either Part A or Part B benefits, depending on the type of claim submitted; (2) any co-pay, deductible, or both that has been applied is accurate; (3) claimed services are allowable; (4) benefits are available for the services submitted on the claim; and (5) the services on the claim have not been paid on another claim (either for the same type of services or on another type of claim). If it cannot verify any of these conditions, the CWF returns a response and identifies the reason for the rejection. The response also includes additional content, called trailers, that identifies the correct information so that Medicare contractors can take any necessary actions. This report uses the terms "duplicate monthly ESRD-related services" ("duplicate services"), "duplicate claims," and "duplicate MCPs" as appropriate to discuss these conditions.

Claims are processed by the CWF in the same order in which they are received, regardless of the dates of service or the date on which the Medicare contractor received the claim.

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.¹⁰

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.¹¹

⁹ 42 CFR § 414.314(a)(2) and the Manual, chapter 8, section 140.

¹⁰ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹¹ 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.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$12,174,514 in Medicare MCPs to physicians for 53,608 claims for monthly ESRD-related services with dates of service in CY 2016, CY 2017, or CY 2018—claims that we identified (using computer matching, data mining, and other data analysis techniques) as at risk for noncompliance with Federal requirements. Specifically, we focused on instances in which multiple MCPs were made for the same beneficiary for the same month. This report focuses on selected risk areas and does not represent an overall assessment of all claims for ESRD-related services submitted by the physicians for Medicare reimbursement.

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 enough, 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

CMS did not always make Medicare MCPs to physicians for monthly ESRD-related services provided in CYs 2016 through 2018 in accordance with Federal requirements. Specifically, of the 53,608 claims covered by this audit, 23,695 claims were for services for which physicians reported monthly ESRD-related CPT codes more than once for the same beneficiary for the same month.¹² The 23,695 claims consisted of:

- 21,763 claims that resulted in \$3,963,618 in overpayments for instances in which different physicians reported monthly ESRD-related CPT codes for the same beneficiary for the same month, and
- 1,932 claims that resulted in \$291,813 in overpayments for instances in which the same physician reported monthly ESRD-related CPT codes more than once for the same beneficiary for the same month.

¹² Only one physician can bill for an MCP. Other physicians providing ESRD-related services for less than a full month can bill only on a per diem basis (footnote 2).

Overpayments associated with these 23,695 claims totaled \$4,255,431. As of the publication of this report, these overpayments included claims outside of the 4-year reopening period.^{13, 14} In addition, beneficiaries were responsible for up to \$1,092,149 in cost sharing for these claims.

Furthermore, we identified potential overpayments related to 1,598 claims totaling \$289,169 for instances in which different physicians reported a monthly ESRD-related CPT code on the same day to different Medicare contractors for the same beneficiary for the same month of service. We recognize that not all of the 1,598 claims are unallowable. However, in each of these cases we were unable to determine which CPT code was reported first on any given day; therefore, we are setting aside these potentially duplicate claims for CMS to review and determine which claims should have been paid and which should have been denied. The beneficiary cost sharing associated with these claims was \$74,563.

These errors occurred primarily because CMS did not have adequate claims processing controls in place, to include system edits, to identify and prevent the overpayments associated with physicians reporting more than one CPT code per month for monthly ESRD-related services. CMS's *Medicare Claims Processing Manual* (the Manual) describes claims processing controls, and the Medicare contractors had system edits in place. However, the edits were not adequate to prevent all overpayments.

FEDERAL REQUIREMENTS

Federal regulations allow only one MCP per month for each ESRD patient to cover most outpatient dialysis-related physician services.¹⁵ The physician who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management is the physician who should report the CPT code for the services provided to the patient during the month. Medicare contractors, in turn, must ensure that: (1) only one MCP is made for any ESRD patient per month; (2) duplicate charges billed as a duplicate MCP or as separate charges for services covered by the monthly payment are denied; and (3) in cases when several physicians form a team to provide monthly continuity of services to a group of patients, the Medicare contractor makes only one MCP for each ESRD patient (the Manual, chapter 8, §§ 140, 140.1, 140.1.1, and 140.4). Therefore, according to CMS officials, the first CPT code reported (i.e., the first claim received) is the allowable claim.

