JUN 17 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006 (A-01-08-00528)

The attached final report provides the results of our review of place-of-service coding for physician services processed by Medicare Part B carriers during calendar years 2005 and 2006.

To account for the increased expense that physicians incur by performing services in their offices, Medicare Part B reimburses physicians at a higher rate for certain services performed in their offices. However, when physicians perform these same services in facility settings, such as outpatient hospitals or ambulatory surgical centers (ASC), Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate. Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare Part B carriers. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the payment if the service was performed in a facility setting.

The objective of our audit was to determine whether physicians correctly coded the office place of service on claims submitted to and paid by Part B carriers.

Physicians did not always correctly code the office place of service on claims submitted to and paid by Part B carriers. Physicians correctly coded the claims for 21 of the 150 services that we sampled. However, physicians incorrectly coded the claims for 129 sampled services by using the office place-of-service code for services that were actually performed in outpatient hospitals or ASCs. The incorrect coding resulted in overpayments totaling $6,797.

Based on these sample results, we estimated that carriers nationwide overpaid physicians $20.2 million for incorrectly coded services provided during the 2-year period that ended December 31, 2006. We attribute the overpayments to internal control weaknesses at the physician billing level and to insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

We recommend that the Centers for Medicare & Medicaid Services (CMS) instruct its Part B carriers to:

- recover the $6,797 in overpayments for the sampled services,

- review our information on the 857,761 nonsampled services to identify services estimated at $20,163,015 that were potentially billed with incorrect place-of-service codes and work with the physicians who provided the services to recover any overpayments,

- strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes, and

- work with fiscal intermediaries and program safeguard contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

In comments on our draft report, CMS concurred with our recommendations and described the actions that it planned to take to implement them. CMS requested that we provide the data necessary to recover the overpayments for the sampled services. With respect to the nonsampled services, CMS stated that it would attempt to determine the cost-effectiveness of recovering overpayments on a pilot basis.

We will provide CMS with the requested data on the sampled services. We will also provide CMS with carrier-specific data, sorted by physician and facility provider numbers, to help ensure the cost-effectiveness of its recovery activity for the nonsampled services.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-01-08-00528 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PLACE-OF-SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY MEDICARE PART B CARRIERS DURING CALENDAR YEARS 2005 AND 2006

Daniel R. Levinson
Inspector General

June 2009
A-01-08-00528

Office of Inspector General

http://oig.hhs.gov

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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.

EXECUTIVE SUMMARY

BACKGROUND

Medicare Part B pays for services that physicians provide to program beneficiaries. Although physicians routinely perform many of these services in an outpatient hospital department or a freestanding ambulatory surgical center (ASC), some of these services may also be performed in nonfacility settings such as a physician's office. To account for the increased overhead expense that physicians incur by performing services in their offices, Medicare reimburses physicians at a higher rate for certain services performed in their offices. However, when physicians perform these same services in facility settings, such as outpatient hospitals or ASCs, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate.

Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare Part B carriers. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the payment if the service was performed in a facility setting.

Our audit covered 857,911 office-coded physician services valued at $74,881,647 and provided from January 1, 2005, through December 31, 2006, that matched outpatient hospital or ASC claims for the same type of service provided to the same beneficiary on the same day.

OBJECTIVE

The objective of our audit was to determine whether physicians correctly coded the office place of service on claims submitted to and paid by Part B carriers.

SUMMARY OF FINDING

Physicians did not always correctly code the office place of service on claims submitted to and paid by Part B carriers. Physicians correctly coded the claims for 21 of the 150 services that we sampled. However, physicians incorrectly coded the claims for 129 sampled services by using the office place-of-service code for services that were actually performed in outpatient hospitals or ASCs. The incorrect coding resulted in overpayments totaling $6,797.

Based on these sample results, we estimated that carriers nationwide overpaid physicians $20.2 million for incorrectly coded services provided during the 2-year period that ended December 31, 2006. We attribute the overpayments to internal control weaknesses at the physician billing level and to insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services (CMS) instruct its Part B carriers to:

- recover the $6,797 in overpayments for the sampled services,

- review our information on the 857,761 nonsampled services to identify services estimated at $20,163,015 that were potentially billed with incorrect place-of-service codes and work with the physicians who provided the services to recover any overpayments,

- strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes, and

- work with fiscal intermediaries and program safeguard contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations and described the actions that it planned to take to implement them. CMS requested that we provide the data necessary to recover the overpayments for the sampled services. With respect to the nonsampled services, CMS stated that it would attempt to determine the cost-effectiveness of recovering overpayments on a pilot basis. CMS's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We will provide CMS with the requested data on the sampled services. We will also provide CMS with carrier-specific data, sorted by physician and facility provider numbers, to help ensure the cost-effectiveness of its recovery activity for the nonsampled services. In designing its pilot, CMS should consider that approximately 1,400 physicians and physician groups, about 1 percent of our audit population, accounted for more than 50 percent of the claims.

