Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORIDIAN HEALTHCARE SOLUTIONS, LLC, MADE $8.8 MILLION IN IMPROPER MONTHLY CAPITATION PAYMENTS TO PHYSICIANS AND QUALIFIED NONPHYSICIAN PRACTITIONERS IN JURISDICTION E FOR CERTAIN SERVICES RELATED TO END-STAGE RENAL DISEASE

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June 2023
A-09-21-03016

Office of Inspector General

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Report in Brief
Date: June 2023
Report No. A-09-21-03016

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

Noridian Healthcare Solutions, LLC, Made $8.8 Million in Improper Monthly Capitation Payments to Physicians and Qualified Nonphysician Practitioners in Jurisdiction E for Certain Services Related to End-Stage Renal Disease

Why OIG Did This Audit

Medicare makes monthly capitation payments (MCPs) to physicians and qualified nonphysician practitioners managing patients in a dialysis center. The MCP covers most outpatient dialysis-related physician services furnished to enrollees with end-stage renal disease (ESRD). In FY 2016, the Centers for Medicare & Medicaid Services estimated that there was $107 million in overpayments for ESRD-related services billed for enrollees 20 years of age and older who had four or more face-to-face visits by a physician or qualified nonphysician practitioner per month, which corresponded to an improper payment rate of 21 percent.

Our objective was to determine whether Noridian Healthcare Solutions, LLC (Noridian), made MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance.

How OIG Did This Audit

Our audit covered Medicare Part B payments of $46.7 million for certain ESRD-related services, which we grouped into 189,683 enrollee-months with dates of service from April 1 through December 31, 2020 (audit period). We selected a random sample of 100 enrollee-months. An enrollee-month consisted of all Part B claim lines for an enrollee who received ESRD-related services and was 20 years of age or older with four or more visits by a physician or qualified nonphysician practitioner in that month.

What OIG Found

Noridian did not make some MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance. Of the sampled 100 enrollee-months, 74 met the requirements; however, the remaining 26 enrollee-months did not meet 1 or more of the requirements. As a result, Noridian made improper MCPs of $4,663 to physicians and qualified nonphysician practitioners. Enrollees were responsible for $1,162 in coinsurance related to the improper payments. These improper payments occurred because Noridian's oversight was not sufficient to ensure that physicians and qualified nonphysician practitioners met Medicare billing requirements for ESRD-related services. On the basis of our sample results, we estimated that for our audit period Noridian made approximately $8.8 million in improper MCPs to physicians and qualified nonphysician practitioners for ESRD-related services. We also estimated that Medicare enrollees paid approximately $2.2 million in coinsurance for the improperly paid ESRD-related services.

What OIG Recommends and Noridian Comments

We recommend that Noridian: (1) recover $4,663 in improper payments made to physicians and qualified nonphysician practitioners for the 26 sampled enrollee-months; (2) notify the physicians and qualified nonphysician practitioners to refund $1,162 in coinsurance that was collected for the 26 sampled enrollee-months; and (3) update the educational material on its website as well as any previously provided webinars to include all Medicare requirements and guidance for billing and documenting ESRD-related services and continue to perform medical record reviews as part of the Targeted Probe and Educate program, which could have saved the Medicare program an estimated $8.8 million and could have saved Medicare enrollees up to an estimated $2.2 million for our audit period. The report contains one other recommendation.

Noridian concurred with all of our recommendations and described actions that it had taken or planned to take to address our recommendations, including updating the educational material on its website to include all Medicare requirements and guidance for billing and documenting ESRD-related services.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare makes monthly capitation payments (MCPs) to physicians and qualified nonphysician practitioners managing patients in a dialysis center.[1] The MCP covers most outpatient dialysis-related physician services furnished to Medicare enrollees with end-stage renal disease (ESRD).[2] In this report, we refer to covered outpatient dialysis-related physician services provided to these enrollees as "ESRD-related services."[3] In fiscal year (FY) 2016, the Centers for Medicare & Medicaid Services (CMS) estimated that there was $107 million in overpayments for ESRD-related services billed for enrollees 20 years of age and older who had four or more face-to-face visits by a physician or practitioner per month, which corresponded to an improper payment rate of 21 percent.[4] Physicians and practitioners bill for these services using Current Procedural Terminology (CPT)[5] code 90960. Therefore, we conducted this audit to determine whether Noridian Healthcare Solutions, LLC (Noridian), a Medicare Administrative Contractor (MAC), made improper MCPs to physicians and practitioners in Jurisdiction E for these ESRD-related services from April 1 through December 31, 2020 (audit period).