¹³ 42 CFR § 405.980(b)(2) (permitting a contractor to reopen an initial determination within 4 years for good cause) and 42 CFR § 405.980(c)(2) (permitting a supplier to request that a contractor reopen within 4 years for good cause).

¹⁴ Nevertheless, a physician can request that a contractor reopen an initial determination for the purpose of reporting and returning overpayments under the 60-day rule without being limited by the 4-year reopening period. 42 CFR § 405.908(c)(4).

¹⁵ 42 CFR § 414.314(a)(1). See also the Manual, chapter 8, sections 140 and 140.1, and *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004; Final Rule*; 68 Fed. Reg. 63196, 63220 (Nov. 7, 2003).

DIFFERENT PHYSICIANS REPORTED CURRENT PROCEDURAL TERMINOLOGY CODES FOR THE SAME BENEFICIARY FOR THE SAME MONTH

Monthly ESRD-related services provided in CYs 2016 through 2018 included 21,763 claims for duplicate services. In each of these cases, a physician reported a CPT code for monthly ESRD-related services that had been previously reported by a different physician (using the same or different monthly ESRD-related CPT codes) for the same beneficiary for the same month of service. These claims resulted in \$3,963,618 in overpayments. An example appears in Table 2.

Table 2: Two Physicians Reported CPT Codes for the Same Beneficiary

Beneficiary	Physician	Service Period	CPT Code Reporting Date	CPT Code	Payment	Beneficiary Cost-Sharing Responsibility	Status
A	1	5/2018	6/7/2018	90962	\$142.72	\$36.41	First Claim
A	2	5/2018	11/7/2018	90960	\$235.81	\$60.16	Overpayment

Physicians 1 and 2 both reported a CPT code for ESRD-related services provided to Beneficiary A for May 2018. Physician 1 reported on June 7, 2018; this claim was allowable. Physician 2 reported a CPT code on November 7, 2018, for the same beneficiary for the same month of ESRD-related services, and this claim should have been denied, because physician 1 had already reported a CPT code for May 2018 services provided to Beneficiary A. Therefore, the Medicare contractor should not have paid an MCP to Physician 2.

THE SAME PHYSICIANS REPORTED CURRENT PROCEDURAL TERMINOLOGY CODES MORE THAN ONCE FOR THE SAME BENEFICIARY FOR THE SAME MONTH

Monthly ESRD-related services provided in CYs 2016 through 2018 included an additional 1,932 claims for duplicate services. In each of these cases, the same physician reported monthly ESRD-related CPT codes more than once for the same beneficiary for the same month of service. These claims resulted in \$291,813 in overpayments. An example appears in Table 3.

Table 3: A Physician Submitted Duplicate CPT Codes for the Same Beneficiary

Beneficiary	Physician	Service Period	CPT Code Reporting Date	CPT Code	Payment	Beneficiary Cost-Sharing Responsibility	Status
B	3	11/2016	2/24/2017	90960	\$226.47	\$57.77	First Claim
B	3	11/2016	2/28/2017	90960	\$226.47	\$57.77	Overpayment

Physician 3 reported a CPT code on February 24, 2017, for ESRD-related services provided to Beneficiary B for November 2016; this claim was allowable. On February 28, 2017, Physician 3 again reported the CPT code for ESRD-related services provided to the same beneficiary for the

same month of services. Physician 3 had already reported the November 2016 ESRD-related services for Beneficiary B on February 24, 2017, so the claim submitted on February 28, 2017, should have been denied. Therefore, Physician 3 should not have received the second MCP.

