

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID  
PHYSICIANS FOR CO-SURGERY  
AND ASSISTANT-AT-SURGERY  
SERVICES THAT WERE BILLED  
WITHOUT THE APPROPRIATE  
PAYMENT MODIFIERS**

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## Report in Brief

Date: November 2022

Report No. A-01-20-00503

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



### Why OIG Did This Audit

Under the Medicare Part B program, the Centers for Medicare & Medicaid Services (CMS) makes a reduced payment to physicians who work together as co-surgeons to perform a surgical procedure on the same patient during the same operative session. We conducted this audit because of the potential risk that Medicare was overpaying physicians for co-surgery procedures billed without the appropriate modifier.

Our objective was to determine whether Medicare Part B payments to physicians for potential co-surgery procedures complied with Federal requirements.

### How OIG Did This Audit

Our audit covered \$15.4 million in Medicare Part B payments for services performed during calendar years 2017 through 2019 (audit period) in which two different providers separately billed an identical procedure code for the same beneficiary and on the same day. We selected a stratified random sample of 100 services for review that were billed by one of the providers from our sampling frame without a co-surgery or assistant-at-surgery modifier. We also identified and reviewed 127 corresponding services that were billed by providers with the same procedure code for the same beneficiary on the same day as our sampled services.

## Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers

### What OIG Found

From our 100 statistically sampled services, we found that 69 did not comply with Federal requirements. Specifically, these statistically sampled services included 49 that were incorrectly billed without the co-surgery modifier, 14 that were incorrectly billed without an assistant-at-surgery modifier, and 6 that were incorrectly billed as duplicate services. These statistically sampled service errors resulted in overpayments of \$31,545. Based on the results of our statistical sample, we estimated that Medicare made \$4.9 million in improper payments for physician surgical services during our audit period. In addition to the statistically sampled services, based on our review of the 127 corresponding services, we further found that 62 of these corresponding services did not comply with Federal requirements. These corresponding service errors resulted in overpayments of \$24,471. Altogether, these statistically sampled and corresponding service errors occurred primarily because CMS did not have adequate system controls to identify and prevent such payments.

### What OIG Recommends and CMS Comments

We recommend that CMS: (1) recover the portion of the \$56,016 in Medicare Part B overpayments that are within the 4-year claim reopening period; (2) instruct the Medicare contractors to, based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) strengthen its system controls to detect and prevent improper payments to providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services—which could have saved approximately \$4.9 million during our audit period; and (4) update Medicare requirements and corresponding educational material to improve providers' understanding of the Part B billing requirements for co-surgery procedures.

In written comments on our draft report, CMS concurred with our recommendations and described actions that it planned to take to address our recommendations, such as strengthening its system controls to detect and prevent improper payments to providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Under the Medicare Part B program, the Centers for Medicare & Medicaid Services (CMS) makes a reduced payment to physicians for co-surgery procedures when two physicians work together to perform a surgical procedure on the same patient during the same operative session. Each physician must bill their respective co-surgery service using a modifier “62” to receive a reduced payment amount for the procedure. We conducted this audit because of the potential risk that Medicare was overpaying physicians for co-surgery procedures billed without the appropriate modifier.

### OBJECTIVE

Our objective was to determine whether Medicare Part B payments to physicians for potential co-surgery procedures complied with Federal requirements.

### BACKGROUND

#### The Medicare Program

The Medicare program provides health insurance to people who are 65 years old and over, people with disabilities, and people with end-stage renal disease. Medicare Part B provides supplementary medical insurance for medical and other health services, including physicians’ surgical services provided by physicians and nonphysician practitioners (i.e., physician assistants, nurse practitioners, and clinical nurse specialists).<sup>1</sup> CMS administers the Medicare program and contracts with 7 Medicare administrative contractors (MACs) across 12 jurisdictions nationwide to, among other things, process and pay Medicare Part B claims, review medical records for selected claims, and educate providers about Medicare billing requirements.

#### The Medicare Physician Fee Schedule

Under Medicare Part B, Healthcare Common Procedure Coding System (HCPCS) procedure codes, modifiers, and their descriptions are used for the purpose of reporting physicians’

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<sup>1</sup> We generally refer to physicians and nonphysician practitioners who perform physicians’ surgical services as “providers” for reporting purposes.

surgical services.<sup>2</sup> Reimbursement rates for physicians' surgical services are based primarily on CMS's Medicare Physician Fee Schedule (MPFS).<sup>3</sup> Additional rate adjustments may be made based on the presence of certain modifiers.<sup>4</sup> In order to receive Medicare Part B payments, a provider must bill for each respective physician's surgical service performed on a claim using the correct procedure code and, if required, append any applicable modifiers.<sup>5</sup>

## **Medicare Part B Billing Requirements for Co-Surgery Services**

When two physicians together perform a surgical procedure on the same patient during the same operative session, Medicare considers this procedure a co-surgery. Co-surgery may be medically necessary due to the complexity of a surgical procedure or the patient's condition that requires the skills of two physicians. Under Medicare Part B, the MPFS allows physicians' surgical services to be billed as co-surgeries, provided that the procedure code has a co-surgery indicator of "1" or "2" and that the use of two physicians was medically necessary.<sup>6</sup> When billing for co-surgery procedures, each physician must append a "62" modifier (co-surgery

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<sup>2</sup> The HCPCS codes used for this audit are the five-character codes and descriptions obtained from Current Procedure Terminology (CPT®), copyright 2017–2019 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 report should refer to the most current version of the CPT available from AMA. A modifier is a two-character code reported with a HCPCS or CPT code and is used to give Medicare additional information needed to process a claim. Our audit relates to the CPT procedure codes and modifiers used when billing a surgical service on a claim line item. Throughout the report, we refer to these types of claim line items as "services."

