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OFFICE OF INSPECTOR GENERAL

CODING TRENDS OF MEDICARE EVALUATION AND MANAGEMENT SERVICES

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EXECUTIVE SUMMARY: CODING TRENDS OF MEDICARE EVALUATION AND MANAGEMENT SERVICES
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WHY WE DID THIS STUDY

Between 2001 and 2010, Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion. During this same time, Medicare payments for evaluation and management (E/M) services increased by 48 percent, from $22.7 billion to $33.5 billion. E/M services have been vulnerable to fraud and abuse. In 2009, two health care entities paid over $10 million to settle allegations that they fraudulently billed Medicare for E/M services. The Centers for Medicare & Medicaid Services (CMS) also found that certain types of E/M services had the most improper payments of all Medicare Part B service types in 2008. This report is the first in a series of evaluations of E/M services. Subsequent evaluations will determine the appropriateness of Medicare payments for E/M services and the extent of documentation vulnerabilities in E/M services.

HOW WE DID THIS STUDY

Using the Part B Analytics Reporting System, we analyzed E/M services provided to beneficiaries to determine coding trends from 2001 to 2010. Using Part B Medicare claims data, we analyzed physicians' E/M claims to identify physicians who consistently billed higher level (i.e., more complex and more expensive) E/M codes in 2010. We did not determine whether the E/M claims from these physicians were inappropriate.

WHAT WE FOUND

From 2001 to 2010, physicians increased their billing of higher level E/M codes in all types of E/M services. Among these physicians, we identified approximately 1,700 who consistently billed higher level E/M codes in 2010. Although these physicians differed from others in their billing of E/M codes, they practiced in nearly all States and represented similar specialties. The physicians who consistently billed higher level E/M codes also treated beneficiaries of similar ages and with similar diagnoses as those treated by other physicians.

WHAT WE RECOMMEND

CMS concurred with our recommendations to (1) continue to educate physicians on proper billing for E/M services and (2) encourage its contractor to review physicians' billing for E/M services. CMS partially concurred with our third recommendation, to review physicians who bill higher level E/M codes for appropriate action.

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OBJECTIVES

1. To determine coding trends of Medicare evaluation and management (E/M) services from 2001 to 2010.
2. To identify and describe physicians who consistently billed higher level E/M codes in 2010.

BACKGROUND

E/M services are visits with beneficiaries by physicians and nonphysician practitioners, hereinafter referred to as physicians, to assess and manage patients' health.[1] Between 2001 and 2010, Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion. During this same time, Medicare payments for E/M services increased by 48 percent, from $22.7 billion to $33.5 billion.[2, 3] The number of E/M services billed also increased by 13 percent, from 346 million to 392 million.[4] Additionally, the average Medicare payment amount per E/M service increased by 31 percent, from approximately $65 to $85.[5]

E/M services have been vulnerable to fraud and abuse. In 2009, two health care entities paid over $10 million to settle allegations that they fraudulently billed Medicare for E/M services. One health care entity allegedly billed Medicare for higher levels of E/M services than were actually delivered to patients.[6] In a separate case, a health care entity allegedly submitted false claims to Medicare, which included E/M services as well as unnecessary home visits, tests, and procedures.[7] In 2008, the Centers for Medicare & Medicaid Services (CMS) found that

[1] American Medical Association (AMA), *Current Procedural Terminology* (CPT), 2010.

[2] Office of Inspector General (OIG) analysis of 2001 and 2010 Part B Analytic Reports (PBAR) National Procedure Summary File.

[3] Medicare payment refers to total Medicare-allowed amounts, which are 100 percent of the payment made to a physician by both Medicare and the beneficiary. Medicare pays 80 percent of allowed charges, and the beneficiary is responsible for the remaining 20 percent.

[4] OIG analysis of 2001 and 2010 PBAR National Procedure Summary File.

[5] Ibid.

[6] United States ex rel. Wendy Buterakos v. Ascension Health and Genesys Health System, Civil Action No. 06-10550 (E.D. Mich. 2009).

[7] United States and State of Michigan v. Visiting Physicians Association, Civil Action No. 09-1377 (E.D. Mich. 2009).

certain E/M visit types had the most improper payments of all Medicare Part B services.[8]

E/M services are grouped into visit types, such as office visits, hospital visits, and consultations. Each visit type reflects the type of service, the place of service, and the patient's status. For example, there are two types of office visits (new patient and established patient) and two types of hospital visits (initial and subsequent).

Most E/M services are billed using CPT codes that define the complexity level of the service.[9] Hereinafter, we refer to CPT codes that correspond to E/M services as "E/M codes." Each visit type has three to five E/M codes. Higher level codes represent more complex visits. For example, an office visit with a new patient can be billed using one of five E/M codes, from 99201 (the lowest complexity level code) to 99205 (the highest complexity level code). Medicare payment depends on the complexity of the visit. To illustrate, Medicare pays approximately $37 for 99201 and $191 for 99205.[10] Overall, payment rates for all E/M services ranged from $19 to $213 in 2010.

The level of an E/M service corresponds to the amount of skill, effort, time, responsibility, and medical knowledge required for the physician to deliver the service to the patient. To accurately determine the appropriate complexity level of an E/M service, physicians must use the following three key components: patient history, physical examination, and medical decisionmaking. See Appendix A for a description and an example of the three key components used in determining the appropriate complexity level for an E/M service.

Medicare Requirements for E/M Services

General provisions of the Social Security Act (the Act) govern Medicare reimbursement for all services, including E/M services. Section 1862(a)(1)(A) of the Act states that Medicare will cover only services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or to improve functioning.[11]

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[8] CMS, *Improper Medicare Fee-For-Service Payments Report - May 2008 Long Report*. Table 9a: Top 20 Service Types with Highest Improper Payments: Carriers and Medicare Administrative Contractors (MAC).

[9] AMA, *CPT*, 2010. Three visit types do not have complexity levels; these are hospital observation discharge services (99217), standby services (99360), and other E/M services (99499).

[10] OIG analysis of 2010 PBAR National Procedure Summary file.

[11] Social Security Act § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A).

In 1983, CMS adopted the CPT coding system as part of the Healthcare Common Procedure Coding System (HCPCS) and mandated that physicians use this system to bill E/M services. Physicians are responsible for billing the appropriate E/M code to Medicare. It is inappropriate for a physician to bill a higher level, more expensive code when a lower level, less expensive code is warranted.[12]

Physicians must also accurately and thoroughly document that the E/M service was reasonable and necessary. Section 1833(e) of the Act prohibits payment for a claim that is missing necessary information.[13] For E/M services, physicians must use either the *1995* or *1997 Documentation Guidelines for Evaluation and Management Services* to document the medical record with the appropriate clinical information.[14]

CMS routinely updates its coverage requirements for E/M services. In 2006, CMS implemented new E/M codes for visits in rest homes and nursing facilities based on AMA coding changes.[15] In 2010, CMS also discontinued payment of E/M codes for inpatient and outpatient consultations and required that physicians bill for these consultations using one of the remaining E/M codes that accurately represents the place of service and the complexity of the visit.[16, 17, 18]

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[12] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1. Accessed at https://www.cms.gov/manuals/downloads/clm104c12.pdf on May 16, 2011. See also Appendix A.

[13] Social Security Act § 1833(e), 42 U.S.C. § 1395l(e).

[14] CMS, *Evaluation and Management Services Guide 2010*. December 2010. Accessed at https://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf on June 14, 2011.

[15] CMS, Change Request 4212, Transmittal 775, *Home Care and Domiciliary Visits* (Dec. 2, 2005), which revised CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.14. Accessed at http://www.cms.gov/manuals/downloads/clm104c12.pdf on June 10, 2011.

[16] Consultations reflect a type of E/M service that involves a specific request for help with a diagnosis or course of treatment on a limited basis.

[17] CMS, *National Correct Coding Initiative Policy Manual for Medicare Services*. Ch. XI, version 16.3, p. 28, 2011.