BENEFICIARY COST-SHARING RESPONSIBILITY ASSOCIATED WITH OVERPAYMENTS MADE FOR DUPLICATE SERVICES

For these 23,695 claims for which either different physicians (21,763 claims) or the same physicians (1,932 claims) reported CPT codes for duplicate services, beneficiaries were responsible for as much as \$1,092,149 in associated cost sharing (the Medicare Part B deductible and the 20-percent coinsurance).

DIFFERENT PHYSICIANS SUBMITTED POTENTIALLY DUPLICATE CLAIMS ON THE SAME DAY TO DIFFERENT MEDICARE CONTRACTORS

We identified potential overpayments related to an additional 1,598 claims totaling \$289,169 for instances in which different physicians reported a monthly ESRD-related CPT code on the same day to different Medicare contractors for the same beneficiary for the same month of service. We recognize that not all of the 1,598 claims are unallowable. However, in each of these cases we were unable to determine which CPT code was reported first on any given day; therefore, we are setting aside these 1,598 potentially duplicate claims for CMS to review and determine which claims should have been paid and which should have been denied.

Additionally, for these 1,598 claims, beneficiaries were responsible for as much as \$74,563 in cost sharing. An example illustrating both the Medicare MCPs and the beneficiary cost sharing appears in Table 4.

Table 4: Physicians Reported CPT Codes for the Same Beneficiary on the Same Day to Two Different Medicare Contractors

Medicare Contractor	Beneficiary	Physician	Service Period	CPT Code Reporting Date	CPT Code	Payment	Beneficiary Cost-Sharing Responsibility
1	C	4	9/2018	10/5/2018	90962	\$125.52	\$32.02
2	C	5	9/2018	10/5/2018	90961	\$189.74	\$48.40

Physicians 4 and 5 reported CPT codes on the same day to Medicare contractors 1 and 2 for ESRD-related services provided to Beneficiary C for the same month—September 2018. Because we cannot determine which of the two claims was received first, we cannot determine which is the overpayment.

Therefore, we are setting aside the 1,598 potentially duplicate claims (totaling \$289,169) as well as the associated beneficiary cost sharing (\$74,563) for CMS to determine which claims should have been paid and which should have been denied.

INADEQUATE CLAIMS PROCESSING CONTROLS TO INCLUDE SYSTEM EDITS

These errors occurred primarily because CMS did not have adequate claims processing controls in place, to include system edits, to identify and prevent the overpayments associated with physicians reporting more than one CPT code per month for monthly ESRD-related services. The Manual describes claims processing controls, such as directions to Medicare contractors to identify duplicate claims and deny claims for duplicative services, and the Medicare contractors had system edits in place. However, the edits were not adequate to detect and prevent all overpayments.

EFFECT OF PAYMENT ERRORS

Physicians reported multiple CPT codes for monthly ESRD-related services provided in CYs 2016 through 2018 and received overpayments totaling \$4,255,431, and beneficiaries were overcharged a total of as much as \$1,092,149 through Medicare cost-sharing provisions. We are setting aside, for review and determination by CMS, an additional \$289,169 in potential overpayments and an additional \$74,563 in beneficiary cost sharing that were associated with 1,598 claims for instances in which different physicians reported a CPT code on the same day to different Medicare contractors for monthly ESRD-related services provided to the same beneficiary for the same month of service.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services direct the Medicare contractors to:

- recover the \$3,963,618 for instances in which different physicians reported CPT codes and received MCPs for monthly ESRD-related services provided to the same beneficiary for the same month of service (for claims that are within the 4-year reopening period);¹⁶
- recover the \$291,813 from physicians for instances in which the same physicians reported more than one CPT code and received MCPs for monthly ESRD-related services provided to the same beneficiary for the same month of service (for claims that are within the 4-year reopening period);

¹⁶ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare administrative contractor or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Physicians have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a physician exercises his or her right to an appeal, the physician does not need to return overpayments until after the second level of appeal.

