

REPORT HIGHLIGHTS



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Emergency Department Procedure Codes Used on Medicare Claims for Services Billed With Nonemergency Department Sites of Service Resulted in Over \$15 Million in Improper and Potentially Improper Payments

Why OIG Did This Audit

- Medicare billing for emergency department services is not appropriate if the site of service is other than an emergency department. Physicians and hospitals (providers) should use emergency department procedure codes only when an enrollee has received care in an emergency department.
- We reviewed emergency department procedure codes that providers billed for dates of service in 2021 and 2022 to determine whether [CMS](#) ensured compliance with Medicare requirements for claims that were billed using emergency department procedure codes, but the place of service or revenue center code was billed as being provided in a nonemergency department place of service.

What OIG Found

CMS did not ensure compliance with Medicare requirements for claims that were billed using emergency department procedure codes, but the place of service code (for physician claims) or revenue center code (for hospital claims) was billed as a nonemergency. Medicare improperly paid physicians for 9,749 procedures totaling \$922,524 that physicians improperly billed for emergency department procedures with nonemergency place of service codes. Medicare also made \$14.2 million in potentially improper payments to hospitals for claims billed with emergency department procedure codes and nonemergency revenue center codes. In addition, enrollees may have been held responsible for Part B deductibles that the hospitals potentially should not have charged.

CMS did not ensure that Medicare contractors had adequate claims processing controls in place—specifically system edits—to identify and prevent the improper payments. Additionally, CMS did not provide adequate guidance to ensure that hospitals complied with Medicare requirements when billing for these services.

What OIG Recommends

We made five recommendations, including that CMS direct the Medicare contractors to: recover the \$922,524 in improper payments made to physicians, assess \$14.2 million in potentially improper payments made to hospitals to determine their allowability and recoup any improper payments, and instruct hospitals to reimburse enrollees for deductibles that the hospitals should not have charged. We made procedural recommendations regarding the implementation or refinement of claims processing controls, the billing guidance to hospitals, and the review of claims after our audit period. The full recommendations are in the report.

CMS concurred with our first recommendation and detailed steps it plans to take in response to that recommendation. CMS did not concur with our other four recommendations.