[18] *CY 2010 Physician Fee Schedule Final Rule.* 74 Fed. Reg. 61738, 61767–78 (Nov. 5, 2009); CMS, Change Request 6740, Transmittal 1875, *Revisions to Consultation Services Payment Policy* (Dec. 14, 2009). Accessed at http://www.cms.gov/Transmittals/Downloads/R2282CP.pdf on September 6, 2011. Telehealth consultations are the only type of consultation not eliminated by CMS for Medicare payment. As of January 2010, physicians bill for these consultations using HCPCS codes G0425–G0427 (initial inpatient telehealth consultations) or G0406–G0408 (followup inpatient telehealth consultations).

Medicare Payments for E/M Services

The Omnibus Budget Reconciliation Act of 1989 mandated the establishment of the Medicare physician fee schedule, which sets payment rates for all physician services, including E/M services.[19, 20] See Appendix B for a list of visit types, E/M codes, complexity levels, and Medicare payment rates in 2010.

Payment rates for the Medicare physician fee schedule are updated each year using the sustainable growth rate (SGR) system, which is designed to control Medicare spending on physician services.[21] Medicare physician payment rates are adjusted to reflect differences between actual and target spending for certain types of Part B goods and services.[22] If actual spending for these goods and services exceeds target spending, physician payment rates are reduced. If actual spending for these goods and services is lower than target spending, physician payment rates are increased.[23]

Since the payment reduction in 2002, Congress has overridden SGR fee schedule reductions and has instead either maintained or moderately increased payment rates.[24] As a result of the legislative overrides, the SGR system requires that payment rates be reduced by about 30 percent in 2012.[25]

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[19] Omnibus Budget Reconciliation Act of 1989, P. L. No. 101-239 § 6102. Social Security Act § 1848, 42 U.S.C. 1395w-4. The Medicare physician fee schedule is derived using a resource-based relative value scale, which includes three resource components: (1) total physician work, (2) practice expenses, and (3) malpractice expenses. Each component is measured in terms of relative value units (RVUs). The Medicare physician fee schedule payment rates are based on RVUs, adjusted for geography, and multiplied by a national conversion factor to derive dollar amounts.

[20] Section 1848(a)(1) of the Act established the Medicare physician fee schedule as the basis for Medicare reimbursement for all physician services beginning in January 1992.

[21] Social Security Act § 1848(f), 42 U.S.C. §1395w-4(f).

[22] Annual spending targets are updated each year by applying a growth rate known as the sustainable growth rate (SGR). The SGR formula incorporates four factors: (1) inflation, (2) changes in enrollment in Medicare's fee-for-service program, (3) the estimated 10-year average annual growth rate of real gross domestic product per capita, and (4) the impact of changes in law or regulation. These factors are multiplied to yield an overall rate of growth. To determine the next year's spending target, the previous year's target is increased by the overall rate of growth estimated for the next year.

[23] Congressional Budget Office (CBO), *The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates*, September 2006, p. 5. Accessed at http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf on June 20, 2011.

[24] CMS, *Letter to the Medicare Payment Advisory Commission (MedPAC) regarding the CY 2012 Physician Fee Schedule*, March 2011. Accessed at http://www.cms.gov/SustainableGRatesConFact/ on June 20, 2011.

[25] CBO, *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies*, June 2011. Accessed at http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf on August 12, 2011.

Medicare Claims Processing and Program Safeguards

CMS uses several contractors to prevent and reduce Medicare fraud, waste, and abuse. Specifically, CMS contracts with MACs to process and pay Medicare claims. MACs are responsible for conducting medical reviews and developing provider education on identified areas of vulnerability.[26] They also create local coverage determinations, implement electronic edits, or use proactive data analysis to monitor areas of vulnerability.[27]

Additionally, CMS contracts with Recovery Audit Contractors (RAC) to identify improper payments. RACs are responsible for conducting postpayment reviews to identify and correct improper payments.[28] If an improper payment is identified, RACs notify MACs to take administrative action.

CMS contracts with Zone Program Integrity Contractors (ZPIC) to identify and prevent fraud and abuse.[29] ZPICs are responsible for conducting investigations, developing cases of suspected fraud, and referring cases to law enforcement, as appropriate.[30]

CMS has one contractor that produces comparative billing reports, which show a physician's billing pattern for various procedures or services and compares that physician's billing pattern to those of his or her peers.[31] Comparative billing reports provide details about physicians' coding and billing practices to prevent improper payments.

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[26] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch.1, § 1.3.1. Accessed at http://www.cms.gov/manuals/downloads/pim83c01.pdf on May 6, 2011.

[27] Proactive data analysis includes identifying patterns of potential billing errors concerning Medicare coverage and physician coding through data analysis and evaluation of other information.

[28] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch.1, § 1.3.1. Accessed at http://www.cms.gov/manuals/downloads/pim83c01.pdf on May 6, 2011. Postpayment review includes both automated (medical record not needed) and complex (medical record needed) reviews.

[29] The Medicare Prescription Drug, Improvement and Modernization Act of 2003, P.L. No. 108-173 § 911, required CMS to replace its current claims processing contractors (fiscal intermediaries and carriers) with MACs. Also, CMS is in the process of replacing the legacy benefit integrity contractors, known as Program Safeguard Contractors, with ZPICs.

[30] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 1, § 1.7.B. Accessed at http://www.cms.gov/manuals/downloads/pim83c01.pdf on May 6, 2011.

[31] Safeguard Services, LLC. *Comparative Billing Report Services Overview*. Accessed at http://www.safeguard-servicesllc.com/cbr/default.asp on November 1, 2011.

Related OIG Work

In 2006, OIG reported that 75 percent of consultations, one type of E/M service, did not meet Medicare coverage requirements, resulting in $1.1 billion in improper Medicare payments.[32] The report also found that consultations billed at the highest level were miscoded 95 percent of the time. As of 2010, CMS discontinued the payment of E/M consultation codes.[33]

OIG is conducting a series of evaluations of E/M services provided to Medicare beneficiaries in 2010. OIG plans to issue two others in addition to this report. One will determine the appropriateness of Medicare payments for E/M services.[34] The other will assess the extent of documentation vulnerabilities in E/M services using electronic health record systems.[35]

METHODOLOGY

To analyze coding trends from 2001 to 2010, we used the PBAR National Procedure Summary files. To analyze physician billing patterns, we used the carrier file from the National Claims History (NCH) file in 2010. We limited our analysis to E/M codes that correspond to visit types with three to five levels.[36] We did not determine whether the services billed by physicians who consistently billed higher level E/M codes were inappropriate or fraudulent.

Determining the Coding Trends of E/M Services From 2001 to 2010

Using PBAR data files, we determined the coding trends of E/M services from 2001 to 2010. The PBAR data files include the total number of services and payments for each E/M code. For each year, we calculated the frequency with which physicians billed E/M codes to Medicare.

[32] OIG, *Consultations in Medicare: Coding and Reimbursement*, OEI-09-02-00030, March 2006.

[33] 74 Fed. Reg. 61738, 61768 (Nov. 25, 2009).

[34] OEI-04-10-00181, in progress.

[35] OEI-04-10-00182, in progress.

[36] The excluded E/M codes represent 6 percent of Medicare payments for E/M services in 2010. These E/M codes are: 12 codes that represent the length of the visit as either more or less than a time threshold (99238–99239, 99291–99292, 99315–99316, 99354–99357, and 99406–99407), 2 stand-alone E/M codes (99217 and 99318), unlisted E/M service (99499), and codes with under $100,000 in Medicare payments in 2010.

Identifying and Describing Physicians Who Consistently Billed Higher Level E/M Codes in 2010

Using the 2010 NCH Carrier file, we identified all physicians who performed at least 100 Medicare E/M services in 2010.[37] To identify physicians who consistently billed higher level E/M codes, we first identified physicians whose average E/M code level was in the top 1 percent of their specialties.[38, 39] From that subset of physicians, we identified those who billed the two highest codes within a visit type at least 95 percent of the time. Physicians who met both criteria are hereinafter referred to as physicians who consistently billed the two highest level E/M codes. The remaining physicians are referred to as other physicians.

