

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PART B OVERPAID
AND BENEFICIARIES INCURRED
COST-SHARE OVERCHARGES OF
OVER \$1 MILLION FOR THE
SAME PROFESSIONAL SERVICES**

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Deputy Inspector General
for Audit Services**

**September 2022
A-06-21-05003**

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: September 2022
Report No. A-06-21-05003

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



Why OIG Did This Audit

We performed survey work on calendar year 2019 Medicare Part B claims and found that Critical Access Hospitals (CAHs) were paid for professional services provided by health care practitioners that received payment for the same services provided at the CAH. Generally, Medicare should not pay both a CAH and health care practitioner for professional services.

Our objective was to determine whether Medicare Part B payments to CAHs for professional services and payments made to health care practitioners for the same services complied with Federal requirements.

How OIG Did This Audit

Our audit covered 40,026 Medicare Part B claims, 20,013 claims submitted by CAHs and 20,013 claims submitted by health care practitioners, for the same professional services provided to the same beneficiaries on the same dates of service from March 1, 2018, through February 28, 2021 (audit period). Medicare paid CAHs \$1.0 million and paid health care practitioners \$872,858 for these 40,026 claims.

We reviewed Federal requirements for reassigning professional billing rights to CAHs. To conduct our audit, we used data analysis techniques to identify overpayments for professional billing by both the CAH and the health care practitioner.

Medicare Part B Overpaid and Beneficiaries Incurred Cost-Share Overcharges of Over \$1 Million for the Same Professional Services

What OIG Found

Not all Medicare Part B payments made to CAHs for professional services and payments made to health care practitioners complied with Federal requirements. For the 40,026 claims we audited, CAHs and health care practitioners each submitted an equal number of claims. However, for each date of service, only one of the claims complied with Federal requirements. As a result, Medicare administrative contractors (MACs) paid providers \$907,438 more than they should have been paid, and beneficiaries were held responsible for \$281,321 more than they should have been.

These overpayments occurred because CMS did not have claim system edits to prevent and detect duplicate professional services claims for the same date of service, beneficiary, and procedure.

What OIG Recommends and CMS Comments

We recommend that CMS (1) direct the MACs to recover the \$331,448 from the CAHs for 12,156 claims for which the health care practitioners had not reassigned their billing rights to the CAHs and \$83,412 in cost-sharing overcharges to Medicare beneficiaries that are within the 4-year reopening period and (2) direct the MACs to recover the \$575,990 from health care practitioners for 7,857 claims for which the health care practitioners had reassigned their billing rights to the CAHs and \$197,909 in cost-sharing overcharges to beneficiaries that are within the 4-year reopening period. See the audit report for additional recommendations.

CMS concurred with all recommendations except the recommendation to develop system edits or alternative means to prevent and detect overpayments for professional service payments. We maintain that our recommendation is valid. CMS provided reasons why it did not concur with our recommendation to develop and implement system edits to prevent and detect overpayments for professional service payments. In addition, CMS stated that additional action may not be appropriate at this time due to the low dollar amount of the errors. CMS could conduct postpayment review of professional claim data, like the OIG audit methodology discussed in this report, to detect duplicate claims. If CMS developed alternative means to detect duplicate professional service payments, CMS could recoup payments from providers, and beneficiaries would be reimbursed for any overcharges.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare Part B pays for covered outpatient services and professional services at Critical Access Hospitals (CAHs). CAHs are rural hospitals that must meet certain requirements, such as being located more than 35 miles from another hospital, providing no more than 25 inpatient beds, and having an average annual length of stay of 96 hours or less. We performed survey work on calendar year 2019 Medicare Part B claims and found that CAHs were paid for professional services provided by physicians or other practitioners (together “health care practitioners”) who received payment for the same services provided at the CAH during an outpatient encounter. These payments were for the same beneficiary, date of service, and procedure. Generally, Medicare should not pay both a CAH and health care practitioner for professional services.

OBJECTIVE

Our objective was to determine whether Medicare Part B payments to CAHs for professional services and payments made to health care practitioners for the same services complied with Federal requirements.