<sup>3</sup> CMS establishes the MPFS that includes a listing of physician services that are payable under Medicare Part B (42 CFR § 414.4). The fee schedule amount for a physician service is computed as the product of the relative value units for the service, the geographic adjustment factor, and the annual conversion factor (42 CFR § 414.20). CMS updates the MPFS on an annual basis and makes periodic adjustments to incorporate any midyear changes.

<sup>4</sup> CMS establishes uniform national definitions of services, codes to represent services, and modifiers to the codes (42 CFR § 414.40).

<sup>5</sup> The Social Security Act (the Act) § 1833(e) states that: "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

<sup>6</sup> The MPFS specifies that for procedure codes with a co-surgery indicator of 1: "Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure." The MPFS also specifies that for procedure codes with a co-surgery indicator of 2: "Co-surgeons permitted and no documentation required if the two-surgeon specialty requirement is met."

modifier) to the respective surgical service.<sup>7</sup> By appending the co-surgery modifier to the procedure code on the claim, each physician receives a reduced payment, equal to 62.5 percent of the MPFS amount for the billed service.<sup>8</sup>

### **Medicare Part B Billing Requirements for Assistant-at-Surgery Services**

When a provider supports a primary physician in charge of performing a procedure as a surgical assistant, Medicare considers this procedure to have had an assistant-at-surgery. Under Medicare Part B, the MPFS allows physicians' surgical services to be billed as assistant-at-surgeries, provided that the procedure code has an assistant-at-surgery indicator of "0" or "2" and that the use of an assistant-at-surgery was medically necessary.<sup>9</sup> When billing for assistant-at-surgery services, the provider must append the appropriate assistant-at-surgery modifier to the respective procedure code.<sup>10</sup> By appending an assistant-at-surgery modifier to

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<sup>7</sup> CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, § 40.8 states: "If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier '-62.' Co-surgery also refers to the surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the [MPFS]." We refer to the "62" modifier as the "co-surgery modifier" for reporting purposes.

<sup>8</sup> 56 Fed. Reg. 59502, 59516 (Nov. 25, 1991) established the Medicare Part B payment policy for the co-surgery modifier under the physician fee schedule. It states: "For co-surgeons (modifier 62), we will continue the current predominant carrier practice of paying 125 percent of the global fee and dividing the payment equally between the two surgeons. No payment will be made for an assistant-at-surgeon in these cases." In accordance with this policy, the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the MPFS (CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, § 40.8). Although CMS's subregulatory guidance, referenced here and stated in the previous footnote above, somewhat suggests that co-surgeons should be in different specialties, Federal Laws and Regulations do not require co-surgeons to be in different specialties as a general rule. We confirmed with CMS that its Medicare Part B policy allows for co-surgery billing when co-surgeons are in the same specialty, provided that the use of two physicians in the same specialty was medically necessary. Accordingly, when billing for co-surgery procedures, each physician must append the co-surgery modifier to the respective procedure code, regardless of whether they are in the same or different specialties.

<sup>9</sup> The MPFS specifies that for procedure codes with an assistant-at-surgery indicator of 0: "Payment restrictions for assistants-at-surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity." The MPFS also specifies that for procedure codes with an assistant-at-surgery indicator of 2: "Payment restrictions for assistants-at-surgery does not apply to this procedure. Assistant-at-surgery may be paid."

<sup>10</sup> In accordance CMS's policy for assistant surgery services, the "80," "81," or "82" modifier is required to be appended to the respective procedure code when the assistant surgeon is a physician, and the "AS" modifier is required be appended to the respective procedure code when the assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist (CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, § 20.4.3). We refer to these modifiers as the "assistant-at-surgery modifiers" for reporting purposes.

the procedure code on the claim, the provider receives a reduced payment equal to 16 percent of the established MPFS amount for the billed surgical service.<sup>11</sup>

### **CMS and Medicare Administrative Contractor Claims Processing System Edits**

The MACs submit Medicare Part B physician claims that they received from providers to CMS's centralized Common Working File (CWF) system for prepayment validation. As part of the validation process, the CWF performs a series of automated system edits that makes a claim approval, adjustment, or rejection determination. This includes performing duplicate service edits that check incoming claims to see whether there is an existing claim for the same beneficiary already in the system billed with the same HCPCS code on the same day. Under certain conditions, if the co-surgery modifier is present, the procedure will bypass the duplicate service edit for an approved payment. According to CMS, the CWF system has edits that will only allow providers to append assistant-at-surgery modifiers for certain procedure codes on a claim.

The MACs have system edit controls to help ensure that co-surgery and assistant surgery services are correctly billed. In general, the MACs' controls prevent payments for procedures billed with a co-surgery or assistant-at-surgery modifier if the MPFS indicates that such billing is unallowable. These controls also may suspend payments if the MPFS indicates that a manual review of additional documentation to establish the medical necessity of such services is required. The MACs also have varying duplicate service system edits that, under certain conditions, may deny suspected duplicate payments to different providers who bill for the same procedure code for the same beneficiary on the same day.

### **Medicare Requirements for Physicians To Identify and Return Overpayments**

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of: (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>12</sup>

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<sup>11</sup> The Act § 1848(i)(2)(A) and 56 Fed. Reg. 59502, 59516 (Nov. 25, 1991) established the Medicare Part B payment policy for assistant-at-surgery services by specifying that payments to a physician serving as an assistant-at-surgery must not exceed 16 percent of the MPFS amount for the global surgical service involved. Federal regulation also provides that Medicare Part B payments for an assistant-at-surgery service furnished by a physician assistant, nurse practitioner, or clinical nurse specialist may not exceed 85 percent of the fee schedule amount that would be allowed under the MPFS if the assistant-at-surgery service were furnished by a physician (42 CFR §§ 414.52 and 414.56).