Using the 2010 NCH file, we identifed the State and specialty for each physician.[40] We also used this file to analyze the ages and diagnoses of beneficiaries treated by each physician.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

[37] We used the National Provider Identifier (NPI) field from the NCH Carrier file to determine the number of physicians, and we did not verify whether those NPIs were valid. Claims submitted by physicians who provided fewer than 100 E/M services represented less than 2 percent of Medicare payments and approximately 30 percent of all physicians who provided E/M services.

[38] Physicians who provided E/M services in 2010 represented 66 specialties.

[39] We calculated each physician's average percentile in his or her specialty across all visit types, weighted by volume, to account for differences in the frequency of billing E/M codes for each specialty.

[40] We selected the physician's State listed on the claim. This variable includes 50 States and the District of Columbia, as well as Puerto Rico, the Virgin Islands, U.S. possessions, and Guam.

FINDINGS

From 2001 to 2010, physicians increased their billing of higher level E/M codes in all visit types

Based on the percentage of services billed for each E/M code within each visit type, physicians increased their billing of higher level (i.e., more complex and more expensive) E/M codes in all 15 visit types from 2001 to 2010.[41] Appendix C shows the percentage of services billed for each E/M code in all visit types from 2001 to 2010.

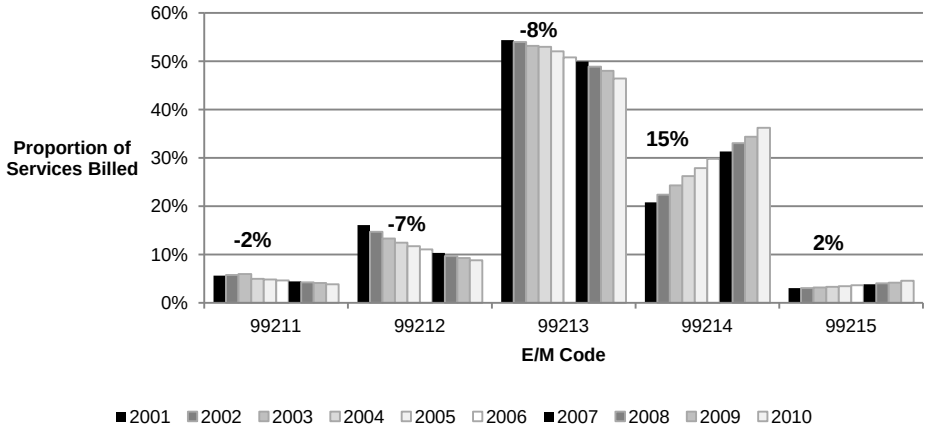
To illustrate the shift in physicians' billing of higher level E/M codes, we provide details on three visit types: (1) established patient office visits, (2) subsequent inpatient hospital care, and (3) emergency department visits. Large proportions of Medicare payments went for these three visit types in 2010, and different types of shifts in billing to higher level codes were made in each type.

Established patient office visits

This visit type represented the largest amount of Medicare payments for E/M services in 2010. Figure 1 shows the percentage of these services billed for each E/M code from 2001 to 2010, with the percentage difference between 2001 and 2010 above each code's set of bars. While the middle code (99213) was billed most often during the 10-year period of our review, there was a shift in billing from the three lower level E/M codes to the two higher level codes. Combined, physicians increased their billing of the two highest level E/M codes (99214 and 99215) by 17 percent from 2001 to 2010.

[41] From 2001 to 2009, there were 15 visit types for E/M services. In 2010, inpatient and outpatient consultations were no longer permitted by CMS for payment, resulting in 13 visit types. Therefore, the trends for consultations are from 2001 to 2009.

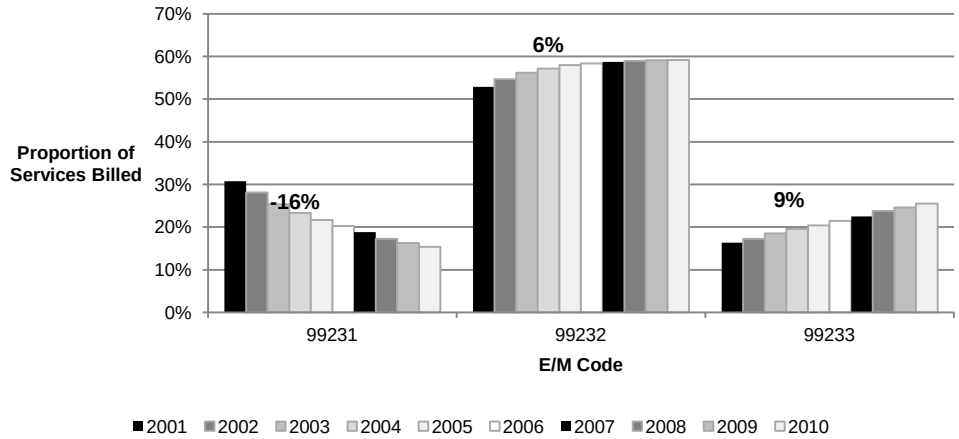
Figure 1: Percentage of E/M Codes Billed for Established Patient Office Visits From 2001 to 2010



Subsequent inpatient hospital care

This visit type represented the second-largest amount of Medicare payments for E/M services in 2010. Figure 2 shows the percentage of these services billed for each E/M code from 2001 to 2010, with the percentage difference between 2001 and 2010 above each code's set of bars. In 10 years, physicians' billing shifted from lower level to higher level codes. For example, the billing of the lowest level code (99231) decreased 16 percent, while the billing of the two higher level codes (99232 and 99233) increased 6 and 9 percent, respectively.

Figure 2: Percentage of E/M Codes Billed for Subsequent Inpatient Hospital Care From 2001 to 2010

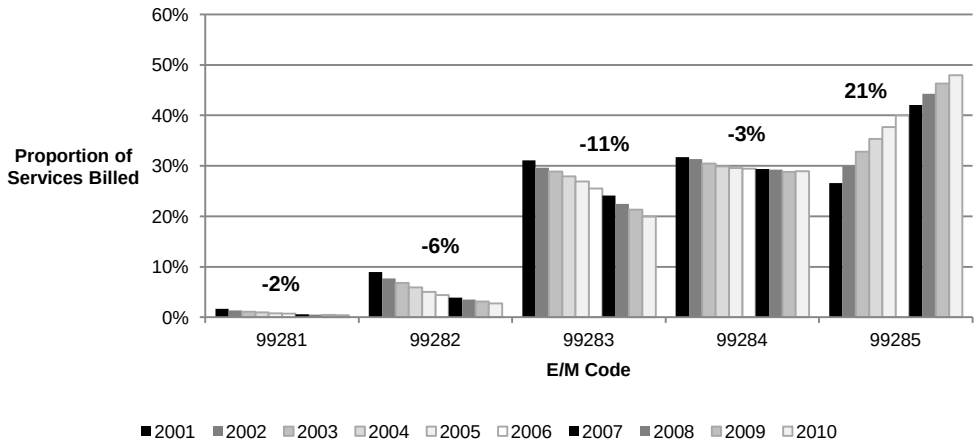


Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Emergency department visits

This visit type represented the fifth-largest amount of Medicare payments for E/M services in 2010. Figure 3 shows the percentage of these services billed for each E/M code from 2001 to 2010, with the percentage difference between 2001 and 2010 above each code's set of bars. In 10 years, physicians' billing of the highest level code (99285) rose 21 percent, increasing from 27 to 48 percent. During the same time, physicians' billing of all other codes decreased. Physicians billed the lowest level code (99281) less than 3 percent of the time.