OBJECTIVE

Our objective was to determine whether Noridian made MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance.

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[1] Qualified nonphysician practitioners consist of clinical nurse specialists, nurse practitioners, and physician assistants. In this report, we also refer to qualified nonphysician practitioners as "practitioners."

[2] ESRD is a medical condition in which a person's kidneys permanently cease functioning, leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.

[3] The payment for ESRD-related services represents a range of physician and practitioner services provided during the month, such as the establishment of a dialyzing cycle, outpatient evaluation and management of dialysis visits, telephone calls, and patient management during dialysis.

[4] CMS publishes detailed improper payment rate information in the annual Medicare Fee-for-Service Improper Payments Report and appendices. The estimated overpayments for ESRD-related services were included as part of the appendices.

[5] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 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 document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

BACKGROUND

The Medicare Program and the Role of Medicare Administrative Contractors

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with ESRD. CMS administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services, including physician services furnished to individuals who have been determined to have ESRD.

CMS contracts with MACs to, among other things, process and pay claims; determine provider compliance with Medicare coverage, coding, documentation, and billing rules; and educate providers on Medicare billing requirements. MACs also perform medical record reviews as part of CMS's Targeted Probe and Educate (TPE) program, which includes one-on-one education to reduce claim errors and denials for providers that have high denial rates or unusual billing practices. Each MAC is responsible for processing claims submitted by health care providers within 1 of 12 designated regions, or jurisdictions, of the United States and its territories.[6]

Noridian Healthcare Solutions, LLC

During our audit period, Noridian was the MAC for Jurisdiction E, which covers California, Hawaii, Nevada, and the U.S. territories of American Samoa, Guam, and Northern Mariana Islands.

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

Physicians and practitioners may be paid an MCP for ESRD-related services provided in outpatient dialysis facilities (center-based).[7, 8] The amount of payment for the MCP is determined under the Medicare physician fee schedule.[9] The payment amount varies based on the age of the enrollee and the number of face-to-face visits that a physician or practitioner provides during each calendar month in which the enrollee receives ESRD-related services. The payment amount also varies based on the geographic location where the ESRD-related services are provided.

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[6] Health care providers include institutional providers, physicians, practitioners, and suppliers.

[7] 42 CFR § 414.314(a). See also CMS's *Medicare Claims Processing Manual,* Pub. No. 100-04 (the Manual), chapter 8, § 140. This report focuses on physician services paid under the physician MCP method, but physicians may elect to be paid under the initial method instead. Under the initial method, the MAC pays a facility for routine professional services furnished by physicians, and the payment is added to the facility's composite rate payment (42 CFR § 414.313). The physician may not be paid under both methods for the same service (42 CFR § 414.310(e)).

[8] The term "center-based" refers to services performed in one of the multiple types of facilities identified in the Manual, chapter 8, section 10.9.

[9] 42 CFR § 414.314(c).

Physicians and practitioners bill the MACs using the appropriate CPT codes based on an enrollee's age and whether ESRD-related services are provided to the enrollee during one visit, two to three visits, or four or more visits in a calendar month. The payment amount is the lowest for one visit, higher for two to three visits, and the highest for four or more visits per month.

Figure 1 shows the three CPT codes that are specific to center-based ESRD enrollees who are 20 years of age and older. In this audit, we reviewed claims billed with CPT code 90960.

Figure 1: CPT Codes for ESRD-Related Services

CPT Code	Description
90960	ESRD-related services monthly, for enrollees 20 years of age and older with **four or more face-to-face visits** by a physician or qualified nonphysician practitioner per month.
90961	ESRD-related services monthly, for enrollees 20 years of age and older with **two to three face-to-face visits** by a physician or qualified nonphysician practitioner per month.
90962	ESRD-related services monthly, for enrollees 20 years of age and older with **one face-to-face visit** by a physician or qualified nonphysician practitioner per month.

These three CPT codes are to be billed once per calendar month. The enrollee's age at the end of the month is the age used to determine the appropriate CPT code. Visits must be furnished face-to-face by a physician or practitioner.[10] At least one of the visits must include a clinical examination of the vascular access site.[11, 12]

[10] The Manual, chapter 8, §§ 140.1.b and 140.1.c.

[11] Vascular access is an opening made in the skin and blood vessel during a short operation. During dialysis, blood flows out of the access site into a hemodialysis machine. After the blood is filtered in the machine, it flows back through the access site into the body.