BACKGROUND

Critical Access Hospitals

The Balanced Budget Act of 1997 authorized States to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare may become CAHs. Under Section 1834(g)(1) of the Social Security Act (the Act) and Federal regulations (42 CFR §§ 410.152(k) and 413.70(b)), CAHs are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment Method. Under the Standard Payment Method, CAHs are paid a facility fee of 101 percent of the reasonable cost to the CAH of furnishing outpatient services reduced by any Part B deductible and coinsurance amounts; the CAH is not paid for any costs of physician services or other professional services to CAH outpatients (42 CFR §§ 410.152(k) and 413.70(b)(1)-(2)). Under Section 1834(g)(2) of the Act and Federal regulations (42 CFR § 413.70(b)(3)(i)), a CAH may elect the Optional (Elective) Payment Method, under which it is paid for both facility services and professional services provided to its outpatients.

Professional Services Payments

Under the Standard Payment Method, physicians and other professionals providing physician services to CAH outpatients are paid the facility rate under the Medicare Physician Fee Schedule (MPFS) (42 CFR §§ 414.4 and 414.22(b)(5)(i)(A)). Under the Optional (Elective)

Payment Method, when professional services are furnished at the CAH by physicians or other practitioners who have reassigned their rights to bill for those services to the CAH, the CAH is paid for those services at 115 percent of the MPFS facility rate less any Part B deductible or coinsurance (42 CFR § 413.70(b)(3)(ii)). When the professional services are provided by a physician in a Health Professional Shortage Area, the professional services fee paid to the CAH is 115 percent of the MPFS rate that has been increased by 10-percent in accordance with 42 CFR § 414.67.¹

Reassigning Professional Services Billing Rights

Under section 1834(g) of the Act and Federal regulations (42 CFR § 413.70(b)(3)(i)(B)), even if a CAH elects the Optional (Elective) Payment Method, practitioners furnishing professional services to CAH outpatients have the option whether to reassign their billing rights to the CAH under 42 CFR part 424, subpart F, or file claims for professional services through their Medicare Parts A and B Medicare administrative contractor (MAC). Practitioners reassigning their billing rights to a CAH may complete Form CMS-855R (Form 855R), which the CAH will forward to its Parts A and B MAC. The Parts A and B MAC will have the practitioners sign an attestation that clearly states that they will not bill the Part B MAC for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. This attestation will remain at the CAH (*Medicare Claims Processing Manual*, chapter 4, § 250.2). The MAC is to create a Provider Enrollment Chain and Ownership System (PECOS) record when a paper application is made on Form 855R. Practitioners may also reassign their billing rights to a CAH through the online PECOS. The reassignment information is retained in the PECOS maintained by CMS and is the agency's system of record for enrollment information.

Medicare Requirements for Providers To Identify, Report, 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.² 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.³

¹ See *Medicare Claims Processing Manual*, ch. 4, § 250.2, for guidance.

² The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

³ 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. 7670 (Feb. 12, 2016).

HOW WE CONDUCTED THIS AUDIT

Our audit covered 40,026 Medicare Part B claims, 20,013 claims submitted by CAHs and 20,013 claims submitted by health care practitioners, for the same professional services provided to the same beneficiaries on the same dates of service from March 1, 2018, through February 28, 2021 (audit period). Medicare Part B MACs paid CAHs \$1,021,450 and paid health care practitioners \$872,858 for these 40,026 claims. Table 1 shows the total payments made for claims associated with the same beneficiary, date of service, and service. Beneficiaries were responsible for cost sharing of \$245,148 for claims billed by CAHs and \$293,876 for claims billed by health care practitioners for these 40,026 claims. Table 1A shows the beneficiary cost share responsibility for these claims associated with the same beneficiary, date of service, and service.