Figure 3: Percentage of E/M Codes Billed for Emergency Department Visits From 2001 to 2010



*Percentages do not sum to zero because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

In 2010, approximately 1,700 physicians consistently billed higher level E/M codes

In 2010, nearly 370 million E/M services were provided by approximately 442,000 physicians nationwide. Of that population, 3,008 had an average E/M code level in the top 1 percent of their specialties. Among these physicians, 1,669 billed the 2 highest level E/M codes within a visit type at least 95 percent of the time. These 1,669 physicians represented less than 1 percent of all physicians who performed E/M services in 2010. These physicians substantially differed from others in their billing of E/M codes.

In total, Medicare paid almost $108 million for E/M services performed by physicians who consistently billed the two highest level E/M codes in 2010. On average, physicians who consistently billed the two highest level E/M codes did so 98 percent of the time in 2010, compared to others who billed these codes 53 percent of the time.

As a result, Medicare paid on average $205 more per beneficiary and $43 more per E/M service to physicians who consistently billed higher level codes. Of these physicians, 916 billed the two highest level codes 100 percent of the time, corresponding to $54 million in Medicare payments. Table 1 compares the E/M coding groups.

Table 1: Number of Physicians, Beneficiaries, E/M Services, and Average Medicare Payment per E/M Service and per Beneficiary by E/M Coding Group in 2010

E/M Coding Group	Number of Physicians	Number of Beneficiaries	Number of E/M Services	Average Medicare Payment per E/M Service	Average Medicare Payment per Beneficiary
Physicians Who Consistently Billed Higher Level E/M Codes	1,669	76,132	828,646	$131.24	$426.56
Other Physicians	440,321	29,950,855	368,800,457	$88.25	$221.62
Total	**441,990**	**30,026,987**	**369,629,103**	**--**	**--**

Source: OIG analysis of 2010 NCH Carrier file.

Physicians who consistently billed higher level E/M codes practiced in nearly all States, represented similar specialties, and treated beneficiaries of similar ages and with similar diagnoses as those of other physicians

Physicians who consistently billed higher level E/M codes practiced in most (47 of 50) States as well as the District of Columbia, the Virgin Islands, and Puerto Rico.[42, 43] However, some States had a greater percentage of these physicians compared to their percentage of other physicians. For example, California had 17 percent of physicians who consistently billed higher level E/M codes compared to 8 percent of other physicians. See Appendix D for the percentage of physicians in each State by E/M coding group.

Overall, physicians who billed for E/M services represented 66 specialties, with most specializing in internal medicine, family practice, and emergency medicine. Physicians who consistently billed the two highest level E/M codes collectively represented 80 percent (53 of 66) of those specialties. Of these physicians, the majority also specialized in internal medicine, family practice, and emergency medicine. Table 2 shows the six specialties with the largest percentage of physicians by E/M coding group in 2010.

[42] Three States (Montana, Nebraska, and Wyoming), U.S. possessions, and Guam did not have physicians who consistently billed higher level codes in 2010.

[43] Less than 1 percent of physicians (114 of 441,990) did not provide information in their claims data about their practice locations.

Table 2: Specialties With the Largest Percentage of Physicians by E/M Coding Group in 2010

Specialty	Physicians Who Consistently Billed Higher Level E/M Codes	Other Physicians
Internal Medicine	19.8%	18.1%
Family Practice	12.2%	14.7%
Emergency Medicine	9.9%	7.1%
Nurse Practitioner	4.4%	5.2%
Obstetrics and Gynecology	4.3%	1.9%
Cardiovascular Disease, Cardiology	4.0%	4.8%
Total*	**54.6%**	**51.8%**

*The remaining specialties represented 45.4 percent of physicians who consistently billed higher level E/M codes and 48.2 percent of other physicians.
Source: OIG analysis of 2010 NCH Carrier file.

Further, 28 specialties (42 percent) had less than 1 percent of physicians who consistently billed higher level E/M codes. See Appendix E for the percentage of physicians in each specialty by E/M coding group.

Approximately 30 million beneficiaries received E/M services from physicians in 2010. Overall, physicians who consistently billed the two highest level E/M codes and other physicians treated beneficiaries of similar ages. Beneficiaries treated by physicians who consistently billed higher level E/M codes were on average 70 years old. Beneficiaries treated by other physicians were on average 72 years old.

Physicians who consistently billed higher level E/M codes had beneficiaries with diagnoses similar to those of beneficiaries treated by other physicians. Appendix F lists the most common diagnoses in 2010 and the percentage of services listing the diagnosis for each E/M coding group. Approximately the same percentage of beneficiaries were diagnosed with the three most common diagnoses for each E/M coding group: hypertension (6 percent), benign hypertension (6 percent), and type II diabetes (4 percent).

CONCLUSION AND RECOMMENDATIONS

Between 2001 and 2010, Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion. During this same time, Medicare payments for E/M services increased by 48 percent, from $22.7 billion to $33.5 billion. Several factors contributed to these overall increases, including increases in the number of services provided and in the average payment rate for E/M services.

However, changes in physicians' billing of E/M codes also contributed to this increase. Based on the percentage of services billed for each E/M code within each visit type, we found that physicians increased their billing of higher level, more complex and expensive E/M codes and reduced their billing of lower level, less complex and expensive E/M codes in all 15 visit types from 2001 to 2010.

In addition, approximately 1,700 physicians billed higher level, more complex and expensive E/M codes in 2010 at least 95 percent of the time. Although these physicians differed from others in their billing of E/M codes, they practiced in nearly all States, represented similar specialties, and treated beneficiaries of similar ages and with similar diagnoses.

This report is the first in a series of evaluations of E/M services. We did not determine whether physicians who billed higher level E/M codes in 2010 billed inappropriately. Subsequent evaluations will determine the appropriateness of Medicare payments for E/M services and the extent of documentation vulnerabilities in E/M services.

Therefore, we recommend that CMS:

Continue To Educate Physicians on Proper Billing for E/M Services

CMS should continue to provide educational outreach on E/M services to physicians. These efforts can focus on how to determine the appropriate E/M code for the service provided and the criteria used in making that determination, particularly for visit types that experienced shifts in billing.

Educational outreach to physicians is a longstanding and widespread activity that CMS undertakes to inform physicians about the specific policies, rules, and regulations relevant to the services they provide. Outreach can include letters that describe inappropriate billing practices, face-to-face meetings, telephone conferences, seminars, and workshops.

Encourage Its Contractor To Review Physicians' Billing for E/M Services

CMS should encourage its contractor to review physicians' billing for E/M services and produce comparative billing reports. Such reports provide a documented analysis of a physician's billing pattern compared to those of his or her peers. These reports provide helpful insights into physicians' billing patterns to avoid improper Medicare payments. CMS may also find these reports helpful for identifying and monitoring physicians who consistently bill higher level E/M codes.

Review Physicians Who Bill Higher Level E/M Codes for Appropriate Action

CMS should conduct additional reviews of physicians who consistently bill higher level E/M codes to ensure that their claims are appropriate. If CMS determines that inappropriate claims have been paid, it should take steps to recover those overpayments. To assist CMS, we have separately provided a list of the approximately 1,700 physicians we identified as consistently billing higher level E/M codes in 2010. We will also consider these physicians for further review in our continuing series of evaluations of E/M services.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our first and second recommendations and partially concurred with our third recommendation. With regard to our first recommendation, CMS recently updated E/M educational products and is seeking new ways of educating providers on proper billing for E/M services, such as exploring the use of Web-based learning tools.

With regard to the second recommendation, CMS will issue a Technical Direction Letter to MACs with a link to our report. CMS will also inform MACs that our findings are informational and shall be considered a source of data as MACs prioritize workloads. CMS is also planning to develop and issue a comparative billing report aimed at 5,000 physicians across the country who have consistently billed for high level E/M codes. The report, which will include the 1,700 physicians identified in our study, is not intended to be punitive or to be an indication of fraud, but is intended to be proactive and will provide information about the physicians' coding and billing practices. According to CMS, this should help providers identify potential errors in billing practices and make changes to help prevent improper billing and payment in the future.