[12] Effective January 1, 2005, CMS added ESRD-related services to the list of Medicare telehealth services, allowing the use of an interactive telecommunication system to provide the required visits, except that a physician or qualified nonphysician practitioner must furnish a face-to-face, "hands on" examination (without the use of an interactive telecommunication system) of the vascular access site at least once per month (69 Fed. Reg. 66235, 66236, 66276–66277 (Nov. 15, 2004)). Effective March 31, 2020, on an interim basis in light of the COVID-19 public health emergency, CMS permitted the monthly examination of the vascular access site to be furnished as a Medicare telehealth service (85 Fed. Reg. 19230, 19242 (Apr. 6, 2020)). This waiver was in effect throughout our audit period.

A billing physician or practitioner may use other physicians or practitioners to provide some of the visits during the month. However, the billing physician or practitioner must provide at least one face-to-face visit during the month with the patient. The billing physician or practitioner does not have to be present when other physicians or practitioners provide visits. The other physician or practitioner must be a partner, an employee of the same group practice, or an employee of the billing physician or practitioner. The physician or practitioner who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management of the patient should submit the claim for the monthly service.[13]

Payment for ESRD-related services is made at 80 percent of the Medicare-approved MCP amount after an enrollee's Medicare Part B deductible has been met.[14] The enrollee is responsible for the deductible and 20-percent coinsurance for ESRD-related services provided by physicians and practitioners.[15]

Prior Office of Inspector General Audit

A prior Office of Inspector General (OIG) audit found that CMS did not always make Medicare MCPs to physicians for monthly ESRD-related services provided from calendar years 2016 through 2018 in accordance with Federal requirements.[16] Specifically, 23,695 claims were for services for which physicians reported monthly ESRD-related CPT codes more than once for the same enrollee for the same month. The claims consisted of: (1) 21,763 claims that resulted in $4 million in overpayments for instances in which different physicians reported codes for services for the same enrollee for the same month and (2) 1,932 claims that resulted in $291,813 in overpayments for instances in which the same physician reported codes more than once for services for the same enrollee for the same month.

Medicare Requirements for Physicians and Qualified Nonphysician Practitioners 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

[13] 68 Fed. Reg. 63195, 63219–63220 (Nov. 7, 2003); the Manual, chapter 8, § 140.1.c.

[14] Medicare pays nurse practitioners, physician assistants, and clinical nurse specialists 85 percent of the participating Medicare physician fee schedule amount.

[15] Social Security Act § 1881(b)(3)(A)(ii); 42 CFR § 414.314(a)(2); the Manual, chapter 8, § 140.

[16] *Medicare Made Millions of Dollars in Overpayments for End-Stage Renal Disease Monthly Capitation Payments* (A-07-19-05117), issued May 24, 2021.

(2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[17]

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.[18]

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B payments of $46.7 million for 189,694 claim lines for certain ESRD-related services, which we grouped into 189,683 enrollee-months with dates of service during our audit period.[19] The enrollee coinsurance associated with these ESRD-related services totaled $11.7 million. Each enrollee-month consisted of claim lines reported with: (1) CPT code 90960, (2) Medicare as the primary payer, and (3) a payment amount greater than $100. We selected a simple random sample of 100 enrollee-months, for which Medicare paid $24,594.

We requested supporting medical record documentation from physicians and practitioners for the sampled enrollee-months. We reviewed the documentation to determine whether the physicians and practitioners met Medicare billing requirements for ESRD-related services, but we did not use a medical reviewer to determine whether these services were medically necessary. However, we shared the findings for some of the sampled enrollee-months with Noridian's medical review staff to confirm that Noridian agreed with our determinations for enrollee-months that did not meet Medicare requirements and guidance for ESRD-related services.[20]

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 describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

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

[18] 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.

[19] An enrollee-month consisted of all Medicare Part B claim lines for an enrollee who received ESRD-related services and was 20 years of age or older with four or more face-to-face visits by a physician or qualified nonphysician practitioner in that month.