| Table 1: Payments for CAH and Health Care Practitioner Claims Associated With the Same Beneficiary, Date of Service, and Service | | | | | |
|---|--|---------------------|-------------------------|--|-----------------------|
| CAH Claims | Health Care Practitioner Claims | Total Claims | Payments to CAHs | Payments to Health Care Practitioners | Total Payments |
| 20,013 | 20,013 | 40,026 | \$1,021,450 | \$872,858 | \$1,894,308 |

| Table 1A: Cost Share for the Same Beneficiary, Date of Service, and Service | | | | | |
|--|--|---------------------|-----------------------|--|-------------------------|
| CAH Claims | Health Care Practitioner Claims | Total Claims | CAH Cost Share | Health Care Practitioner Cost Share | Total Cost Share |
| 20,013 | 20,013 | 40,026 | \$245,148 | \$293,876 | \$539,024 |

For our audit period, we reviewed the Federal requirements for reassigning professional billing rights to CAHs and CMS's internal controls specific to claims containing professional services submitted by both CAHs and health care practitioners. To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments for professional services billing by both the CAH and the health care practitioner.

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.

The Appendix contains the details of our audit scope and methodology.

FINDINGS

Not all Medicare Part B payments made to CAHs for professional services and payments made to health care practitioners complied with Federal requirements. For the 40,026 claims we audited, CAHs and health care practitioners each submitted an equal number of claims. However, for each date of service, only one of the claims complied with Federal requirements.⁴ As a result, MACs paid providers \$907,438 more than they should have been paid, and beneficiaries were held responsible for \$281,321 more than they should have been. As of the publication of this report, these amounts include claims outside of the 4-year claim reopening period.

Specifically, MACs overpaid:

- CAHs \$331,448 for 12,156 claims that were associated with services provided by health care practitioners who had not reassigned their billing rights to the CAHs and
- health care practitioners \$575,990 for 7,857 claims even though the health care practitioners had reassigned their billing rights to CAHs.

In addition, beneficiaries were incorrectly held responsible for \$281,321 in Medicare cost sharing. Table 2 shows the overpayments for the same beneficiary, date of service, and service based on the PECOS and claim information.

| Table 2: Overpayments for the Same Beneficiary, Date of Service, and Service | | | | | | |
|---|-------------------------|--|--|-----------------------|--|---------------------------|
| 20,013 Claims With Overpayments | | | | | | |
| CAH Claims | CAH Overpayments | Health Care Practitioner Claims | Health Care Practitioner Overpayments | CAH Cost Share | Health Care Practitioner Cost Share | Total Overpayments |
| 12,156 | \$331,448 | 7,857 | \$575,990 | \$83,412 | \$197,909 | \$1,188,759 |

These overpayments occurred because CMS did not have claim system edits to prevent and detect duplicate professional services claims for the same date of service, beneficiary, and procedure.

⁴ Our audit was limited to determining whether Medicare Part B payments to CAHs and health care practitioners for the same professional services provided to the same beneficiaries on the same dates of service complied with Federal requirements and did not include reviewing the medical necessity of services or compliance with other Medicare requirements.

CRITICAL ACCESS HOSPITALS BILLED AND WERE PAID FOR SERVICES PERFORMED BY HEALTH CARE PRACTITIONERS WHO HAD NOT REASSIGNED THEIR BILLING RIGHTS

Under section 1834(g)(1) of the Social Security Act and Federal regulations (42 CFR §§ 410.152(k) and 413.70(b)), CAHs are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment Method. Under section 1834(g)(2) of the Act and Federal regulations (42 CFR § 413.70(b)(3)(i)), a CAH may elect the Optional (Elective) Payment Method, under which it bills the Part B MAC for both Medicare Part B facility services and Medicare Part B professional services for its outpatients. Under Section 1834(g) of the Act and Federal regulations (42 CFR § 413.70(b)(3)(i)(B)), even if a CAH elects the Optional (Elective) Payment Method, practitioners furnishing professional services to CAH outpatients have the option whether to reassign their billing rights to the CAH under 42 CFR part 424, subpart F, or file claims for professional services through their MAC. CAHs cannot bill Medicare Part B for outpatient professional services provided by health care practitioners without reassignments. The CAH must forward a copy of the completed form 855R to the MAC and keep the original form on file. Practitioners must sign an attestation that clearly states that they will not bill Medicare Part B for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH (*Medicare Claims Processing Manual*, chapter 4, section 250.2).