With regard to the third recommendation, CMS stated that it will take appropriate action and forward the names of the 1,700 physicians to MACs. CMS will direct each MAC to focus on the top 10 high billers in its jurisdiction. CMS stated that it and its contractors must weigh the cost and benefit of E/M reviews against reviews of more costly Part B services.

We support CMS's efforts to address these issues and encourage it to continue making progress. For the full text of CMS's comments, see Appendix G. We did not make any changes to the report based on CMS's comments.

APPENDIX A

Three Key Components Used To Determine the Appropriate Complexity Level for an Evaluation and Management Service

As defined by the Current Procedural Terminology (CPT) manual, evaluation and management (E/M) codes, which correspond to three to five complexity levels within a visit type, include seven basic components: patient history, physical examination, medical decisionmaking, counseling, coordination of care, the nature of the patient's presenting problem (i.e., the reason for the visit), and time. The first three components are key to determining the correct E/M code. The next three are contributory factors to selecting the correct code, meaning that these components are not required for every patient visit. Time is the final component. The physician must use the following three key components to determine the appropriate code:[44]

1. Extent of patient history—physicians use their clinical judgment and assess the nature of the patient's presenting problems to determine the depth of the history needed to complete the service. A patient history can be classified into one of four types:
   - problem focused (brief history of present illness or problem);
   - expanded problem focused (brief history of present illness with problem-pertinent system review);
   - detailed (extended history of present illness with pertinent past, family, and social history directly related to the presenting problem; includes review of a limited number of additional systems); and
   - comprehensive (extended history of present illness with review of body systems directly related to the patient's problems; complete past, family, and social history).
2. Extent of physical examination—based on clinical judgment and the presenting medical problems, the physician can perform one of four types of examination:

[44] The requirements for each key component are summarized in this Appendix. The full requirements for each key component are available in the *1995* and *1997 Documentation Guidelines for Evaluation and Management Services*. Accessed at https://www.cms.gov/MLNProducts/Downloads/1995dg.pdf and https://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf on September 15, 2011.

- problem focused (limited examination of the affected body area or organ system),
- expanded problem focused (limited examination of affected area or systems with other symptomatic or related organ systems),
- detailed (extended examination of affected body area and other related systems), and
- comprehensive (a general multisystem examination or a complete examination of a single organ system).

3. Complexity of the physician's medical decisionmaking—based on factors needed to establish a diagnosis and/or select a management option:
   - the number of possible diagnoses or the number of options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and other information that physicians must obtain, review, and analyze; and the risk of significant complications, morbidity, and/or mortality; and
   - four types of medical decisionmaking are recognized: straightforward, low complexity, moderate complexity, and high complexity.

Table A-1 illustrates the key components used to determine the appropriate E/M code for a new patient office visit. There are five levels of complexity for this office visit. Physicians must document the medical record with the appropriate information to support the E/M code billed to Medicare.

Table A-1: Key Components Used To Determine the Appropriate E/M Code for a New Patient Office Visit

E/M Code	Presenting Problem(s)	Key Components		
		Patient History Type	Examination Type	Medical Decisionmaking Type
99201	Self-limited or minor; the physician typically spends 10 minutes face-to-face with the patient and/or family	Problem focused	Problem focused	Straightforward
99202	Low to moderate severity; the physician typically spends 20 minutes face-to-face with the patient and/or family	Expanded problem focused	Expanded problem focused	Straightforward
99203	Moderate severity; the physician typically spends 30 minutes face-to-face with the patient and/or family	Detailed	Detailed	Low complexity
99204	Moderate to high severity; the physician typically spends 45 minutes face-to-face with the patient and/or family	Comprehensive	Comprehensive	Moderate complexity
99205	Moderate to high severity; the physician typically spends 60 minutes face-to-face with the patient and/or family	Comprehensive	Comprehensive	High complexity

Source: The Centers for Medicare & Medicaid Services' *Evaluation & Management Services Guide 2010.* Available online at https://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf. Accessed on September 14, 2011.

APPENDIX B

Visit Types, Evaluation and Management Codes, Complexity Levels, and Medicare Payment Rates in 2010

Visit Type	E/M Code*	Complexity Level	2010 Average Medicare Payment Rate	2010 Total Medicare Payments	Percentage of Total Medicare Payments
New Patient Office Visit	99201	Low	$36.62	$15,623,525	8.8%
	99202	Medium-low	$65.26	$198,932,791	
	99203	Medium	$96.60	$865,066,628	
	99204	Medium-high	$151.33	$1,266,274,265	
	99205	High	$190.56	$613,011,381	
Established Patient Office Visit	99211	Low	$19.04	$158,096,550	48.3%
	99212	Medium-low	$38.14	$720,721,085	
	99213	Medium	$64.80	$6,467,110,957	
	99214	Medium-high	$97.35	$7,580,662,763	
	99215	High	$132.14	$1,307,379,597	
Initial Observation Care	99218	Low	$63.30	$7,081,475	0.4%
	99219	Medium	$105.67	$39,038,293	
	99220	High	$148.93	$83,259,376	
Initial Inpatient Hospital Care	99221	Low	$95.98	$185,197,152	10.0%
	99222	Medium	$131.31	$969,495,783	
	99223	High	$193.55	$2,203,799,227	
Subsequent Inpatient Hospital Care	99231	Low	$38.29	$494,267,314	18.3%
	99232	Medium	$70.01	$3,484,362,095	
	99233	High	$100.97	$2,162,757,831	
Observation or Inpatient Hospital Care	99234	Low	$130.76	$8,893,024	0.2%
	99235	Medium	$171.43	$25,926,468	
	99236	High	$213.60	$31,612,362	
Office/Outpatient Consultation**	99241	Low	$0.00	$0	0.0%
	99242	Medium-low	$0.00	$0	
	99243	Medium	$33.25	$133	
	99244	Medium-high	$0.00	$0	
	99245	High	$1.00	$3	
Inpatient Consultation**	99251	Low	$0.00	$0	0.0%
	99252	Medium-low	$34.92	$70	
	99253	Medium	$51.95	$104	
	99254	Medium-high	$2.69	$527	
	99255	High	$41.14	$123	

*E/M codes are evaluation and management codes.
**Effective January 1, 2010, the consultation codes were no longer recognized by the Centers for Medicare & Medicaid Services for Medicare Part B payment. The average Medicare payment amount and total Medicare payments for consultation codes in 2010 are from claims in our data that were paid improperly.

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Visit Types, Evaluation and Management Codes, Complexity Levels, and Medicare Payment Rates in 2010 (Continued)

Visit Type	E/M Code	Complexity Level	2010 Average Medicare Payment Rate	2010 Total Medicare Payments	Percentage of Total Medicare Payments
Emergency Department Visit	99281	Low	$20.38	$1,635,403	7.4%
	99282	Medium-low	$39.76	$20,976,556	
	99283	Medium	$60.58	$230,221,062	
	99284	Medium-high	$115.75	$638,227,691	
	99285	High	$172.91	$1,579,304,457	
Initial Nursing Facility Care	99304	Low	$86.38	$24,933,368	1.0%
	99305	Medium	$121.58	$100,300,736	
	99306	High	$155.65	$194,595,076	
Subsequent Nursing Facility Care	99307	Low	$40.67	$150,954,283	4.2%
	99308	Medium-low	$62.28	$572,235,515	
	99309	Medium-high	$81.70	$538,574,010	
	99310	High	$119.48	$132,388,679	
New Patient Domiciliary/Rest Home Visit	99324	Low	$54.82	$2,744,951	0.1%
	99325	Medium-low	$80.49	$3,363,321	
	99326	Medium	$131.20	$4,760,505	
	99327	Medium-high	$169.94	$5,957,293	
	99328	High	$199.00	$4,700,288	
Established Patient Domiciliary/Rest Home Visit	99334	Low	$57.32	$22,684,625	0.6%
	99335	Medium-low	$87.86	$61,796,402	
	99336	Medium-high	$121.31	$85,457,177	
	99337	High	$172.64	$30,917,995	
New Patient Home Visit	99341	Low	$56.51	$1,392,733	0.1%
	99342	Medium-low	$82.67	$4,544,302	
	99343	Medium	$132.72	$6,150,275	
	99344	Medium-high	$172.14	$10,933,245	
	99345	High	$206.24	$14,233,439	
Established Patient Home Visit	99347	Low	$56.02	$12,219,650	0.8%
	99348	Medium-low	$84.21	$47,388,999	
	99349	Medium-high	$121.05	$116,579,054	
	99350	High	$164.83	$78,267,681	
Total*				**$33,587,009,674**	**100%**

*Total does not sum to 100 percent because of rounding.