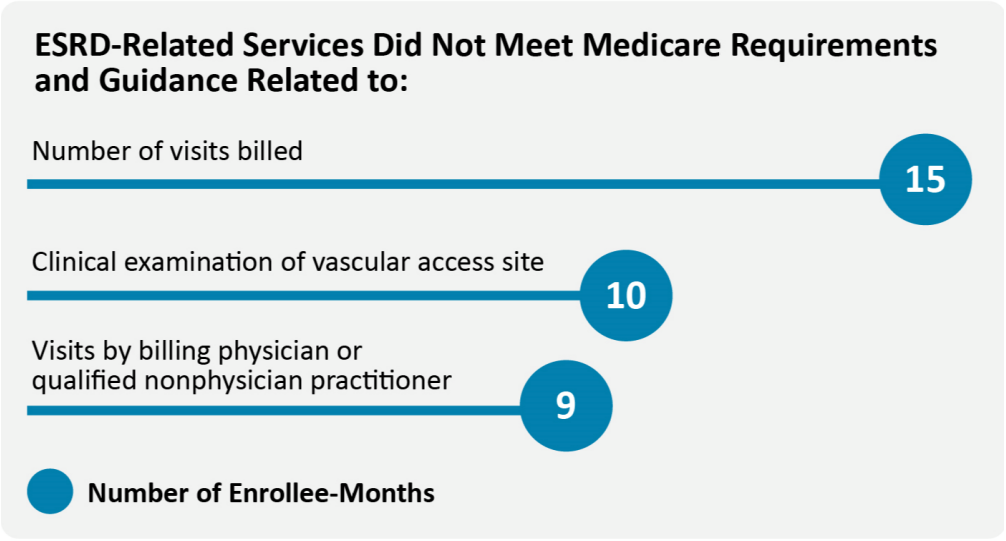
[20] Noridian reviewed a total of 17 sampled enrollee-months and agreed with our determinations.

FINDINGS

Noridian did not make some MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance. Of the sampled 100 enrollee-months, 74 met the requirements; however, the remaining 26 enrollee-months did not meet 1 or more of the requirements.[21]

Figure 2 shows the number of sampled enrollee-months that did not meet Medicare requirements and guidance. The number of enrollee-months in the figure totals more than 26 because 7 enrollee-months did not meet 1 or more of the requirements.

Figure 2: Sampled Enrollee-Months That Did Not Meet Medicare Requirements and Guidance



As a result, Noridian made improper MCPs of $4,663 to physicians and practitioners for the 26 sampled enrollee-months. Enrollees were responsible for $1,162 in coinsurance related to the improper payments. These improper payments occurred because Noridian's oversight, including its education of providers on billing and documenting ESRD-related services and performing medical record reviews, was not sufficient to ensure that physicians and practitioners met Medicare billing requirements for ESRD-related services.

On the basis of our sample results, we estimated that for our audit period Noridian made approximately $8.8 million in improper MCPs to physicians and practitioners for ESRD-related

[21] We did not review 1 enrollee-month because the physician, who retired before the beginning of our audit, sold the practice to two separate entities, which were unable to provide the medical records. We treated this enrollee-month as a non-error.

services.[22] We also estimated that Medicare enrollees paid approximately $2.2 million in coinsurance for the improperly paid ESRD-related services.[23]

MEDICARE REQUIREMENTS AND GUIDANCE

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

As a basis for Medicare payment, the provider, supplier, or enrollee, as appropriate, must furnish to the intermediary or carrier (i.e., the MAC) sufficient information to determine whether payment is due and the amount of payment (42 CFR § 424.5(a)(6)).

CPT code 90960 is used to bill for "End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month" (American Medical Association (AMA), *CPT 2020 Professional*).

At least one of the visits must include a clinical examination of the vascular access site furnished face-to-face, ''hands on,'' by a physician, a clinical nurse specialist, a nurse practitioner, or a physician's assistant.[24]

Billing physicians or practitioners may use other physicians or practitioners to provide some of the visits during the month. However, the billing physician or practitioner must provide at least one face-to-face visit with the patient during the month. The billing physician or practitioner does not have to be present when other physicians or practitioners provide visits. The other physician or practitioner must be a partner, an employee of the same group practice, or an employee of the billing physician or practitioner. The physician or practitioner who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management of the patient should submit the claim for the monthly service.[25]

[22] We estimated for our audit period that Noridian made improper MCPs of $8,844,899.

[23] We estimated for our audit period that Medicare enrollees could have saved $2,204,799 in coinsurance.

[24] See footnote 12.

[25] 68 Fed. Reg. 63195, 63219–63220 (Nov. 7, 2003); the Manual, chapter 8, § 140.1.c.