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INTRODUCTION

BACKGROUND

Medicare Part B Payments for Physician Services

Medicare Part B pays for services that physicians provide to program beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. These services may be provided in facility settings, such as outpatient hospital departments and freestanding ambulatory surgical centers (ASC), or in physician offices.

Physicians are paid for services according to the Medicare physician fee schedule. This schedule is based on a payment system that includes three major categories of costs required to provide physician services: practice expense, physician work, and malpractice insurance.

Medicare Reimbursement for Practice Expense

Practice expense reflects the overhead costs involved in providing a service. To account for the increased practice expense that physicians incur by performing services in their offices, Medicare reimburses physicians at a higher rate for certain services performed in their offices rather than in an outpatient hospital or an ASC. Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare Part B carriers. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the service if the service was performed in a facility setting.

Medicare claim form instructions specifically state that each provider or practitioner is responsible for becoming familiar with Medicare coverage and billing requirements. Some physician offices submit their own claims to Medicare; other offices hire billing agents to submit their claims. Physicians are responsible for any Medicare claims submitted by billing agents.

Medicare Contractors

Medicare Part B carriers, under contract with the Centers for Medicare & Medicaid Services (CMS), process and pay claims submitted by physicians, clinical laboratories, suppliers, and ASCs. Medicare Part A fiscal intermediaries, also under contract with CMS, process and pay claims submitted by outpatient hospitals.[1]

As authorized by the Health Insurance Portability and Accountability Act of 1996, CMS contracts with program safeguard contractors to perform Medicare program integrity activities. Under CMS's Umbrella Statement of Work, these contractors conduct medical reviews, cost report audits, data analyses, provider education, and fraud detection and prevention.

[1]Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to transfer the functions of carriers and fiscal intermediaries to Medicare administrative contractors by October 2011.

Prior Office of Inspector General Reports

Our previous reviews found that several carriers overpaid physicians who did not correctly identify the place of service on their billings. (See Appendix A.) Our recommendations in those reports called for the carriers to educate physicians regarding proper billing, recover identified overpayments, and analyze postpayment data to detect and recover overpayments for improperly billed claims. The carriers generally concurred with our recommendations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether physicians correctly coded the office place of service on claims submitted to and paid by Part B carriers.

Scope

Our nationwide audit covered 857,911 office-coded physician services valued at $74,881,647 and provided from January 1, 2005, through December 31, 2006, that matched outpatient hospital or ASC claims for the same type of service provided to the same beneficiary on the same day.[2]

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the carriers or the physicians' offices. Therefore, we limited our review of internal controls at the carriers to the payment controls in place to prevent overpayments resulting from place-of-service billing errors. We limited our review of internal controls at physicians' offices to obtaining an understanding of controls related to developing and submitting Medicare claims.

Our fieldwork consisted of contacting ASCs, outpatient hospitals, and physicians nationwide from June through October 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- identified physician services provided during calendar years 2005 and 2006 that had varying payment levels depending on the place of service;

- matched physician claims for services with varying payment levels that were coded as having been performed in a physician's office to claims from outpatient hospitals or

[2]These services excluded services provided by First Coast Service Options, Inc., during 2005. Those services were addressed in report number A-01-07-00518.