Source: Office of Inspector General analysis of 2010 Part B Analytic Reports National Procedure Summary file.

APPENDIX C

Coding Trends for Evaluation and Management Codes in All Visit Types from 2001 to 2010

Table C-1: Established Patient Office Visit

	Percentage of Services**										Difference Between 2001 and 2010
E/M Code*	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99211	6%	6%	6%	5%	5%	5%	4%	4%	4%	4%	(2%)
99212	16%	15%	13%	12%	12%	11%	10%	10%	9%	9%	(7%)
99213	54%	54%	53%	53%	52%	51%	50%	49%	48%	46%	(8%)
99214	21%	22%	24%	26%	28%	30%	31%	33%	34%	36%	15%
99215	3%	3%	3%	3%	3%	4%	4%	4%	4%	5%	2%

*E/M codes are evaluation and management codes.
**Percentages may not sum to 100 because of rounding.
Source: Office of Inspector General (OIG) analysis of Part B Analytics Reports (PBAR) National Procedure Summary files from 2001 to 2010.

Table C-2: Subsequent Inpatient Hospital Care

	Percentage of Services*										Difference Between 2001 and 2010
E/M Code	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99231	31%	28%	25%	23%	22%	20%	19%	17%	16%	15%	(16%)
99232	53%	55%	56%	57%	58%	58%	59%	59%	59%	59%	6%
99233	16%	17%	18%	20%	20%	21%	23%	24%	25%	25%	9%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-3: Initial Inpatient Hospital Care

	Percentage of Services*										Difference Between 2001 and 2010
E/M Code	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99221	7%	6%	6%	5%	5%	5%	5%	5%	5%	9%	2%
99222	39%	38%	37%	36%	36%	35%	33%	32%	32%	36%	(3%)
99223	54%	56%	57%	59%	59%	60%	62%	63%	64%	55%	1%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-4: New Patient Office Visit

	Percentage of Services*										Difference Between 2001 and 2010
E/M Code	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99201	5%	5%	4%	4%	3%	3%	3%	3%	3%	2%	(2%)
99202	25%	24%	23%	22%	21%	21%	20%	19%	19%	13%	(12%)
99203	37%	38%	39%	40%	41%	42%	42%	43%	43%	37%	0%
99204	23%	24%	25%	26%	26%	26%	26%	27%	27%	35%	12%
99205	9%	9%	9%	9%	9%	9%	8%	8%	8%	13%	4%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-5: Emergency Department Visit

E/M Code	Percentage of Services*										Difference Between 2001 and 2010
	2001	2002	2003	2004	2005	2006	2007	2008	2009[+]	2010[+]	
99281	2%	1%	1%	1%	1%	1%	1%	1%	0%	0%	(2%)
99282	9%	8%	7%	6%	5%	4%	4%	3%	3%	3%	(6%)
99283	31%	30%	29%	28%	27%	25%	24%	22%	21%	20%	(11%)
99284	32%	31%	30%	30%	30%	29%	29%	29%	29%	29%	(3%)
99285	27%	30%	33%	35%	38%	40%	42%	44%	46%	48%	21%

*Percentages may not sum to 100 because of rounding.
[+]The percentages for E/M code 99281 in 2009 and 2010 are nonzero values that round to 0 percent.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-6: Subsequent Nursing Facility Care

E/M Code	Percentage of Services*										Difference Between 2006 and 2010**
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99311	40%	36%	33%	30%	28%	--	--	--	--	--	--
99312	48%	49%	51%	52%	54%	--	--	--	--	--	--
99313	12%	14%	17%	18%	18%	--	--	--	--	--	--
99307	--	--	--	--	--	24%	21%	20%	19%	18%	(6%)
99308	--	--	--	--	--	45%	45%	45%	45%	45%	0%
99309	--	--	--	--	--	26%	28%	29%	30%	32%	6%
99310	--	--	--	--	--	5%	6%	6%	6%	5%	0%

*Percentages may not sum to 100 because of rounding.
**As of 2006, the E/M codes 99311–99313 were eliminated and replaced with E/M codes 99307–99310. For this reason, we determined the difference in the percentage of services between 2006 and 2010 rather than between 2001 and 2010.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-7: Initial Nursing Facility Care

E/M Code	Percentage of Services*										Difference Between 2006 and 2010**
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99301	18%	16%	15%	14%	13%	--	--	--	--	--	--
99302	30%	30%	28%	28%	28%	--	--	--	--	--	--
99303	51%	54%	57%	58%	59%	--	--	--	--	--	--
99304	--	--	--	--	--	12%	10%	9%	9%	12%	0%
99305	--	--	--	--	--	34%	32%	31%	32%	35%	1%
99306	--	--	--	--	--	54%	58%	59%	59%	53%	(1%)

*Percentages may not sum to 100 because of rounding.
**As of 2006, the E/M codes 99301–99303 were eliminated and replaced with E/M codes 99304–99306. For this reason, we determined the difference in the percentage of services between 2006 and 2010 rather than between 2001 and 2010.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-8: Established Patient Home Visit

E/M Code	Percentage of Services*										Difference Between 2001 and 2010
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99347	23%	20%	19%	17%	16%	14%	12%	11%	11%	10%	(13%)
99348	36%	35%	33%	31%	31%	29%	28%	27%	26%	25%	(11%)
99349	29%	31%	34%	35%	37%	41%	42%	42%	42%	43%	14%
99350	12%	13%	15%	16%	16%	16%	18%	20%	21%	21%	9%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-9: Established Patient Domiciliary/Rest Home Visit

E/M Code	Percentage of Services*										Difference Between 2006 and 2010**
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99331	38%	34%	30%	28%	27%	--	--	--	--	--	--
99332	46%	48%	49%	50%	51%	--	--	--	--	--	--
99333	15%	18%	20%	22%	22%	--	--	--	--	--	--
99334	--	--	--	--	--	26%	23%	22%	21%	20%	(6%)
99335	--	--	--	--	--	39%	38%	36%	36%	35%	(4%)
99336	--	--	--	--	--	28%	33%	35%	35%	36%	8%
99337	--	--	--	--	--	7%	7%	8%	9%	9%	2%

*Percentages may not sum to 100 because of rounding.
**As of 2006, the E/M codes 99331–99333 were eliminated and replaced with E/M codes 99334–99337. For this reason, we determined the difference in the percentage of services between 2006 and 2010 rather than between 2001 and 2010.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-10: Initial Observation Care

E/M Code	Percentage of Services*										Difference Between 2001 and 2010
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99218	21%	18%	17%	15%	14%	13%	12%	12%	11%	11%	(10%)
99219	43%	43%	42%	41%	41%	40%	39%	37%	36%	36%	(7%)
99220	36%	39%	41%	44%	45%	47%	49%	51%	53%	54%	18%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-11: Observation or Inpatient Hospital Care

E/M Code	Percentage of Services*										Difference Between 2001 and 2010
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99234	30%	28%	26%	25%	24%	23%	22%	22%	20%	19%	(11%)
99235	42%	42%	42%	42%	42%	42%	41%	41%	42%	41%	(1%)
99236	28%	30%	31%	32%	34%	35%	37%	37%	38%	40%	12%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-12: New Patient Home Visit