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

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, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>13</sup>

## HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B payments to providers—specifically, in cases where a service billed by one provider (Provider A)<sup>14</sup> matched to a corresponding service separately billed by a different provider (Provider B)<sup>15</sup> performing the same procedure for the same beneficiary on the same date of service. We restricted our review to procedure codes that contained an MPFS co-surgery indicator of “1” or “2,” and therefore, the cases we identified represented potential co-surgery services.<sup>16</sup> Although co-surgery was the primary focus for this audit, we recognized that some of these potential co-surgery services could alternatively represent assistant-at-surgery or duplicate services.<sup>17</sup> However, distinguishing between co-surgery, assistant-at-surgery, or duplicate services for this audit could only be determined by reviewing the claims data from both providers and the medical records from at least one of the providers.

The sampling frame for this audit consisted of 21,297 services, with payments totaling \$15,441,710. We selected a stratified random sample of 100 services totaling \$105,668 that were billed by one of the providers from our sampling frame (i.e., billed by the Provider A group) without a co-surgery or assistant-at-surgery modifier for procedures that were performed during calendar years 2017 through 2019 (audit period). These services covered a variety of surgical procedures, including services related to spinal fusions, knee replacements, and endovascular repairs, among others. For each of the 100 statistically sampled services, we contacted each provider and evaluated compliance with Federal requirements for Medicare billing by reviewing the claims data along with the associated medical records (e.g., operative reports) and responses to our questions obtained from these providers to determine whether

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<sup>13</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*, part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

<sup>14</sup> Throughout this report, we refer to this group of providers as the Provider A group.

<sup>15</sup> Throughout this report, we refer to this group of providers as the Provider B group.

<sup>16</sup> The MPFS provides indicator fields that identify whether a modifier may apply to a procedure code. If a procedure code has a co-surgery indicator of “1” or “2,” then two surgeons performing the procedure as co-surgeons may be paid for the service, provided that the use of two surgeons was medically necessary.

<sup>17</sup> Many procedure codes with a co-surgery indicator of “1” or “2” also have an assistant-at-surgery indicator of “0” or “2” and, therefore, are alternatively allowed to be billed as an assistant-at-surgery, provided that the assistant-at-surgery was medically necessary. The potential for incorrect duplicate service billing is a general risk when the same procedure code is billed multiple times for the same beneficiary on the same date of service.

or not the statistically sampled service was performed as a co-surgery. Since we did not use medical review for this audit, we did not assess the medical necessity of the services. We projected the resulting overpayments associated with our sample findings to our sampling frame to calculate the estimated amount of improper payments made during our audit period.

We also identified 127 corresponding services totaling \$103,892 that were billed by providers with the same procedure code for the same beneficiary on the same day as our statistically sampled services. These 127 corresponding services included the 100 services that were billed by the Provider B group (for the services also billed by the Provider A group) along with 27 additional services.<sup>18</sup> Altogether, these 127 corresponding services were billed either with or without a co-surgery or assistant-at-surgery modifier, but were not included in our statistical sample. We reviewed them separately from our statistical sample. For each of the corresponding 127 services, we evaluated compliance with Medicare billing requirements by reviewing the claims data, coupled with our findings from the associated statistically sampled services, to make our determination. We did not separately contact the Provider B group and did not assess the medical necessity of these corresponding services. Since these 127 corresponding services were not directly part of our statistical sample, we calculated any resulting overpayments associated with these services separately from our statistical sample estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

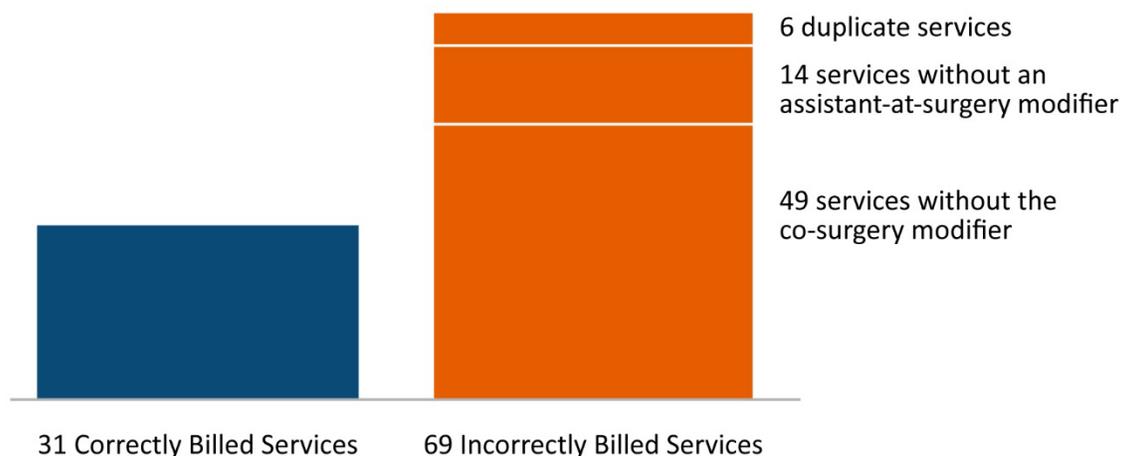
## FINDINGS

Medicare Part B payments to physicians for co-surgery procedures did not always comply with Federal requirements. Based on our sample review of the Provider A group, we found that 31 of the 100 statistically sampled services complied with Federal requirements. However, 69 of the 100 statistically sampled services did not comply with Federal requirements, including 49 that were incorrectly billed without the co-surgery modifier, 14 that were incorrectly billed without an assistant-at-surgery modifier, and 6 that were incorrectly billed as duplicate services. (Figure 1, on the following page, shows the number of services that complied and did not comply with Federal requirements.) These statistically sampled service errors resulted in overpayments of \$31,545.