CMS recognizes the PECOS as its system of record for Medicare provider enrollment data and acknowledges that it is essential that the PECOS contains accurate information. Using PECOS, we determined that CAHs billed and were paid for 12,156 claims totaling \$331,448 that were associated with health care practitioners who had not reassigned their billing rights to the CAH. For these claims, beneficiaries were responsible for up to \$83,412 in cost sharing.

Table 2A shows examples in which the health care practitioner did not reassign billing rights to the CAH, although the CAH billed and was paid for the service.

Table 2A: Examples of CAH Overpayments for the Same Beneficiary, Date of Service, and Service

| Claim | Procedure Code | Procedure Type | Payment to CAH | Cost Share | |
|-------|----------------|--|----------------|------------|-----------------|
| 1 | 93010 | Electrocardiogram | \$7.90 | \$1.75 | \$9.65 |
| 2 | 99291 | Critical Care | \$279.29 | \$61.96 | \$341.25 |
| 3 | 93010 | Electrocardiogram | \$7.90 | \$1.75 | \$9.65 |
| 4 | 27792 | Fracture and/or Dislocation Procedures on the Leg (Tibia and Fibula) and Ankle Joint | \$266.89 | \$124.76 | \$391.65 |
| 5 | 93010 | Electrocardiogram | \$7.63 | \$1.64 | \$9.27 |

We found that CMS did not have claim system edits to prevent and detect overpayments for professional services for the same date of service, beneficiary, and procedure.

HEALTH CARE PRACTITIONERS BILLED AND WERE PAID FOR SERVICES THEY PERFORMED BUT HAD REASSIGNED THEIR BILLING RIGHTS TO THE CRITICAL ACCESS HOSPITALS

Under section 1834(g)(1) of the Social Security Act and Federal regulations (42 CFR §§ 410.152(k) and 413.70(b)), CAHs are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment Method. Under section 1834(g)(2) of the Act and Federal regulations (42 CFR § 413.70(b)(3)(i)), a CAH may elect the Optional (Elective) Payment Method, under which it bills the Part B MAC for both Medicare Part B facility services and Medicare Part B professional services for its outpatients. If physicians or other practitioners reassign their Medicare Part B billing rights under 42 CFR part 424, subpart F, and agree to be included under a CAH's Optional (Elective) Payment Method, they must not bill the MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective. The CAH must forward a copy of the completed Form CMS-855R to the MAC and keep the original form on file. Practitioners must sign an attestation that clearly states that they will not bill Medicare Part B for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH (*Medicare Claims Processing Manual*, chapter 4, section 250.2).

CMS recognizes the PECOS as its system of record for Medicare provider enrollment data and acknowledges that it is essential that the PECOS contains accurate information. Using PECOS, we determined that health care practitioners who reassigned their billing rights to CAHs billed and were paid for 7,857 claims totaling \$575,990. For these claims, beneficiaries were responsible for up to \$197,909 in cost sharing. MACs also made payments to health care practitioners for the 7,857 services associated with these claims, and those beneficiaries were responsible for the associated cost sharing. Table 2B (next page) shows examples of instances in which the health care practitioners who reassigned billing rights to the CAHs also billed and were paid for the services.

Table 2B: Examples of Health Care Practitioner Overpayments for the Same Beneficiary, Date of Service, and Service

| Claim | Procedure Code | Procedure Type | Payment to Health Care Practitioner | Cost Share | Total Overpayment |
|-------|----------------|---|-------------------------------------|------------|-------------------|
| 1 | 52235 | Cystourethroscopy, With Fulguration and/or Resection | \$111.62 | \$57.76 | \$169.38 |
| 2 | 66984 | Intraocular Lens Procedure | \$393.29 | \$125.41 | \$518.70 |
| 3 | 93010 | Electrocardiogram | \$9.29 | \$2.37 | \$11.66 |
| 4 | 99215 | Established Patient Office or Other Outpatient Services | \$114.74 | \$22.69 | \$137.43 |
| 5 | 49505 | Repair Initial Inguinal Hernia, age 5 Years or Older | \$364.23 | \$95.79 | \$460.02 |