E/M Code	Percentage of Services*										Difference Between 2001 and 2010
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99341	24%	21%	18%	16%	14%	13%	12%	11%	10%	10%	(14%)
99342	28%	27%	26%	26%	24%	23%	23%	22%	22%	21%	(7%)
99343	17%	18%	19%	19%	19%	19%	20%	18%	18%	18%	1%
99344	14%	17%	19%	19%	21%	21%	21%	21%	23%	25%	11%
99345	16%	17%	18%	20%	21%	23%	25%	27%	27%	27%	11%

*Percentages may not sum to 100 because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-13: New Patient Domiciliary/Rest Home Visit

E/M Code	Percentage of Services*										Difference Between 2006 and 2010**
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99321	36%	34%	32%	30%	29%	--	--	--	--	--	--
99322	37%	36%	37%	36%	37%	--	--	--	--	--	--
99323	27%	30%	32%	34%	34%	--	--	--	--	--	--
99324	--	--	--	--	--	29%	29%	28%	28%	27%	(2%)
99325	--	--	--	--	--	28%	25%	25%	24%	22%	(6%)
99326	--	--	--	--	--	20%	19%	18%	19%	19%	(1%)
99327	--	--	--	--	--	14%	17%	17%	17%	19%	5%
99328	--	--	--	--	--	10%	11%	12%	13%	13%	3%

*Percentages may not sum to 100 because of rounding.
**As of 2006, the E/M codes 99321–99323 were eliminated and replaced with E/M codes 99324–99328. For this reason, we determined the difference in the percentage of services between 2006 and 2010 rather than between 2001 and 2010.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-14: Inpatient Consultation

E/M Code	Percentage of Services*										Difference Between 2001 and 2009**
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99251	4%	4%	3%	3%	3%	2%	2%	2%	2%	--	(2%)
99252	10%	10%	9%	9%	8%	8%	7%	7%	7%	--	(3%)
99253	26%	26%	26%	25%	25%	25%	25%	24%	25%	--	(1%)
99254	39%	40%	41%	42%	43%	43%	44%	44%	45%	--	6%
99255	20%	20%	21%	21%	21%	21%	22%	22%	22%	--	2%

*Percentages may not sum to 100 because of rounding.
**As of January 2010, the Centers for Medicare & Medicaid Services (CMS) no longer recognizes for Medicare payment the E/M codes for consultations. For this reason, we determined the difference in the percentage of services between 2001 and 2009 rather than between 2001 and 2010. However, there were some inappropriately paid claims, which we do not include in this table.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Table C-15: Office/Outpatient Consultation

E/M Code	Percentage of Services*										Difference Between 2001 and 2009**
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
99241	5%	4%	3%	3%	3%	3%	2%	2%	2%	--	(3%)
99242	14%	13%	13%	12%	11%	11%	10%	9%	9%	--	(5%)
99243	33%	33%	33%	33%	33%	33%	33%	33%	33%	--	0%
99244	35%	36%	36%	37%	38%	39%	40%	41%	42%	--	7%
99245	14%	14%	14%	14%	14%	15%	15%	15%	15%	--	1%

*Percentages may not sum to 100 because of rounding.
**As of January 2010, CMS no longer recognizes for Medicare payment the E/M codes for consultations. For this reason, we determined the difference in the percentage of services between 2001 and 2009 rather than between 2001 and 2010. However, there were some inappropriately paid claims, which we do not include in this table.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

APPENDIX D

Percentage of Physicians by State and Evaluation and Management Coding Group

State	Percentage of Physicians Who Consistently Billed Higher Level E/M Codes*	Percentage of Other Physicians
California	17.1%	8.2%
New York	11.3%	7.3%
Florida	9.6%	6.3%
Texas	6.7%	6.2%
Arizona	4.3%	1.9%
Michigan	3.8%	3.7%
Illinois	3.5%	4.3%
Maryland	3.3%	2.1%
New Jersey	3.2%	3.3%
Pennsylvania	3.2%	5.0%
Ohio	2.6%	4.1%
Georgia	2.4%	2.6%
Massachusetts	2.3%	3.2%
North Carolina	2.2%	3.4%
Tennessee	1.9%	2.3%
Virginia	1.7%	2.5%
Washington	1,6%	2.2%
Colorado	1.5%	1.3%
Louisiana	1.5%	1.4%
Alabama	1.2%	1.4%
Minnesota	1.1%	2.0%
Wisconsin	1.1%	2.2%
Nevada	1.0%	0.6%
New Mexico	1.0%	0.6%
Puerto Rico	1.0%	0.6%
West Virginia	1.0%	0.7%
Mississippi	0.8%	0.9%
Oklahoma	0.7%	1.2%
Oregon	0.7%	1.1%
South Carolina	0.7%	1.4%
Kentucky	0.7%	1.5%

*E/M codes are evaluation and management codes.

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Percentage of Physicians by State and Evaluation and Management Coding Group (Continued)

State	Percentage of Physicians Who Consistently Billed Higher Level E/M Codes	Percentage of Other Physicians
Indiana	0.6%	2.2%
Arkansas	0.5%	0.8%
Missouri	0.5%	2.0%
Connecticut	0.4%	1.5%
District of Columbia	0.4%	0.3%
Kansas	0.4%	1.0%
Utah	0.4%	0.6%
Delaware	0.4%	0.4%
Hawaii	0.3%	0.3%
Iowa	0.2%	1.1%
Maine	0.2%	0.6%
New Hampshire	0.2%	0.6%
Rhode Island	0.2%	0.4%
South Dakota	0.1%	0.3%
Virgin Islands	0.1%	0.0%
Unknown	0.1%	0.0%
Alaska	0.1%	0.2%
Idaho	0.1%	0.5%
North Dakota	0.1%	0.3%
Vermont	0.1%	0.3%
Montana	--	0.4%
Nebraska	--	0.6%
Wyoming	--	0.2%
U.S. Possessions	--	0.0%
Guam	--	0.0%
Missing	--	0.0%
Total	**100%**	**100%**

Source: Office of Inspector General analysis of 2010 National Claims History Carrier File.

APPENDIX E

Percentage of Physicians by Specialty and Evaluation and Management Coding Group

Specialty	Physicians Who Consistently Billed Higher Level E/M Codes*	Other Physicians
Internal Medicine	19.8%	18.1%
Family Practice	12.2%	14.7%
Emergency Medicine	9.9%	7.1%
Nurse Practitioner	4.4%	5.2%
Obstetrics and Gynecology	4.3%	1.9%
Cardiovascular Disease, Cardiology	4.0%	4.7%
Orthopedic Surgery	3.9%	4.1%
Psychiatry	3.8%	1.8%
General Surgery	3.2%	3.5%
Ophthalmology	3.2%	2.3%
Anesthesiology	2.6%	0.6%
Physician Assistant	2.3%	4.0%
Optometry	2.2%	1.8%
Otolaryngology	2.2%	1.7%
Neurology	2.0%	2.3%
Gastroenterology	1.9%	2.4%
General Practice	1.4%	1.4%
Pulmonary Disease	1.3%	1.8%
Physical Medicine and Rehabilitation	1.2%	1.4%
Urology	1.2%	1.9%
Endocrinology	1.1%	0.9%
Nephrology	1.1%	1.5%
Podiatry	1.1%	2.9%

*E/M codes are evaluation and management codes.