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<sup>18</sup> The 27 additional services involved some cases in which the providers billed for the same service more than once and other cases in which more than two providers billed for the same service.

**Figure 1: Statistically Sampled Service Findings**



Based on the results of our statistical sample, we estimated that Medicare made \$4,939,586 in improper payments for physician surgical services during our audit period, including: (1) an estimated \$2.1 million in overpayments associated with errors related to the co-surgery modifier (i.e., the incorrectly billed co-surgery services), and (2) an estimated \$2.8 million in overpayments associated with errors unrelated to the co-surgery modifier (i.e., the incorrectly billed assistant-at-surgery and duplicate services).

In addition to the statistically sampled services, based on our review of the 127 corresponding services (includes services billed by the Provider B group), we further found that 62 of these corresponding services did not comply with Federal requirements, including 33 that were incorrectly billed without the co-surgery modifier, 16 that were incorrectly billed without an assistant-at-surgery modifier, and 13 that were incorrectly billed as duplicate services. These corresponding services were billed with the same procedure codes for the same beneficiary on the same day as our statistically sampled services. These corresponding service errors resulted in overpayments of \$24,471.

Altogether, these statistically sampled and corresponding service errors occurred primarily because CMS did not have adequate system controls to detect and prevent payments to providers that: (1) did not append the required co-surgery modifier to co-surgery procedures, (2) did not append the required assistant-at-surgery modifier to assistant-at-surgery procedures, or (3) received duplicate payments for the same procedures.

### **CMS MADE IMPROPER PAYMENTS TO PHYSICIANS FOR CO-SURGERY PROCEDURES BILLED WITHOUT A CO-SURGERY MODIFIER**

When billing for co-surgery procedures under Medicare Part B, each physician must append the co-surgery modifier to the respective procedure code to ensure that each receives a reduced payment equal to 62.5 percent of the fee schedule amount for the service performed (56 Fed. Reg. 59502, 59516 (Nov. 25, 1991)).

For 49 of the 100 statistically sampled services, Medicare paid physicians for co-surgery procedures that providers incorrectly billed without the required co-surgery modifier, resulting in overpayments of \$14,347.<sup>19</sup> In each case, based on our review of the claims data along with the medical records and responses to our questions that we obtained from the Provider A group, we determined that two physicians together performed the respective surgical procedure on the same patient during the same operation as co-surgeons and that neither physician acted as an assistant-at-surgery. The following is an example of one of the co-surgery procedures that we encountered.

#### **An Example of an Incorrect Medicare Co-Surgery Payment**

A physician (Provider A) worked together with another physician (Provider B) in a different specialty to perform a thoracic endovascular repair procedure (HCPCS code 33880). Provider A attested that this service was in fact performed as a co-surgery, as supported by operative report contained in the medical records. However, Provider A did not append the “62” modifier to the service as required and explained that the co-surgery modifier was incorrectly omitted due to a billing error. Consequently, Provider A received an incorrect payment of \$1,346 instead of a correct reduced payment of \$841 (62.5 percent of the original payment amount). As a result, Medicare overpaid Provider A \$505 for this sampled service. Provider B’s corresponding co-surgery service was correctly billed with the “62” modifier and, therefore, was paid correctly.

For the majority of these 49 services, the providers agreed that the co-surgery modifier should have been appended to their billed services and generally attributed the incorrect billing to some type of coding error (e.g., billing, data entry, or human error). However, some of the providers believed that they billed for the services correctly, and for most of these services, the providers misinterpreted the co-surgery billing requirements, as highlighted by the following examples:

- For five of these services, which involved bilateral co-surgery procedures, the providers believed the co-surgery modifier was not required because they performed these

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<sup>19</sup> For 35 of the 49 incorrectly billed statistically sampled services, we calculated the improper payment amounts by applying the 62.5 percent co-surgery modifier payment adjustment to the original physician payment amounts, resulting in overpayments of \$13,475. The other 14 incorrectly billed statistically sampled services were associated with bilateral co-surgery procedures that were billed without a bilateral modifier (“50”), which would have increased the fee schedule amount by 150 percent for the service performed (56 Fed. Reg. 59502, 59516 (Nov. 25, 1991)). As a conservative approach for these 14 statistically sampled services, we factored both the 150 percent bilateral modifier and 62.5 percent co-surgery modifier payment rates into our repricing. This came to a net 93.75 percent payment adjustment that we applied to the original payment amounts, which resulted in overpayments of \$871 for these 14 statistically sampled services. When combined, all 49 incorrectly billed services resulted in overpayments of \$14,347, which reflects the total difference between what was originally paid and what should have been paid after applying the payment adjustments. Note that the dollar amounts may not add up exactly due to rounding.

procedures on separate sites of the body and because the two physicians were in the same specialty.<sup>20</sup> However, to comply with Federal requirements, co-surgeons performing procedures (including bilateral procedures) must bill their services using the co-surgery modifier regardless of whether they are in the same or different specialty.

- For four other services, which involved spinal instrumentation co-surgery procedures, the providers believed the co-surgery modifier was not required because the American Medical Association's (AMA's) CPT codebook states that the co-surgery modifier should not be appended to spinal instrumentation codes. However, under Medicare Part B, Federal requirements and CMS policy takes precedence over any conflicting CPT codebook guidance.<sup>21</sup>

In addition to the statistically sampled services, we further found that 33 of the 127 corresponding services (which includes services billed by the Provider B group) did not comply with Federal requirements based on our review of the claims data coupled with our findings from the associated statistically sampled services. Providers billed for these respective corresponding services with the same procedure code for the same beneficiary on the same day. We determined that these corresponding services were performed as co-surgeries, but the providers who billed the corresponding services did not append the co-surgery modifier. These errors resulted in additional overpayments of \$6,170.