SERVICES RELATED TO END-STAGE RENAL DISEASE DID NOT MEET MEDICARE REQUIREMENTS AND GUIDANCE

For 26 sampled enrollee-months, ESRD-related services did not meet Medicare requirements and guidance related to the number of visits billed, clinical examination of the vascular access site, and visits by the billing physician or practitioner:[26]

- **Number of Visits Billed.** Enrollees did not have four or more face-to-face visits by a physician or practitioner during the enrollee-month (15 sampled enrollee-months). The documentation did not support that the enrollees had the required number of visits for the billed CPT code. For example, a physician received a $233 payment from Noridian for billing ESRD-related services for an enrollee with four or more face-to-face visits during the sampled enrollee-month. The medical records provided to us supported that the physician provided only one face-to-face visit during the enrollee-month. Therefore, the physician should have been paid $152 instead of $233, an improper payment of $81. In addition, the enrollee was responsible for $60 in coinsurance related to the sampled enrollee-month, which should have been $39.

- **Clinical Examination of Vascular Access Site.** At least one of the four face-to-face visits did not include a clinical examination of the vascular access site furnished by a physician or practitioner (10 sampled enrollee-months). The documentation did not support that the clinical examinations were provided. For example, a physician received a $257 payment from Noridian for billing ESRD-related services for an enrollee with four or more face-to-face visits during the sampled enrollee-month.[27] (The enrollee was responsible for $63 in coinsurance related to that enrollee-month.) The medical records provided to us did not support that at least one of the four visits included an examination of the vascular access site furnished by the physician or nurse practitioner. Therefore, the physician should not have been paid the $257, and the enrollee should not have been responsible for the $63 in coinsurance.

- **Visits by Billing Physician or Practitioner.** The physician or practitioner who provided the complete assessment of the enrollee, established the enrollee's plan of care, and provided the face-to-face visits during the enrollee-month was not the same physician or practitioner who submitted the claim for the monthly services (9 sampled enrollee-months). The documentation did not support that the physician or practitioner who submitted the claim for the monthly services provided any of the services. For example, a physician received a $247 payment from Noridian for billing ESRD-related services for an enrollee with four or more face-to-face visits during the sampled enrollee-month. (The enrollee was responsible for $62 in coinsurance related to that

[26] The number of enrollee-months in the bulleted list totals more than 26 because 7 enrollee-months did not meet more than 1 of the requirements.

[27] Three of the four visits were provided by a physician, and one visit was provided by a nurse practitioner.

enrollee-month.) The medical records provided to us did not support that the billing physician provided the complete assessment, established the enrollee's plan of care, and provided the face-to-face visits during the enrollee-month. Instead, the medical records showed that another physician established the plan of care and provided one face-to-face visit, which included the complete assessment, and a nurse practitioner provided the remaining three face-to-face visits. Therefore, the billing physician should not have been paid the $247, and the enrollee should not have been responsible for the $62 in coinsurance.

NORIDIAN'S OVERSIGHT WAS NOT SUFFICIENT TO ENSURE THAT PHYSICIANS AND QUALIFIED NONPHYSICIAN PRACTITIONERS MET MEDICARE BILLING REQUIREMENTS

Improper payments occurred because Noridian's oversight, including its education of providers on billing and documenting ESRD-related services and performing medical record reviews, was not sufficient to ensure that physicians and practitioners met Medicare billing requirements for ESRD-related services.

Noridian provided educational material and guidance on its website that summarized the requirements for billing and documenting ESRD-related services under the physician MCP method; however, the information on the website did not include all of the Medicare requirements. Specifically, Noridian's educational material did not specify that at least one of the visits must include a clinical examination of the vascular access site furnished by a physician, a clinical nurse specialist, a nurse practitioner, or a physician's assistant. In addition, Noridian conducted a webinar in September 2020 that included billing information on how to properly bill for ESRD-related services; however, the webinar was not archived on its website, so providers could not access it.

Noridian's oversight also included performing medical record reviews related to ESRD-related services under CMS's TPE program.[28] After reviewing the results of Noridian's medical record reviews, we confirmed that some of the errors identified by those reviews were identical to the ones we identified in our audit—for example, that documentation did not support the level of services billed and did not support that the physician who provided the monthly ESRD-related services was the same physician who billed for the monthly services. Although Noridian offered one-on-one education to providers whose claims it reviewed, only 30 percent of the providers accepted the education.

If Noridian does not take action to improve its oversight, Medicare will continue to make improper payments to physicians and practitioners for ESRD-related services, and enrollees will be responsible for coinsurance for these services.

[28] Reviews were completed from January 2019 through March 2020.