We found that CMS did not have claim system edits to prevent and detect overpayments for duplicate professional services for the same date of service, beneficiary, and procedure.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs to recover the \$331,448 from the CAHs for 12,156 claims for which the health care practitioners had not reassigned their billing rights to the CAHs and \$83,412 in cost-sharing overcharges to Medicare beneficiaries that are within the 4-year reopening period;
- direct the MACs to recover the \$575,990 from the health care practitioners for 7,857 claims for which health care practitioners had reassigned their billing rights to the CAHs and \$197,909 in cost-sharing overcharges to Medicare beneficiaries that are within the 4-year reopening period;
- request that relevant providers 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;
- coordinate with the MACs to develop and implement claim system edits or alternative means to prevent and detect overpayments for professional service payments;

- direct the MACs to educate CAHs on their obligation not to bill for professional services when health care practitioners do not reassign billing rights to the CAH; and
- direct the MACs to educate health care practitioners on their obligation not to bill for professional services when they have reassigned billing rights to the CAH.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with all but the fourth recommendation. CMS provided information on actions that it planned to take to address the recommendations with which it agreed and reasons why it did not concur with the one recommendation. CMS stated that it plans to direct the MACs to recover improperly paid amounts, analyze OIG's data to identify relevant providers and direct the MACs to notify providers of potential overpayments in accordance with the 60-day rule, and direct the MACs to educate providers.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included in their entirety as Appendix B. A summary of CMS's response to our fourth recommendation and our response is below.

CMS COMMENTS

Regarding our fourth recommendation that CMS coordinate with the MACs to develop and implement claim system edits or alternative means to prevent and detect overpayments for professional service payments, CMS stated that it had previously explored these types of system edits and found them to be inaccurate. CMS stated that there is no requirement to include the rendering provider at the line level on Part A claims, making it difficult to consistently match duplicate Part A and B claims by provider. CMS also stated that providers have up to 1 year to submit a bill for services and that it is not practical for CMS to withhold payment on a claim for up to a year because a duplicate claim could be filed at a later point that year. CMS noted that the current standards for the submission of a health claim are developed by a standards division organization, and any changes to the standard would need to be made by the standards development organization. CMS added that it and the MACs direct limited program integrity resources to areas with the highest return and highest need. Given the inaccuracy and complexity of system edits and the proportionally low dollar amount to be potentially in error in this report, CMS said, this area may not meet the requirements for additional action at this time.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering CMS's comments, we maintain that this recommendation is valid. CMS provided reasons why it did not concur with our recommendation to develop and implement system edits to prevent and detect overpayments for professional service payments. In

addition, CMS stated that additional action may not be appropriate at this time due to the low dollar amount of the errors. While the amount of dollars in error may be low in comparison to the overall cost of the program, they are in excess of \$1 million during our audit period. CMS could conduct postpayment review of professional claim data, like the OIG audit methodology discussed in this report, to detect duplicate claims. If CMS developed alternative means to detect duplicate professional service payments, CMS could recoup payments from providers, and beneficiaries would be reimbursed for any overcharges.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 40,026 Medicare Part B claims that CAHs and health care practitioners submitted for professional services provided from March 1, 2018, through February 28, 2021. We reviewed the Federal requirements for professional services billing by CAHs and health care practitioners and CMS's internal controls to prevent payment of claims submitted by both CAHs and health care practitioners for the same service. We reviewed all billed and paid claims for professional services submitted by CAHs and health care practitioners for the same beneficiary and date of service during the audit period to determine whether CMS's controls prevented payments from being made to both CAHs and health care practitioners for the same service.

To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify any claims for the same service submitted by both the CAH and the health care practitioner. After removing claims that contained certain modifiers, our audit covered 20,013 claims submitted by CAHs and 20,013 claims submitted by health care practitioners for the same professional services for the beneficiary and date of service during the audit period. CAHs were paid \$1,021,450, and health care practitioners were paid \$872,858 for these 40,026 claims. For the 40,026 claims, beneficiaries incurred cost-sharing amounts of \$245,148 for services billed by CAHs and \$293,876 for services billed by health care practitioners.