### **CMS MADE IMPROPER PAYMENTS TO PHYSICIANS AND PRACTITIONERS FOR ASSISTANT-AT-SURGERY SERVICES BILLED WITHOUT AN ASSISTANT-AT-SURGERY MODIFIER**

When billing for procedures as an assistant-at-surgery under Medicare Part B, the assisting provider must append the assistant-at-surgery modifier to the respective procedure code to receive a reduced payment equal to 16 percent of the fee schedule amount for the service performed (the Social Security Act (the Act) § 1848(i)(2)(A) and 56 Fed. Reg. 59502, 59516 (Nov. 25, 1991)).

For 14 of the 100 statistically sampled services, Medicare paid providers for assistant-at-surgery services that were incorrectly billed without an assistant-at-surgery modifier, resulting in

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<sup>20</sup> These five examples included a bilateral bunion correction procedure performed by podiatrists (HCPCS code 28299), a bilateral breast removal procedure performed by plastic and reconstructive surgeons (HCPCS code 19364), and three bilateral knee replacement procedures performed by orthopedic surgeons (HCPCS code 27447).

<sup>21</sup> Spinal instrumentation is medical hardware that is used to maintain or correct the alignment of spinal segments for a beneficiary. The AMA codebook specifies not to append the co-surgery modifier to spinal instrumentation codes 22840–22848, 22850, 22852, 22853, 22854, or 22859. However, these spinal instrumentation codes that we identified in our sampling frame contained an MPFS co-surgery indicator of “1” or “2,” thus allowing for two physicians performing the procedure as co-surgeons to be paid for the service, as subject to Federal requirements. Based on our communication, CMS acknowledged that CMS policies related to the use of CPT codes are not always identical to the AMA's CPT codebook.

overpayments of \$9,880.<sup>22</sup> In each case, based on our review of the claims data along with the medical records and responses to our questions that we obtained from the Provider A group, we determined that the provider was assisting a primary surgeon who performed the respective surgical procedure. The primary surgeons billed their claims correctly. The following is an example of one of the assistant-at-surgery procedures that we encountered.

**An Example of an Incorrect Medicare  
Assistant-at-Surgery Payment**

A physician assistant (Provider A) assisted a primary surgeon (Provider B) with a hip replacement procedure (HCPCS code 27130) as an assistant-at-surgery. Provider A attested that this service was in fact performed as an assistant-at-surgery procedure, as supported by the operative report record. However, Provider A did not append the assistant-at-surgery “AS” modifier to the service as required and told us this was an inadvertent error. Consequently, Provider A received an incorrect payment of \$906 instead of a correct reduced payment of \$145 (16 percent of the original payment amount). As a result, Provider A was overpaid \$761 for this sampled service. Provider B’s corresponding primary surgeon service was correctly billed.

In addition to the statistically sampled services, we further found that 16 of the 127 corresponding services (which includes services billed by the Provider B group) were performed as assistant-at-surgery services that did not comply with Federal requirements based on our review of the claims data coupled with our findings from the associated statistically sampled services. Providers billed for these respective corresponding services with the same procedure codes for the same beneficiary on the same day as an associated sampled service, but the providers did not append the required assistant-at-surgery modifier to the procedure code. These errors resulted in additional overpayments of \$11,863. The physicians in charge of performing the procedures as primary surgeons correctly billed for the associated statistically sampled services.

**CMS MADE IMPROPER PAYMENTS TO PHYSICIANS AND PRACTITIONERS FOR DUPLICATE SERVICES**

Medicare payment must not be made to a provider for an item or service unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider” (the Act § 1833(e)).

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<sup>22</sup> For all 14 incorrectly billed statistically sampled services, we calculated the improper payment amounts by applying the 16 percent co-surgery modifier payment adjustment to the original physician payment amounts, resulting in overpayments of \$9,880. This overpayment amount reflects the total difference between what was originally paid and what should have been paid.

For 6 of the 100 statistically sampled services, Medicare paid providers for duplicate services, resulting in overpayments of \$7,318.<sup>23</sup> In each case, based on our review of the claims data along with the medical records and responses to audit questions that we obtained from the Provider A group, we determined that these services represented duplicate bills for the procedures that were already covered and paid by Medicare on separate claims. The following is an example of one of the duplicate services that we encountered.

#### **An Example of a Medicare Duplicate Service Payment**

A physician assistant (Provider A) performed a spinal laminectomy and decompression procedure (HCPCS code 63030) as an assistant surgeon alongside a primary surgeon (Provider B). However, Provider A billed this same procedure code twice on separate claims. On the first claim, the assistant-at-surgery “AS” modifier was incorrectly omitted, and thus Provider A billed as the primary surgeon from the statistically sampled service for a payment of \$696. On the second claim, the “AS” modifier was correctly applied to the same procedure code service for a reduced payment of \$111 (16 percent of the statistically sampled service payment amount). The statistically sampled service on the first claim, therefore, represented an incorrect duplicate payment of \$696. As a result, Provider A was overpaid \$696 for this statistically sampled service. Provider B’s corresponding primary surgeon service was correctly billed on a separate third claim.

In addition to the statistically sampled services, we further found that 13 of the 127 corresponding services (which includes services billed by the Provider B group) were billed as duplicate services that did not comply with Federal requirements based on our review of the claims data coupled with our findings from the associated statistically sampled services. Providers billed for these respective corresponding services with the same procedure codes for the same beneficiary on the same day as an associated statistically sampled service but these corresponding services should not have been separately paid since they were already covered by Medicare. These errors resulted in additional overpayments of \$6,439.