MEDICARE IMPROPERLY PAID PHYSICIANS AND QUALIFIED NONPHYSICIAN PRACTITIONERS AN ESTIMATED $8.8 MILLION FOR SERVICES RELATED TO END-STAGE RENAL DISEASE

The improper payments for the 26 sampled enrollee-months totaled $4,663, and enrollees were responsible for $1,162 in coinsurance related to the 26 enrollee-months. On the basis of our sample results, we estimated that Noridian made approximately $8.8 million in improper MCPs to physicians and practitioners for ESRD-related services for our audit period. We also estimated that Medicare enrollees paid approximately $2.2 million in coinsurance for the improperly paid ESRD-related services.

RECOMMENDATIONS

We recommend that Noridian Healthcare Solutions, LLC:

- recover $4,663 in improper payments made to physicians and qualified nonphysician practitioners for the 26 sampled enrollee-months;

- notify the physicians and qualified nonphysician practitioners to refund $1,162 in coinsurance that was collected for the 26 sampled enrollee-months;

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

- update the educational material on its website as well as any previously provided webinars to include all Medicare requirements and guidance for billing and documenting ESRD-related services and continue to perform medical record reviews as part of the TPE program, which could have saved the Medicare program an estimated $8,844,899 and could have saved Medicare enrollees up to an estimated $2,204,799 for our audit period.

NORIDIAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Noridian concurred with all of our recommendations and described actions that it had taken or planned to take to address our recommendations. With respect to our fourth recommendation, as of May 26, 2023, Noridian had updated its static webpages to include information related to billing and documenting ESRD-related services. Furthermore, Noridian's planned actions to address our recommendations included: (1) recovering improper payments through adjustments and issuing demand letters as appropriate to physicians and qualified nonphysician practitioners identified in OIG's sample

and (2) continuing to perform medical record reviews in accordance with CMS direction and Noridian's Medical Review Strategy.

With respect to our finding regarding the clinical examination of the vascular access site, Noridian stated that CMS had provided all MACs with review criteria for medical record reviews. However, Noridian stated: "This criterion does not allow MACs to deny claims if the documentation does not support a clinical examination of the vascular access site." In its comments on our fourth recommendation, Noridian stated that it "will request that CMS update the review criteria for ESRD services to allow all MACs to review documentation related to the monthly assessment of the vascular access [site]." Noridian also stated that it does not have any previously presented webinars on its website.

Noridian's comments appear in their entirety as Appendix D.

With respect to Noridian's comments on CMS criteria for medical record reviews, as we stated in footnote 12 of our report, CMS requires that "a physician or qualified nonphysician practitioner . . . furnish a face-to-face, 'hands on' examination . . . of the vascular access site at least once per month" (69 Fed. Reg. 66235, 66236, 66276–66277 (Nov. 15, 2004)).

We encourage Noridian to seek guidance from CMS regarding the criteria for medical record reviews and take appropriate action to deny claims if the medical record documentation does not support that a physician or qualified nonphysician practitioner furnished at least one face-to-face, "hands on" clinical examination of the vascular access site per month. We also encourage Noridian to ensure that any future webinars on its website include all Medicare requirements and guidance for billing and documenting ESRD-related services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part B payments of $46,736,001 for 189,694 claim lines for certain ESRD-related services, which we grouped into 189,683 enrollee-months with dates of service from April 1, 2020, through December 31, 2020.[29] The enrollee coinsurance associated with these ESRD-related services totaled $11,650,824. Each enrollee-month consisted of claim lines reported with: (1) CPT[30] code 90960, (2) Medicare as the primary payer, and (3) a payment amount greater than $100. We selected a simple random sample of 100 of these enrollee-months, for which Medicare paid $24,594.

We requested supporting medical record documentation from physicians and practitioners for the sampled enrollee-months. We reviewed the documentation to determine whether the physicians and practitioners met Medicare billing requirements for ESRD-related services, but we did not use a medical reviewer to determine whether these services were medically necessary.

We did not perform an overall assessment of Noridian's internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective. Specifically, we interviewed staff at Noridian: (1) regarding the types of provider education it had (including educational materials and webinars) and assessed the effectiveness of that education by determining whether physicians and practitioners billed for ESRD-related services in accordance with Medicare requirements and guidance during our audit period and (2) to identify other oversight activities, such as Noridian's performing of medical record reviews as part of the TPE program.

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 May 2021 to April 2023.