We performed our audit work from March 2021 through June 2022.

METHODOLOGY

To accomplish our objective:

- We reviewed applicable Federal requirements and guidelines.
- We obtained a list of 28,005 CAH and health care practitioner professional claims for the same beneficiary and dates of service from March 1, 2018, through February 28, 2021.
- We used computer matching, data mining, and other data analysis techniques to identify overpayments for duplicate professional billing by both the CAH and the health care practitioner.
- We removed from our list of 28,005 claims, 7,992 claims that contained certain modifiers that indicated that they may not be duplicates:

- We removed 7,490 claims with “26” or “TC” modifiers.⁵ These claims involved instances in which either the CAH billed for the professional component of a service rendered by the same health care practitioner who billed for the technical component of the service, or the CAH and the health care practitioner both billed for the professional component. We could not determine whether these were duplicate claims because these may have been instances of coding errors that were beyond the scope of our audit.
- We removed 458 claims with modifiers for claims for which there was an assistant at surgery.⁶ These claims involved instances in which the CAH billed for the surgical service of the same physician who also billed for the service, but one billed with an assistant surgeon modifier and the other did not. We could not determine whether these were duplicate claims because they appeared to be instances of coding errors that were beyond the scope of our audit.
- We removed 44 claims with modifiers for anesthesia, which represent anesthesiology and medical direction of an anesthesiologist. These claims involved instances in which both the CAH billed for the physician and same physician billed the same procedure code for anesthesiologist or the same modifier for medical direction of an anesthesiologist. We could not determine whether these were duplicate claims because these may have been instances of coding errors that were beyond the scope of our audit.
- For the remaining 20,013 claims, we calculated the amount of overpayments for professional services and the amount that beneficiaries were responsible for in cost sharing.
- We contacted CMS officials to obtain an understanding of CMS’s oversight of professional services billing by CAHs and health care practitioners.
- We discussed the results of the audit 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

⁵ The 26 modifier represents the professional component of a service, and the TC modifier is the technical component of a service. Some services have separate professional and technical components, and the 26 modifier should be appended to the procedure code by the provider who rendered only the professional component of the service. The TC modifier should be appended to the procedure code by the provider who rendered only the technical component of the service. Other procedure codes are “Professional Component Only Codes” or “Technical Component Only Codes.”

⁶ If there is an assistant during surgery, the primary surgeon is paid a full amount and the assistant appends the 80 modifier to his or her claim and is paid a lesser amount.

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: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 1, 2022

TO: Amy Frontz
Deputy Inspector General for Audit Services

FROM: Chiquita Brooks-LaSure *Chiquita Brooks-LaSure*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Part B Overpaid and Beneficiaries Incurred Cost-Share Overcharges of Over \$1 Million for the Same Professional Services (A-06-21-05003)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to protecting the Medicare trust funds by ensuring that Critical Access Hospitals (CAH) and healthcare practitioners are paid according to applicable Medicare statutory and regulatory authorities and that beneficiaries are billed for the proper cost-sharing amounts.

Medicare Part B hospital outpatient payment includes both professional services (services furnished by a health care practitioner) and facility services (use of hospital space and equipment). CAHs, a hospital provider type that can furnish outpatient services, are generally paid under the Standard Payment Method, with CAH facility services paid at 101 percent of reasonable costs. Under this Standard Payment Method, the physician or practitioner bills their outpatient professional services under the Physician Fee Schedule (PFS). CAHs may also elect to instead be paid under the Optional Payment Method. Under the Optional Payment Method, outpatient services are paid based on the sum of Facility services: 101 percent of CAH reasonable costs for facility services and 115 percent of the PFS allowable amount for physician professional services. Under this Method, the CAH bills both facility and professional outpatient services when physician(s) or practitioner(s) reassign their billing rights to the CAH. If a CAH elects this option, each physician or practitioner furnishing professional outpatient CAH services can choose to either reassign their billing rights to the CAH and agree to the Optional Payment Method and must attest in writing they won't bill their Medicare Administrative Contractor (MAC) for professional CAH outpatient services or file claims for their professional services under the Medicare PFS.