ASCs for the same service provided to the same beneficiary on the same date and obtained a sampling frame of 857,911 physician services;

- selected a random sample of 150 paid services, stratified by the type of corresponding facility claim (i.e., outpatient hospital or ASC), from the sampling frame of services that were potentially billed with incorrect place-of-service codes (Appendix B);

- reviewed Common Working File and National Claims History File paid claim data for each sampled service to validate the payment amount and to determine the place of service identified on the claim;

- sent detailed internal control questionnaires and requests for medical and billing records to, and received responses from, the 144 physicians who provided the 150 sampled services;

- reviewed questionnaire responses and medical and billing records and, if necessary, followed up with physicians or their billing agents to request additional information to confirm the correct place of service, identify coding discrepancies, and identify the causes of incorrect coding;

- followed up with outpatient hospitals and ASCs, when necessary, to determine whether the sampled services were performed at the facilities;

- calculated any Medicare overpayments for the sampled services;

- reviewed Common Working File data to determine whether claims for the sampled services had subsequently been adjusted;

- estimated the total value of erroneous claims in the sampling frame (Appendix C); and

- discussed the results of our review with carrier 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Physicians did not always correctly code the office place of service on claims submitted to and paid by Part B carriers. Physicians correctly coded the claims for 21 of the 150 services that we sampled. However, physicians incorrectly coded the claims for 129 sampled services by using the office place-of-service code for services that were actually performed in outpatient hospitals or ASCs. The incorrect coding resulted in overpayments totaling $6,797.

Based on these sample results, we estimated that carriers nationwide overpaid physicians $20.2 million for incorrectly coded services provided during the 2-year period that ended December 31, 2006. We attribute the overpayments to internal control weaknesses at the physician billing level and to insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

PAYMENTS BASED ON INCORRECT PLACE OF SERVICE

Medicare Requirements

Medicare payment for physician services is based on the lower of the actual charge or the physician fee schedule amount.[3]

For a physician to receive the higher nonfacility practice expense payment for a service, the service must meet the requirements of 42 CFR § 414.22(b)(5)(i)(B), which, during the audit period,[4] provided: "The higher non-facility practice expense RVUs [relative value units] apply to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure." CMS publishes a quarterly physician fee schedule in the Federal Register showing those services that have a higher payment rate if performed in a physician's office.

Results of Sample

Physicians incorrectly coded the place of service for 129 of the 150 sampled services.[5] Although all 129 services were coded as having been performed in a physician's office, 79 of the services were actually performed in outpatient hospital settings, and 50 were ASC-approved procedures performed in ASCs.

Of the 129 incorrectly coded services, 9 did not result in overpayments because the physicians' billings did not exceed the Medicare fee schedule amount for the correct facility setting. For each of the 120 remaining services, the physicians' actual charges exceeded the Medicare fee schedule amount associated with the facility place-of-service code. Therefore, when those services were billed with the incorrect office place-of-service code, the physicians were paid the higher nonfacility practice expense payment, to which they were not entitled. As a result, the carriers incorrectly reimbursed the physicians for the overhead portion of their services.

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[3]Section 1848(a)(1) of the Social Security Act, 42 U.S.C. § 1395w-4(a)(1).

[4]Effective January 1, 2008, CMS revised 42 CFR § 414.22(b)(5)(i)(A) and (B) to provide that no facility practice expense payment will be made to physicians for procedures that are performed in an ASC but are not on the ASC-approved procedures list.

[5]For 21 sampled services, physicians correctly coded their offices as the place of service. Our match identified these services as potentially miscoded because they were for beneficiaries who had two evaluation and management procedures performed on the same day, one by a physician in the physician's office and the other by a different practitioner in an outpatient hospital.

Example of Incorrect Coding

The carrier paid a physician $443 for performing a hand surgery procedure coded as having been performed in his office. Our analysis showed that the physician actually performed this procedure in an outpatient hospital and that the fiscal intermediary had reimbursed the hospital for the overhead portion of the service. If the claim had been coded correctly, the physician would have received a payment of $223, which would not have included overhead costs. As a result of the incorrect coding, the physician was overpaid $220.

By repricing claims using the correct place-of-service code, we determined that carriers overpaid physicians $6,797 for the 129 services that physicians had billed incorrectly.

Estimate of Overpayments

Based on these sample results, we estimated that carriers nationwide overpaid physicians $20,169,812 for services provided in 2005 and 2006 that were billed using incorrect place-of-service codes.[6] (See Appendix C.)

Internal Control Weaknesses and Insufficient Postpayment Reviews

Many physicians had not implemented internal controls to prevent billings with incorrect place-of-service codes. Physicians and their billing personnel or billing agents told us that they had coded the place of service incorrectly for one or more of the following reasons:

- Physicians' billing personnel or billing agents were confused about the precise definition of a "physician's office" or were simply following established practice in applying the office place-of-service code.

- Physicians' billing agents were unaware that an incorrect place-of-service code could change the Medicare payment for a specific service.

- Personnel made isolated data entry errors.