[29] An enrollee-month consisted of all Medicare Part B claim lines for an enrollee who received ESRD-related services and was 20 years of age or older with four or more face-to-face visits by a physician or qualified nonphysician practitioner in that month.

[30] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 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 document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, as well as AMA's *CPT 2020 Professional*;

- interviewed staff at Noridian to gain an understanding of: (1) Medicare billing requirements for ESRD-related services, (2) the types of education (such as educational materials and webinars) that Noridian furnished to physicians and practitioners related to billing for ESRD-related services, and (3) Noridian's other oversight activities, such as its performing of medical record reviews specific to monthly ESRD-related services as part of the TPE program;

- interviewed CMS officials to obtain an understanding of Medicare billing requirements for ESRD-related services;

- obtained from CMS's NCH file the Medicare Part B paid claim lines for ESRD-related services with dates of service for our audit period in which physicians or practitioners in Jurisdiction E provided 4 or more face-to-face visits per month to an ESRD enrollee who was 20 years of age or older (billed using CPT code 90960);

- created a sampling frame of 189,694 Medicare Part B claim lines for certain ESRD-related services, which were grouped into 189,683 enrollee-months with dates of service during our audit period, and selected a simple random sample of 100 enrollee-months (Appendix B);

- reviewed data from CMS's Common Working File for the sampled enrollee-months' claim lines to determine whether claim lines had been canceled or adjusted;

- requested supporting documentation from physicians and practitioners for each sampled enrollee-month and determined whether the physicians and practitioners met Medicare billing requirements for certain ESRD-related services;

- shared the findings for some of the sampled enrollee-months with Noridian's medical review staff to confirm that Noridian agreed with our determinations for enrollee-months that did not meet Medicare requirements and guidance;[31]

- calculated the improper payment for each sampled enrollee-month that was improperly billed and calculated the enrollee coinsurance related to the improper payment;

[31] Noridian reviewed 13 of the 26 sampled enrollee-months that did not meet Medicare requirements and guidance and agreed with our determinations. Noridian did not review the remaining 13 sampled enrollee-months because they had the same types of errors as those enrollee-months that Noridian reviewed.

- estimated the potential savings to Medicare if the sampled enrollee-months had been billed in accordance with Medicare requirements and guidance and estimated the enrollee coinsurance associated with the improperly billed enrollee-months (Appendix C); and

- discussed the results of our audit with Noridian 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 189,694 Medicare Part B paid claim lines for certain ESRD-related services, which we grouped into 189,683 enrollee-months totaling $46,736,001 for our audit period. Each enrollee-month in the sampling frame had Medicare as the primary payer, a payment amount greater than $100, dates of service within our audit period, and claim lines that were billed with CPT[32] code 90960, which indicates that these services consisted of four or more visits per month to an ESRD enrollee who was 20 years of age or older. All claim lines in the sampling frame were from Medicare Part B claims that had not been previously reviewed by a CMS contractor. The enrollee coinsurance associated with the enrollee-months totaled $11,650,824.

SAMPLE UNIT

The sample unit was an enrollee-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a total of 100 sample units.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sample units in the sampling frame by Health Insurance Claim number and claim month. We then consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items for review.

[32] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 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 document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total dollar amount of the improper payments for ESRD-related services and the associated coinsurance amount. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval using the empirical likelihood option.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details

No. of Enrollee-Months in Frame	Value of Enrollee-Months in Frame	Value of Coinsurance in Frame	Sample Size	Value of Medicare Payments in Sample	Value of Coinsurance in Sample
189,683	$46,736,001	$11,650,824	100	$24,594	$6,115

Table 2: Sample Results for Improperly Paid ESRD-Related Services

No. of Improperly Paid Enrollee-Months	Value of Improperly Paid Enrollee-Months	Value of Coinsurance Related to Improperly Paid Enrollee-Months
26	$4,663	$1,162

Table 3: Estimated Values of Improper Payments and Associated Coinsurance in the Sampling Frame *(Limits Calculated at the 90-Percent Confidence Level)*

	Medicare Payment for Improperly Paid Enrollee-Months	Coinsurance
Point estimate	$8,844,899	$2,204,799
Lower limit	6,222,797	1,552,162
Upper limit	11,998,024	2,989,056

APPENDIX D: NORIDIAN COMMENTS

noridian
Healthcare Solutions

900 42nd Street S.
Fargo, ND 58103

May 11, 2023

Lori A. Ahlstrand, Regional Inspector General
Office of Inspector General
Office of Audi Services, Region IX
90 - 7th Street, Suite 3-650
San Francisco, CA 94103