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Percentage of Physicians by Specialty and Evaluation and Management Coding Group (Continued)

Specialty	Physicians Who Consistently Billed Higher-Level E/M Codes	Other Physicians
Dermatology	1.0%	2.1%
Neurosurgery	1.0%	0.8%
Hematology-Oncology	0.8%	1.5%
Infectious Disease	0.8%	0.9%
Interventional Pain Management	0.8%	0.4%
Rheumatology	0.8%	0.8%
Radiation Oncology	0.6%	0.6%
Medical Oncology	0.5%	0.5%
Allergy Immunology	0.4%	0.5%
Vascular Surgery	0.4%	0.5%
Geriatric Medicine	0.3%	0.3%
Hand Surgery	0.3%	0.2%
Plastic and Reconstructive Surgery	0.3%	0.5%
Critical Care, Intensivists	0.2%	0.3%
Osteopathic Manipulative Treatment	0.2%	0.1%
Pain Management	0.2%	0.1%
Surgical Oncology	0.2%	0.1%
Thoracic Surgery	0.2%	0.3%
Cardiac Surgery	0.1%	0.2%
Certified Registered Nurse Anesthetist	0.1%	0.0%
Clinic or Group Practice	0.1%	0.0%
Colorectal Surgery, Proctology	0.1%	0.2%
Gynecological Oncology	0.1%	0.2%
Hematology	0.1%	0.1%

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Percentage of Physicians by Specialty and Evaluation and Management Coding Group (Continued)

Specialty	Physicians Who Consistently Billed Higher Level E/M Codes	Other Physicians
Maxillofacial Surgery	0.1%	0.0%
Neuropsychiatry	0.1%	0.0%
Nuclear Medicine	0.1%	0.0%
Oral Surgery, Dentist Only	0.1%	0.0%
Peripheral Vascular Disease	0.1%	0.0%
Preventative Medicine	0.1%	0.0%
Addiction Medicine	--	0.0%
Certified Clinical Nurse Specialist	--	0.1%
Diagnostic Radiology	--	0.1%
Interventional Radiology	--	0.0%
Pediatric Medicine	--	0.2%
Pathology	--	0.0%
Undefined Type	--	0.0%
No Specialty Listed	--	0.0%
Certified Nurse Midwife	--	0.0%
Audiologist	--	0.0%
Radiation Therapy Center	--	0.0%
Licensed Clinical Social Worker	--	0.0%
Public Health or Welfare Agency	--	0.0%
Total	**100.0%**	**100.0%**

Source: Office of Inspector General analysis of 2010 National Claims History Carrier File.

APPENDIX F

Percentage of Most Common Diagnoses by Evaluation and Management Coding Group in 2010

Diagnosis	International Classification of Diseases-Ninth Revision Diagnosis Code	Beneficiaries Treated by Physicians Who Billed Higher Level Codes	Beneficiaries Treated by Other Physicians
Hypertension (no other symptom)	4019	6.0%	5.8%
Benign Hypertension	4011	5.9%	6.3%
Type II Diabetes	25000	4.4%	4.4%
Back Problem (lumbago)	7242	2.2%	1.1%
High Cholesterol (hyperlipidemia)	2724	1.7%	1.6%
Heart Disease (coronary atherosclerosis)	41401	1.2%	1.8%
Abnormal Heart Rhythm (atrial fibrillation)	42731	1.1%	2.6%

Source: Office of Inspector General analysis of 2010 National Claims History Carrier File.

APPENDIX G

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 28 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Coding Trends of Medicare Evaluation and Management Services, OEI-04-10-00180

Thank you for the opportunity to review and comment on the OIG Draft Report entitled, "Coding Trends of Medicare Evaluation and Management" (OEI-04-10-00180). The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG used to review this issue. OIG applied the use of the Part B Analytics Reporting System to analyze Evaluation and Management (E/M) services provided to beneficiaries to determine coding trends from 2001 to 2010. OIG's audit also focused on Part B Medicare claims data to determine physicians' E/M claim patterns to identify physicians who consistently billed at higher levels of E/M codes in 2010.

The OIG's study reports a growing trend of billing at the higher levels for E/M codes in all types of E/M services. OIG first recommends that CMS continue to educate physicians on proper billing for E/M services. The second recommendation in the report advises CMS to encourage contractors to review physicians' billing for E/M services. The last recommendation requests CMS to review physicians who consistently bill higher level E/M codes for appropriate action. CMS has reviewed the report and our responses to the OIG recommendations are below.

OIG Recommendation 1

Continue To Educate Physicians on Proper Billing for E/M Services

CMS should continue to provide educational outreach on E/M services to physicians. These efforts can focus on how to determine the appropriate E/M code for the service provided and the criteria used in making that determination, particularly for visit types that experienced shifts in billing.

Educational outreach to physicians is a longstanding and widespread activity CMS undertakes to inform physicians on the specific policies, rules, and regulations relevant to the services they provide. Outreach can include letters that describe inappropriate billing practices, face-to-face meetings, telephone conferences, seminars, and workshops.

Agency Comments (Continued)

CMS Response

The CMS concurs with the recommendation and agrees that physician education and outreach are critical parts of an effective enforcement strategy. CMS will continue to issue educational documents, such as Medicare Learning Network (MLN) articles. As part of CMS' series of E/M educational products, CMS recently updated the "Evaluation and Management Services Guide" and the "Fact Sheet on E/M Services: Complying with Documentation Requirements." CMS also works collaboratively with contractors to respond to questions and clarify policies when inconsistencies in billing practices arise. Additionally, CMS consistently seeks new ways of educating providers on proper billing for E/M services and, therefore, is exploring the use of web-based learning tools.

OIG Recommendation 2

Encourage Contractors To Review Physicians' Billing for E/M Services

CMS should encourage its contractors to review physicians' billing for E/M services and produce comparative billing reports. Comparative billing reports provide a documented analysis of a physician's billing pattern compared to his/her peers. These reports provide helpful insights into a physician's billing patterns to avoid improper Medicare payments. CMS may also find these reports helpful for identifying and monitoring physicians who consistently bill higher level E/M codes.

CMS Response

The CMS concurs. Current medical strategies for many of the Medicare Administrative Contractors (MACs) include reviews of E/M services for physicians with aberrant billing patterns when compared to their peers. CMS will issue a Technical Direction Letter (TDL) to the Medicare Administrative Contractors (MACs) with a link to the OIG report. CMS will inform the MACs that these findings are informational and shall be considered a source of data as they prioritize their workload, along with all the data they consider. As this report indicates, Medicare pays for millions of E/M services a year. CMS and our MACs balance the respective return on investment of medical review activities focused on E/M services as opposed to more costly Part B services.

In addition, CMS is considering other possible actions in addition to claims review. CMS is planning to develop and issue a Comparative Billing Report (CBR) aimed at 5,000 physicians across the country who have consistently billed for high level E/M codes. The 1,700 physicians identified in this study will be included in the CBR peer profile. CMS expects to release the CBR in May 2012. The CBR is not intended to be punitive or sent as an indication of fraud. The intent is to be proactive and provide statements that will support helpful insights into physician coding and billing practices. Further, this process should help the provider identify potential errors in their billing practices and make changes to help the provider prevent improper billing and payment in the future.

Agency Comments (Continued)

OIG Recommendation 3

Review Physicians Who Bill Higher Level E/M Codes for Appropriate Action

CMS should conduct additional reviews of physicians who consistently bill higher level E/M codes to ensure the claims are correctly coded. If CMS determines that inappropriate claims have been paid, it should take steps to recover those overpayments. To assist CMS, we have separately provided a list of the approximately 1,700 physicians we identified as consistently billing higher level E/M codes in 2010. Additionally, we will consider these physicians for further review in our continuing series of evaluations on E/M services.

CMS Response

The CMS partially concurs with this recommendation. CMS will take appropriate action and forward the 1,700 OIG-identified physicians to the Medicare Administrative Contractors (MACs). CMS will direct each contractor to focus on the top 10 high billers in their jurisdiction, which represents those physicians with the highest billing patterns. Based on the results of those reviews we will determine how best to address the remaining high billers. In conducting this assessment, CMS and the MACs must take into account the respective return on investment of medical review activities. Based on the findings in this report, the average E/M error was approximately $43.00. The average cost to review an E/M claim can range from $30.00 to $55.00. Therefore, CMS and the MACs must weigh the cost benefit of these reviews against more costly Part B services. Lastly, we will instruct the MACs to consider this issue when prioritizing their medical review strategies or other interventions, including education.

We appreciate the effort that went into this report and look forward to continuing to work with OIG on safeguarding the Medicare program.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

Michelle Verges served as the lead analyst. Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to the report include Rachel Daiber; other central office staff who contributed include Kevin Farber, Althea Hosein, and Sandy Khoury.

Office of Inspector General

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