In order to ensure that claims are paid properly, hospitals and health care professionals electing the Optional Method must file a written election with the appropriate MAC, including an application form and an attestation that they will bill properly under that method. These forms are stored at the MACs and/or in CMS's national enrollment database, the Provider Enrollment, Chain, and Ownership System. If no election is filed, the CAH is paid under the Standard Method and should not bill Medicare for professional services. Likewise, once an election for the Optional Method has been filed, the practitioner should no longer bill Medicare for professional services.

Billing in this area is complex, and CMS has previously explored system edits and found them to be inaccurate because there is no requirement to include the rendering provider at the line level on Part A claims, making it difficult to consistently match duplicate Part A and B claims by provider. The lack of corresponding line level Part A rendering provider information would cause the edit to deny too many correct claims. In addition, as discussed above, CMS already imposes attestation requirements to ensure that claims are paid properly. CMS also focuses resources on educating CAHs and practitioners on these requirements through the Medicare Learning Network. CMS appreciates OIG's work on this issue and will consider additional actions consistent with our priorities.

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

OIG Recommendation

CMS should direct the MACs to recover the \$331,448 from the CAHs for 12,156 claims for which the health care practitioners had not reassigned their billing rights to the CAHs and \$83,412 in cost-sharing overcharges to Medicare beneficiaries that are within the 4-year reopening period.

CMS Response

CMS concurs with this recommendation. CMS will direct MACs to recover improperly paid amounts in accordance with our policies and procedures. Providers and suppliers are required by agreement to return any cost-sharing associated with overpayments.

OIG Recommendation

CMS should direct the MACs to recover the \$575,990 from the health care practitioners for 7,857 claims for which health care practitioners had reassigned their billing rights to the CAHs and \$197,909 in cost-sharing overcharges to Medicare beneficiaries that are within the 4-year reopening period.

CMS Response

CMS concurs with this recommendation. CMS will direct MACs to recover improperly paid amounts in accordance with our policies and procedures. Providers and suppliers are required by agreement to return any cost-sharing associated with overpayments.

OIG Recommendation

CMS should request that relevant providers 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 relevant providers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers of the OIG's audit and the potential overpayments and report any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

CMS should coordinate with the MACs to develop and implement claim system edits or alternative means to prevent and detect overpayments for professional service payments.

CMS Response

CMS non-concurs with this recommendation. CMS has previously explored system edits and found them to be inaccurate because there is no requirement to include the rendering provider at the line level on Part A claims, making it difficult to consistently match duplicate Part A and B claims by provider. The lack of corresponding line level Part A rendering provider information would cause the edit to deny too many correct claims.

Under Medicare rules, providers have up to one year to submit a bill for services. It is not practical for CMS to withhold payment on a claim for up to a year in the event that a duplicative claim is filed at a later point that year. It is also important to note that the current standard for the submission of a health claim, ASC X12N 837 Version 5010, is developed by a standards development organization and any changes to the standard would need to be made by the standards development organization. In addition, CMS and the MACs direct limited program integrity resources to the areas with the highest rates of return and highest need. Given the inaccuracy and complexity of system edits and the proportionally low dollar amount found to be potentially in error in this report, this area may not meet those requirements for additional action at this time.

OIG Recommendation

CMS should direct the MACs to educate CAHs on their obligation not to bill for professional services when health care practitioners do not reassign billing rights to the CAH.

CMS Response

CMS concurs with this recommendation and will direct the MACs to continue to educate the CAHs in their jurisdiction.

OIG Recommendation

CMS should direct the MACs to educate health care practitioners on their obligation not to bill for professional services when they have reassigned billing rights to the CAH.

CMS Response

CMS concurs with this recommendation and will direct the MACs to continue to educate health care providers in their jurisdiction.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.