- instruct the physicians to refund beneficiaries the \$1,092,149 in beneficiary cost-sharing (deductible and coinsurance) amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf;
- review the 1,598 claims totaling \$289,169 in MCPs for potentially duplicate claims and \$74,563 in associated beneficiary cost sharing (deductible and coinsurance amounts) and determine which of the claims should have been denied as a duplicate claim for ESRD-related services and
 - recover the portion of any MCPs from the physicians for claims for duplicate services (that are within the 4-year reopening period), and
 - instruct the physicians to refund beneficiaries the portion of the deductible and coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf;
- based on the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the physicians 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 improved claims processing controls, including improved system edits, to prevent and detect overpayments of claims for duplicate services.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not concur with our first recommendation but concurred with all of our other recommendations. For our first recommendation, CMS stated that it recognized the possibility that multiple physicians or NPPs could have fulfilled the billing requirements for the MCP services for the same beneficiary without knowledge of the specific billing of another physician or NPP. CMS said that these physicians or NPPs may not be liable because they could be found to be without fault under the provisions of section 1870(b) of the Act. CMS added that it is “exploring opportunities to improve claim processing controls, including improved system edits, to prevent and detect these types of overpayments in the future. Once any changes are implemented, CMS will provide any relevant provider education.”

CMS concurred with our other five recommendations and described actions that it had taken or planned to take. For our second recommendation, CMS stated that it would instruct Medicare contractors to recover identified overpayments that are within the 4-year reopening period “consistent with relevant law and the agency’s policies and procedures.” For our third recommendation, CMS said that the Medicare contractors would instruct physicians and NPPs

to refund any deductible or coinsurance amounts associated with any cases for which CMS determines that an overpayment was made.

CMS also concurred with our fourth recommendation and stated that its RACs were approved to begin reviewing MCPs for ESRD services in December 2018 (the last month of our audit period). CMS added that it would recover identified overpayments after reviewing our claims data, and that the Medicare contractors would instruct physicians and NPPs to refund any deductible or coinsurance amounts that may have been incorrectly collected. CMS similarly described actions it planned to take in response to our fifth and sixth recommendations, and in a general comment said that it had educated and would continue to educate physicians and NPPs on proper billing.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, are included as Appendix B.

We believe that the actions that CMS described, when fully executed, should resolve all five of the recommendations with which CMS concurred.

After reviewing CMS's comments, we revised our first recommendation for this final report by deleting the phrase "from physicians" from the recommendation that CMS direct the Medicare contractors to recover the \$3,963,618 in improper payments. In so doing, we took into account the provisions of the *Medicare Financial Management Manual*, Pub. No. 100-06, which states that the Medicare contractor will make the determination that the physician is liable or without fault (chapter 3, § 90). Further, this recommendation is not limited to recouping improper payments from physicians. The *Medicare Financial Management Manual* also states: "If the [Medicare contractor] determines that an overpaid [physician] was without fault and therefore not liable for the overpayment, it relieves the [physician] of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault. However, recovery from the beneficiary may be waived if [the Medicare contractor] determine[s] the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience" (chapter 3, § 70).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$12,174,514 in Medicare MCPs to physicians for 53,608 claims for monthly ESRD-related services with dates of service in CY 2016, CY 2017, or CY 2018—claims that we identified (using computer matching, data mining, and other data analysis techniques) as at risk for noncompliance with Federal requirements. Specifically, we focused on instances in which multiple MCPs were made for the same beneficiary for the same month. We evaluated compliance with selected billing requirements to determine whether CMS’s controls prevented overpayments by denying unallowable MCPs. We did not use medical review to determine whether the services were medically necessary.

This report focuses on selected risk areas—i.e., cases in which more than one MCP was made to physicians for ESRD-related services provided to the same beneficiary for the same calendar month—and does not represent an overall assessment of all claims for ESRD-related services submitted by the physicians for Medicare reimbursement.