Report Number: A-09-21-03016

Dear Ms. Ahlstrand:

Noridian Healthcare Solutions, LLC (Noridian) appreciates the opportunity to review and offer comment on the Office of Inspector General's (OIG) draft report entitled: *Noridian Healthcare Solutions, LLC, made $8.8 Million in Improper Monthly Capitation Payments to Physicians and Qualified Nonphysician Practitioners in Jurisdiction E for Certain Services Related to End-Stage Renal Disease*. As noted in the report, Noridian was the Medicare contractor for Jurisdiction E during the entire audit period. As such, Noridian assumes responsibility for all claims processed in the Jurisdiction E and will take all appropriate measures to reduce and prevent improper Medicare payments and protect the integrity of the Medicare Trust Fund. In addition to taking the corrective actions described below relative to End Stage Renal Disease (ESRD) services, Noridian is dedicated to continuously monitoring its internal control environment and collaborating with other Medicare Administrative Contractors (MAC) to mitigate risks of improper payments and improve service delivery for Medicare beneficiaries. Although the claims associated with the CPT® codes noted in this report account for less than one percent of the total claims processed in Jurisdiction E during the audit period, we agree with the OIG's overall assessment that improvements should be undertaken to reduce the number of billing errors. CMS has provided all MACs with review criteria for medical record review. This criterion does not allow MACs to deny claims if the documentation does not support a clinical examination of the vascular access site. Additionally, it is important to note that all Targeted Probe and Educate (TPE) reviews were halted by CMS due to the public health emergency starting in March 2020 through September 1, 2021.

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

OIG Recommendation 1:

Recover $4,663 in improper payments made to physicians and qualified nonphysician practitioners for the 26 sampled enrollee-months.

Noridian Response:

Noridian concurs with the recommendation to recover improper payments made to physicians and qualified nonphysician practitioners noted within the OIG's sample. Adjustments will be made, and demand letters will be issued as appropriate to collect the identified overpayments. Noridian will also continue to research and track debt collection activity on the overpayments identified in the OIG's sample.

OIG Recommendation 2:

Notify the physicians and qualified nonphysician practitioners to refund $1,162 in coinsurance that was collected for the 26 sampled enrollee months.

Noridian Response:

Noridian concurs with this recommendation to notify appropriate physicians and qualified nonphysician practitioners of their responsibilities to refund the $1,162 in co-insurance that was collected.

OIG Recommendation 3:

Based on the results of this audit, notify appropriate physicians and qualified nonphysician practitioners (i.e., those for whom Noridian determines this audit constitutes credible information of potential overpayments) so that the physicians and practitioners 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.

Noridian Response:

Noridian concurs with this recommendation to notify appropriate physicians and qualified nonphysician practitioners of their responsibilities to exercise reasonable diligence to identify, report and return any overpayments in accordance with the 60-day rule. Noridian will track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation 4:

Update the educational material on its website as well as any previously provided webinars to include all Medicare requirements and guidance for billing and documenting ESRD-related services and continue to perform medical record reviews as part of the TPE program, which could have saved the Medicare program as estimated $8,844,899 and could have saved Medicare enrollees up to an estimated $2,204,799 for our audit period.

Noridian Response:

Noridian concurs with this recommendation to update educational material on its website. Noridian does not have any previously presented webinars on its website. Additionally, Noridian will provide an update to the static webpages to include information related to the monthly capitation fee, and assessment of the vascular access device. These updates will be updated on or before May 31, 2023.

Noridian will continue to perform medical record review in accordance with CMS direction and Noridian's Medical Review Strategy. Noridian continuously assesses services billed and develops corresponding actions to reduce improper payments. Finally, Noridian will request that CMS update the review criteria for ESRD services to allow all MACs to review documentation related to monthly assessment of the vascular access device.

In summary, Noridian is aware of the concerns outlined in this draft report and is taking steps to address those concerns. We appreciate the opportunity to comment on this report and the recommendations. Should you have any additional questions on this response and Noridian's actions, please contact Senior Vice President of Government Contracts, Cathy Benoit or JE VP Project Manager, Becky Gunderson.

Sincerely,

Jon Bogenreif, President and Chief Executive Officer, Noridian

CC: Dorinda Fain, JE COR, CMS
Cathy Benoit, SVP of Government Contracts, Noridian
Troy Aswege, SVP Operations, Noridian
Becky Gunderson, JE Project Manager & VP of Project Management, Noridian

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