#### **CMS MADE AN ESTIMATE \$4.9 MILLION IN IMPROPER PART B PAYMENTS THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS**

Based on the results of our statistical sample, we estimated that Medicare made \$4,939,586 in improper payments for physician surgical services during our audit period, including: (1) an estimated \$2,131,354 in overpayments associated with errors related to the co-surgery modifier (i.e., the incorrectly billed co-surgery services); and (2) an estimated \$2,808,232 in

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<sup>23</sup> For all six duplicate services, the entire provider payment amounts were improperly paid, resulting in overpayments of \$7,318.

overpayments associated with errors unrelated to the co-surgery modifier (i.e., the incorrectly billed assistant-at-surgery and duplicate services).

In addition to the statistically sampled services, based on our review of the 127 corresponding services (which includes services billed by the Provider B group), we further found that 62 of these corresponding services did not comply with Federal requirements, including 33 that were incorrectly billed without the co-surgery modifier, 16 that were incorrectly billed without an assistant-at-surgery modifier, and 13 that were incorrectly billed as duplicate services. These corresponding services were billed with the same procedure codes for the same beneficiary on the same day as our statistically sampled services. These corresponding service errors resulted in overpayments of \$24,471.

### **CMS DID NOT HAVE ADEQUATE SYSTEM CONTROLS TO DETECT AND PREVENT THE IMPROPER PAYMENTS WE IDENTIFIED**

During our audit period, CMS did not have adequate system controls (e.g., CWF system edits) to detect and prevent the improper payments in cases in which providers: (1) did not append the required co-surgery modifier, (2) did not append the required assistant-at-surgery modifier, or (3) received duplicate payments for the same procedure. Although CMS had limited controls in place, these controls were primarily intended to detect and prevent duplicate payments to the same provider for the service performed. They did not detect cases in which identical procedure codes were billed by different providers for the same beneficiary on the same date of service and when one or both of the providers omitted the appropriate co-surgery or assistant-at-surgery modifier. The MACs supplemental system edit controls also did not detect or prevent the improper payments that we identified during our audit.

### **RECOMMENDATIONS**

We recommend that the Centers for Medicare & Medicaid Services:

- recover the portion of the \$56,016 in Medicare Part B overpayments that are within the 4-year claim reopening period—including \$31,545 in overpayments for the 69 incorrectly billed statistically sampled services and \$24,471 in overpayments for the 62 incorrectly billed corresponding services;<sup>24</sup>

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<sup>24</sup> OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers 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 provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

- instruct the MACs to, based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;
- strengthen its system controls to detect and prevent improper payments to providers for incorrectly billed: (1) co-surgery services, (2) assistant-at-surgery services, and (3) duplicate services—which could have saved approximately \$4,939,586 during our audit period; and
- update its Medicare requirements and corresponding educational material to improve providers’ understanding of the Medicare Part B billing requirements for co-surgery procedures, including:
  - updating the *Medicare Claims Processing Manual*, chapter 12, section 40.8, to ensure billing providers understand that two physicians performing procedures as co-surgeons (including bilateral procedures) must append the co-surgery modifier regardless of whether they are in the same specialty or in different specialties, and
  - providing additional education material to providers clarifying that spinal instrumentation procedure codes must be billed with a co-surgery modifier under Medicare Part B when performed as a co-surgery.

### **CMS COMMENTS**

In written comments on our draft report, CMS concurred with our recommendations and described actions that it planned to take to address our recommendations, including strengthening its claims processing controls to detect and prevent improper payments to providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services. CMS also said it would continue to educate providers about the Medicare Part B billing requirements for co-surgery procedures. CMS’s comments are included in their entirety as Appendix D.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered Medicare Part B payments to physicians or nonphysician practitioners (i.e., physician assistants, nurse practitioners, and clinical nurse specialists)—specifically, in cases where a service billed by one provider (Provider A) matched to a corresponding service separately billed by a different provider (Provider B) performing the same procedure for the same beneficiary on the same date of service.<sup>25</sup> We restricted our review to procedure codes that contained an MPFS co-surgery indicator of “1” or “2,” and therefore, the cases we identified represented potential co-surgery services.<sup>26</sup> Although co-surgery was the primary focus for this audit, we recognized that some of these potential co-surgery services could alternatively represent assistant-at-surgery or duplicate services.<sup>27</sup> However, distinguishing between co-surgery, assistant-at-surgery, or duplicate services for this audit could only be determined by reviewing the claims data from both providers and the medical records from at least one of the providers.

The sampling frame for this audit consisted of 21,297 services, with payments totaling \$15,441,710. We selected a stratified random sample of 100 services totaling \$105,668 that were billed by one of the providers in our sampling frame (i.e., billed by the Provider A group) without a co-surgery (“62”) or assistant-at-surgery (“80,” “81,” “82,” or “AS”) modifier for procedures that were performed during calendar years 2017 through 2019 (audit period). These services covered a variety of surgical procedures, including services related to spinal fusions, knee replacements, and endovascular repairs, among others. For each of the 100 statistically sampled services, we contacted each provider and evaluated compliance with Federal requirements for Medicare billing by reviewing the claims data along with the associated medical records (e.g., operative reports) and responses to audit questions that we obtained from these providers to determine whether or not the statistically sampled service was performed as a co-surgery. Since we did not use medical review for this audit, we did not assess the medical necessity of the services. We projected the resulting overpayments associated with our sample findings to our sampling frame to calculate the estimated amount of improper payments made during our audit period.

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<sup>25</sup> We generally refer to physicians and nonphysician practitioners who perform physicians’ surgical services as “providers” for reporting purposes.

<sup>26</sup> The MPFS provides indicator fields that identify whether a modifier may apply to a procedure code. If a procedure code has a co-surgery indicator of “1” or “2,” then two surgeons performing the procedure as co-surgeons may be paid for the service, provided that the use of two surgeons was medically necessary.

<sup>27</sup> Many procedure codes with a co-surgery indicator of “1” or “2” are alternatively allowed to be billed as assistant-at-surgeries, provided that the assistant-at-surgery was medically necessary. The potential for incorrect duplicate service billing is a general risk when the same procedure code is billed multiple times for the same beneficiary on the same date of service.