We performed our audit work from March 2019 to March 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and guidelines;
- obtained claims for monthly ESRD-related services with dates of service in CYs 2016, 2017, and 2018;
- used computer matching, data mining, and other data analysis techniques to identify overpayments related to claims for duplicate monthly ESRD-related services;
- interviewed CMS officials to obtain an understanding of CMS’s oversight of and controls over monthly ESRD-related services’ claims;
- provided CMS officials with data supporting the overpayments that we identified and solicited CMS’s input on these findings and their causes; and
- discussed our findings with CMS officials on September 23, 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 enough, 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.




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: April 9, 2021

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

FROM: Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services 

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Made Millions of Dollars in Overpayments for End-Stage Renal Disease Monthly Capitation Payments (A-07-19-05117)

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 recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. For example, CMS's Recovery Audit Contractors were approved to begin reviewing monthly capitation payments (MCPs) for End-Stage Renal Disease (ESRD) in December 2018; which is the last month of the OIG's audit period.¹ As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care physicians and nonphysician practitioners on proper billing. CMS educates health care providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. CMS is exploring opportunities to improve claim processing controls, including improved system edits, to prevent and detect the types of overpayments identified in the OIG's audit in the future and will provide any relevant provider education to further address the issues the OIG identified moving forward.

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

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics-Items/0112-MCP-Monthly-Capitation-Payment-for-ESRD-End-Stage-Renal-Disease-Receiving-4-or-more-Visits-per-Month>

OTG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to recover the \$3,963,618 from physicians for instances in which different physicians reported CPT codes and received MCPs for monthly ESRD-related services provided to the same beneficiary for the same month of service (for claims that are within the 4-year reopening period).

CMS Response

CMS does not concur with this recommendation. CMS recognizes the possibility that multiple physicians or nonphysician practitioners could have fulfilled the billing requirements for the monthly capitation payment services for the same beneficiary without knowledge of the specific billing of another physician or nonphysician practitioner. These physicians or nonphysician practitioners may not be liable because they could be found without fault under section 1870(b) of the Social Security Act. Moving forward, CMS is exploring opportunities to improve claim processing controls, including improved system edits, to prevent and detect these types of overpayments in the future. Once any changes are implemented, CMS will provide any relevant provider education.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to recover the \$291,813 from physicians for instances in which the same physicians reported more than one CPT code and received MCPs for monthly ESRD-related services provided to the same beneficiary for the same month of service (for claims that are within the 4-year reopening period).

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to recover the identified overpayments that are within the 4-year reopening period consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to instruct physicians refund to beneficiaries the \$1,092,149 in beneficiary cost sharing (deductible and coinsurance) amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. The Medicare contractors will instruct the physicians and nonphysician practitioners to refund any deductible or coinsurance amounts associated with the any cases where CMS determines an overpayment was made, and consistent with the rationale above, that may have been incorrectly collected from beneficiaries or from someone on their behalf.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to review the 1,598 claims totaling \$289,169 in MCPs for potentially duplicate claims and \$74,563 in associated beneficiary cost sharing (deductible and coinsurance amounts) and determine which of the claims should have been denied as a duplicate claim for ESRD-related services and recover the portion of any MCPs from the physicians for claims for duplicate services (that are within the 4-year reopening period), and recommend that the

physicians refund to beneficiaries the portion of the deductible and coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. As stated above, CMS's Recovery Audit Contractors were approved to begin reviewing this topic in December of 2018. CMS will review OIG's claims data to determine the appropriate course of action. CMS will recover, as appropriate, any identified overpayments associated with the review consistent with relevant law and the agency's policy and procedures. As part of this process, the Medicare contractors will instruct physicians or nonphysician practitioners 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 the Centers for Medicare & Medicaid Services direct the Medicare contractors to, based on the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify any of those who 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 physicians or nonphysician practitioners to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified physicians or nonphysician practitioners who billed multiple claims for the same beneficiary for the same month of service 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 direct the Medicare contractors to implement improved claims processing controls, including improved system edits, to prevent and detect overpayments of claims for duplicative services.

CMS Response

CMS concurs with this recommendation. CMS will evaluate opportunities to improve claims processing controls, including improved system edits, to prevent and detect overpayments for duplicate services.