- Undetected flaws in the design or implementation of some billing systems caused all claims to be submitted with "physician's office" as the place of service.

Physicians and their staff used the office place-of-service code even though they knew, or should have known, that the service was not performed in the physician's office. Medicare claim form instructions specifically state that each provider or practitioner who submits claims to Medicare is responsible for becoming familiar with Medicare coverage and billing requirements.

[6]Physicians notified us that they had already voluntarily refunded $254,264 of this amount to carriers as a result of our audit. We did not confirm these refunds.

In addition, Medicare carriers had not established sufficient postpayment reviews through coordinated data matches with fiscal intermediaries and program safeguard contractors to identify potential place-of-service coding errors.[7]

RECOMMENDATIONS

We recommend that CMS instruct its Part B carriers to:

- recover the $6,797 in overpayments for the sampled services,

- review our information on the 857,761 nonsampled services to identify services estimated at $20,163,015 that were potentially billed with incorrect place-of-service codes and work with the physicians who provided the services to recover any overpayments,

- strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes, and

- work with fiscal intermediaries and program safeguard contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations and described the actions that it planned to take to implement them. CMS requested that we provide the data necessary to recover the overpayments for the sampled services. With respect to the nonsampled services, CMS stated that it would attempt to determine the cost-effectiveness of recovering overpayments on a pilot basis. CMS's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We will provide CMS with the requested data on the sampled services. We will also provide CMS with carrier-specific data, sorted by physician and facility provider numbers, to help ensure the cost-effectiveness of its recovery activity for the nonsampled services. In designing its pilot, CMS should consider that approximately 1,400 physicians and physician groups, about 1 percent of our audit population, accounted for more than 50 percent of the claims.

[7]Our prior place-of-service audits found that some program safeguard contractors, in coordination with carriers, performed limited postpayment reviews.

APPENDIXES

APPENDIX A

PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date
"Review of Payments Made by National Heritage Insurance Company for Ambulatory Surgical Procedures for Calendar Year 2001" (A-01-02-00524)	July 23, 2003
"Review of Place of Service Coding for Physician Services - Wisconsin Physician Services, Madison, Wisconsin" (A-05-04-00025)	October 5, 2004
"Review of Place of Service Coding for Physician Services - Trailblazer Health Enterprises, LLC, for the Period January 1, 2001, Through December 31, 2002" (A-06-04-00046)	January 21, 2005
"Review of Place of Service Coding for Physician Services" (A-02-04-01010)	January 26, 2005
"Review of Place of Service Coding for Physician Services Processed by National Heritage Insurance Company During Calendar Years 2002 and 2003" (A-01-06-00502)	December 7, 2006
"Review of Place-of-Service Coding for Physician Services Processed by First Coast Service Options, Inc., During Calendar Years 2004 and 2005" (A-01-07-00518)	July 8, 2008

SAMPLE DESIGN AND METHODLOGY

POPULATION

The population consisted of office-coded physician services provided from January 1, 2005, through December 31, 2006, that matched outpatient hospital or ambulatory surgical center (ASC) claims for the same type of service provided to the same beneficiary on the same day.

SAMPLING FRAME

The sampling frame was a database of 857,911 office-coded physician services for calendar years 2005 and 2006 that matched outpatient hospital or ASC claims for the same type of service provided to the same beneficiary on the same day. We stratified the frame into two strata. The first stratum consisted of 786,333 physician services that matched outpatient hospital claims, and the second stratum consisted of 71,578 physician services that matched ASC claims.

SAMPLE UNIT

The sample unit was an office-coded line item of service billed by a physician and matched to a line item of service billed by an outpatient hospital or ASC.

SAMPLE DESIGN

We used a stratified random sample. Stratum 1 represented physician line items of service matched to outpatient hospital line items of service, and stratum 2 represented physician line items of service matched to ASC line items of service.

SAMPLE SIZE

We randomly selected 150 matched line items of service: 100 from stratum 1 and 50 from stratum 2.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLED UNITS

We consecutively numbered the sample units in the frame from 1 to 786,333 for stratum 1 and from 1 to 71,578 for stratum 2. After generating 100 random numbers for stratum 1 and 50 for stratum 2, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the potential overpayments.

SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Sample Size	Value of Sample	Number of Miscoded Services	Value of Miscoded Services
Outpatient hospital	786,333	100	$5,636	79	$1,623
ASC	71,578	50	14,370	50	5,174
Total	**857,911**	**150**	**$20,006**	**129**	**$6,797**

Estimated Value of Miscoded Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$20,169,812
Lower limit	$15,609,795
Upper limit	$24,729,830

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

DATE: APR 2 3 2009

TO: Joseph E. Vengrin
Deputy Inspector General for Audit Services

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report entitled "Review of Place-of-Service Coding for Physician Services Process by Medicare Part B Carriers During Calendar Years 2005 and 2006" (A-01-08-00528)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) Draft Report entitled "Review of Place-of-Service Coding for Physician Services Process by Medicare Part B Carriers During Calendar Years 2005 and 2006."

The Centers for Medicare & Medicaid Services (CMS) works with Medicare fee-for-service (FFS) contractors and provider associations at the national, regional, and local levels to ensure physicians, providers, and other health care professionals and staff who work with them are informed on the technical and policy details of the Medicare program and any new initiatives. CMS provides easy access to this information through outreach, educational products, Web tools, and provider call centers. When problems with operational billing or coding policy are identified, CMS typically conducts additional education both nationally and through its FFS contractors to remind providers of proper procedures.

In addition, once claims have been paid, CMS employs several strategies to ensure the accuracy of payment. CMS coordinates the development of contractor medical review policy and processes to ensure both automated and complex medical reviews are done accurately and appropriately. Medicare FFS Contractors conduct data analysis and adjust their individual medical review priorities based on identified problem areas.

OIG Recommendation
Recover the $6,797 in overpayments for the sampled services.

CMS Response
The CMS concurs that overpayments should be recovered. CMS plans to recover the overpayments identified consistent with the Agency's policies and procedures which include limiting recoveries to those recoveries that are administratively cost effective.

The OIG will be required to furnish, for each overpayment or potential overpayment, the data necessary (Medicare contractor numbers, provider numbers, claims information - including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor-specific data should be written to separate CD-roms or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation
Review our information on the 857,761 nonsampled services to identify services estimated at $20,163,015 that were potentially billed with incorrect place-of-service codes and work with the physicians who provided the services to recover any overpayments.

CMS Response
The CMS concurs with this recommendation with comments. CMS will attempt to determine the cost effectiveness of this activity. There are 857,761 unique claims that would need to be reviewed. The OIG has estimated an average overpayment of approximately $23 a claim. To determine whether it is cost effective, the CMS would need to identify the possible overpaid claims, send requests for detailed medical and billing records, and review the returned records. If an overpayment is identified, the CMS would recover the overpayments identified consistent with the Agency's policies and procedures. CMS will conduct this activity on a pilot basis and determine whether the cost of identification and collection exceeds the return by our Medicare Administrative Contractors. This information will be provided to the Recovery Audit Contractors to determine if this is an area they wish to conduct review for claims on or after October 1, 2007.

OIG Recommendation
The CMS should strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes.

CMS Response
The CMS concurs with this recommendation. CMS is in the process of developing Medicare instructions for place-of-service (POS) codes. These instructions will emphasize the importance of correctly coding the POS as the actual place where the service takes place. They will also provide information regarding the use by physicians of POS code 11 (office), POS code 24 (ambulatory surgical center), and POS code 22 (hospital outpatient department).

In addition, a Medicare Learning Network Matters article will also be published with this information. This article will be used to educate physicians, providers, and suppliers regarding the use of proper POS codes and the need to ensure that the actual place where the service takes place is indicated on the claims form.

OIG Recommendation

Work with fiscal intermediaries and program safeguard contractors to (l) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

CMS Response

The CMS concurs with this recommendation. The Program Safeguard Contractors (PSCs) performed similar projects that focus on the incorrect billing of POS and have discussed the topic with the Data Analysis, Reporting and Trending (DART) Group. When the DART Group meets (via teleconference), PSCs and Zone Program Integrity Contractors (ZPICs) share information about projects that have been successful in their jurisdiction, so other contractors may initiate similar projects. We believe that PSCs and ZPICs have the information they need to initiate such projects and that they can use this OIG report to augment those projects. Additionally, if the OIG can supply CMS with the specific codes identified as high-risk for POS miscoding, we will relay these codes to our contractors to ensure that their projects include those codes so they can take additional steps to develop system edits to target these services in order to recover any identified overpayments.

Thank you again for the opportunity to review this report. We appreciate the OIG's efforts on this study and look forward to working with them on these issues in the future.