We also identified 127 corresponding services totaling \$103,892 that were billed by providers with the same procedure code for the same beneficiary on the same day as our statistically sampled services. These 127 corresponding services included the 100 services that were billed by the Provider B group (for the services also billed by the Provider A group) along with 27 additional services.<sup>28</sup> Altogether, these 127 corresponding services were billed either with or without a co-surgery or assistant-at-surgery modifier, which is why we reviewed them separately from our statistical sample. For each of the 127 corresponding services, we evaluated compliance with Medicare billing requirements by reviewing the claims data, coupled with our findings from the associated statistically sampled services, to make our determination. We did not separately contact the Provider B group and did not assess the medical necessity of these corresponding services. Since these 127 corresponding services were not directly part of our statistical sample, we calculated any resulting overpayments associated with these services separately from our statistical sample estimates.

We assessed CMS's internal controls and compliance with Federal laws and regulations necessary to satisfy this audit's objective. In particular, we assessed the CMS and MAC system edits and any other program monitoring controls that they had in place to ensure that co-surgery and assistant-at-surgery physician services were correctly billed to Medicare Part B with the appropriate modifiers. However, because our audit was limited to these internal control components and underlying principles, it would not necessarily have detected all internal control deficiencies.

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit from February 2020 to September 2022, which included contacting CMS in Baltimore, Maryland.

## **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- communicated with CMS officials to gain a better understanding of the Medicare policies concerning proper billing for co-surgery procedures and the "62" modifier;
- extracted Medicare Part B claims data for physicians' surgical services from CMS's NCH file for the audit period in which two providers submitted identical procedure codes

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<sup>28</sup> The 27 additional services involved some cases in which the providers billed for the same service more than once and other cases in which more than two providers billed for the same service.

(with a co-surgery indicator of “1” or “2”) for the same beneficiary on the same date of service;

- used computer matching, data mining, and other data analysis techniques to identify services at risk for non-compliance with Federal requirements for Medicare billing;
- created a sampling frame of 21,297 services totaling \$15,441,710 in Medicare payments for physicians’ surgical services and selected a stratified random sample of 100 services for detailed review (Appendix B);
- reviewed available data from CMS’s CWF for the statistically sampled services to determine whether they had been canceled or adjusted;
- requested, obtained, and reviewed medical records, billing information, and responses to audit questions from providers to support the 100 statistically sampled services;
- obtained and reviewed additional supporting Medicare Part B line item data from CMS’s NCH file that included 127 corresponding services totaling \$103,892 in Medicare payments for physicians’ surgical services that were billed with the same procedure codes for the same beneficiary on the same dates of service as our statistically sampled services;
- communicated with CMS and each of the MACs to obtain and review the types of system edits and any other program monitoring controls that they have in place to ensure that co-surgery and assistant-at-surgery services are correctly billed to Medicare Part B with the appropriate modifiers;
- communicated with CMS and each of the MACs to obtain and review the type of education that they provide regarding proper Medicare Part B physicians’ surgical service billing for co-surgery and assistant-at-surgery procedures;
- calculated the corrected payment amounts for those statistically sampled services and corresponding services requiring adjustments;
- used the results of the 100 statistically sampled service review to calculate three estimates for: (1) the amount of improper payments due to errors related to the co-surgery modifier—specifically the incorrectly billed co-surgery services, (2) the amount of improper payments due to errors unrelated to the co-surgery modifier—specifically the incorrectly billed assistant-at-surgery and duplicate services, and (3) the combined amount of improper payments for all the statistically sampled service errors (Appendix C); and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of 21,297 claim line items totaling \$15,441,710 in Medicare Part B provider payments for physicians' surgical services with dates of service during the period of January 1, 2017, through December 31, 2019. The frame included line items with payments of \$25 or more and HCPCS codes with a MPFS co-surgery indicator of "1" or "2" (for which co-surgery may be paid). Line items billed with a co-surgery ("62") modifier or assistant-at-surgery ("80," "81," "82," or "AS") modifier were excluded from the frame.

### SAMPLE UNIT

The sample unit was a line item (we referred to line items as "services" for reporting purposes).

### SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata on the basis of the Medicare Part B line item provider payment amount for the physicians' surgical service. We selected 100 line items (Provider A) in total for review, as shown in Table 1.

**Table 1: Frame Description and Sample Size**

Stratum	Line Item Payment Range	Number of Line Items in Frame	Dollar Value in Frame	Sample Size
1	Less than \$718	11,969	\$4,095,180	31
2	\$718 to \$1,232	6,281	6,131,164	36
3	Greater than \$1,232	3,047	5,215,366	33
<b>Total</b>		<b>21,297</b>	<b>\$15,441,710</b>	<b>100</b>

### SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

### METHOD OF SELECTING SAMPLE ITEMS

We sorted the line items within our sampling frame by the "Line Provider Payment Amount" field and then consecutively numbered the sampling frame line items within strata 1 through 3. After generating the random numbers for each of these strata, we selected the corresponding line items for review.

### ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the: (1) improper co-surgery payments, (2) improper assistant-at-surgery and duplicate service payments (the billing issues unrelated to co-surgery services), and (3) the overall improper payment amounts in our sampling frame. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval for each of these estimates.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

**Table 2: Statistical Sample Item Results for Incorrectly Billed Co-Surgery Services**

<b>Stratum</b>	<b>Frame Size (Line Items)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Line Items in Sample</b>	<b>Value of Improper Payments in Sample</b>
1	11,969	\$4,095,180	31	\$12,638	14	\$1,608
2	6,281	6,131,164	36	35,442	19	4,070
3	3,047	5,215,366	33	57,588	16	8,669
<b>Totals*</b>	<b>21,297</b>	<b>\$15,441,710</b>	<b>100</b>	<b>\$105,668</b>	<b>49</b>	<b>\$14,347</b>

\*The dollar amounts may not add up exactly due to rounding.

**Table 3: Statistical Sample Results for Incorrectly Billed Assistant-at-Surgery and Duplicate Services**

<b>Stratum</b>	<b>Frame Size (Line Items)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Line Items in Sample</b>	<b>Value of Improper Payments in Sample</b>
1	11,969	\$4,095,180	31	\$12,638	8	\$2,647
2	6,281	6,131,164	36	35,442	7	5,390
3	3,047	5,215,366	33	57,588	5	9,162
<b>Totals*</b>	<b>21,297</b>	<b>\$15,441,710</b>	<b>100</b>	<b>\$105,668</b>	<b>20</b>	<b>\$17,198</b>

\*The dollar amounts may not add up exactly due to rounding.

**Table 4: Overall Statistical Sample Results for Incorrectly Billed Services**

<b>Stratum</b>	<b>Frame Size (Line Items)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Line Items in Sample</b>	<b>Value of Improper Payments in Sample</b>
1	11,969	\$4,095,180	31	\$12,638	22	\$4,255
2	6,281	6,131,164	36	35,442	26	9,459
3	3,047	5,215,366	33	57,588	21	17,830
<b>Totals*</b>	<b>21,297</b>	<b>\$15,441,710</b>	<b>100</b>	<b>\$105,668</b>	<b>69</b>	<b>\$31,545</b>

\*The dollar amounts may not add up exactly due to rounding.

## ESTIMATES

**Table 5: Estimated Value of Unallowable Payments in the Sampling Frame  
(Limits Calculated at the 90-Percent Confidence Level)**

Estimates	Improper Payments for Co-Surgery Errors*	Improper Payments for Assistant-at-Surgery and Duplicate Service Errors*	Improper Payments for All Sampled Line Item Errors*
Point Estimate	\$2,131,354	\$2,808,232	\$4,939,586
Lower Limit	1,642,972	1,767,427	3,943,719
Upper Limit	2,619,736	3,849,037	5,935,453
<p>*The estimates calculated for the “Improper Payments for Co-Surgery Errors” are mutually exclusive from the estimates calculated for the “Improper Payments for Assistant-at-Surgery and Duplicate Service Errors.” We combined all the sampled line item errors together when calculating the estimates for the “Improper Payments for All Sampled Line Item Errors.”</p>			



## APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*

Washington, DC 20201

**DATE:** October 27, 2022

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

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

**SUBJECT:** Office of Inspector General (OIG) Draft Report - Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers (A-01-20-00503)

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 providing people with Medicare with access to medically necessary services and, at the same time, protecting the Medicare Trust Funds from improper payments.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day, for which separate payment may be allowed. Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session due to the complex nature of the procedures and/or the patient's condition. CMS considers this procedure a co-surgery and makes a reduced payment of 62.5 percent of the global surgery fee schedule amount to physicians for co-surgery procedures when two physicians work together to perform a surgical procedure on the same patient during the same operative session.

Additionally, CMS also makes a reduced payment for assistant-at-surgery services, or when a health care provider supports a primary physician in charge of performing a procedure as a surgical assistant. Specifically, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment. CMS does not allow payment for assistants-at-surgery for surgical procedures in which a physician is used as an assistant-at-surgery in fewer than five percent of the cases for that procedure nationally. Specific to this policy, the Medicare Administrative Contractors (MACs) conduct manual reviews to ensure that assistant-at-surgery services are eligible for payment.

As part of CMS's efforts to reduce improper payments to physicians for co-surgery and assistant-at-surgery services, CMS has maintained national system controls to identify co-surgery procedures that may have been incorrectly billed. Additionally, the MACs have implemented local controls as appropriate for their respective jurisdictions. CMS has also provided provider education and outreach to promote correct billing practices through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

OIG's recommendations and CMS' responses are below.

*Audit of Medicare Part B Payments to Physicians for Co-Surgery Procedures (A-01-20-00503)*

### **OIG Recommendation 1**

Recover the portion of the \$56,016 in Medicare Part B overpayments that are within the 4-year claim reopening period—including \$31,545 in overpayments for the 69 incorrectly billed statistically sampled services and \$24,471 in overpayments for the 62 incorrectly billed corresponding services.

### **CMS Response**

CMS concurs with this recommendation. CMS will recover the identified overpayments consistent with relevant law and the agency's policies and procedures

### **OIG Recommendation 2**

Instruct the MACs to, based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

### **CMS Response**

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate health care providers to notify of potential overpayments. CMS will then instruct its MACs to notify the identified providers 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 3**

Strengthen its system controls to detect and prevent improper payments to providers for incorrectly billed: (1) co-surgery services, (2) assistant-at-surgery services, and (3) duplicate services—which could have saved approximately \$4,939,586 during our audit period.

### **CMS Response**

CMS concurs with this recommendation. CMS will strengthen its claims processing controls to detect and prevent improper payments to health care providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services.

### **OIG Recommendation 4**

Update its Medicare requirements and corresponding educational material to improve providers' understanding of the Medicare Part B billing requirements for co-surgery procedures, including:

- updating the Medicare Claims Processing Manual, chapter 12, section 40.8, to ensure billing providers understand that two physicians performing procedures as co-surgeons (including bilateral procedures) must append the co-surgery modifier regardless of whether they are in the same specialty or in different specialties, and
- providing additional education material to providers clarifying that spinal instrumentation procedure codes must be billed with a co-surgery modifier under Medicare Part B when performed as a co-surgery.

### **CMS Response**

CMS concurs with this recommendation. CMS will update the Medicare Claims Processing Manual consistent with relevant statutory requirements and will continue to educate providers about the Medicare Part B billing requirements for co-surgery procedures.