Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS DID NOT ALWAYS CORRECTLY MAKE CLINIC VISIT PAYMENTS TO HOSPITALS

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Office of Inspector General

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EXECUTIVE SUMMARY

CMS made $7.5 million in incorrect outpatient payments to hospitals for established patients' clinic visits.

WHY WE DID THIS REVIEW

Medicare payments to hospitals for evaluation and management (E/M) outpatient clinic visits vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a 3-year period. The Centers for Medicare & Medicaid Services (CMS) found in its improper payment reviews for 2008 through 2011 that E/M services were frequently miscoded. In addition, in 2009, two health care entities paid more than $10 million to settle allegations that they fraudulently billed Medicare for E/M services (OEI 04-10-00180). This is the first audit that we have conducted relating to E/M outpatient clinic visits (clinic visits).

The objective of our audit was to determine whether CMS correctly made selected outpatient payments to hospitals for established patients' clinic visits for calendar years (CYs) 2010 and 2011.

BACKGROUND

Title XVIII of the Social Security Act established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program and contracts with Medicare Administrative Contractors (MACs) to process and pay hospital claims.

Section 4523 of the Balanced Budget Act of 1997 (BBA) mandated CMS to implement a Medicare outpatient prospective payment system (OPPS) for hospital outpatient services. Sections 201 and 202 of the Balanced Budget Refinement Act of 1999 further modified section 4523 of the BBA. OPPS became effective for services furnished on or after August 1, 2000. Under OPPS, CMS uses Healthcare Common Procedure Coding System (HCPCS) codes to identify outpatient services. When billing for services, hospitals should select the HCPCS codes that best represent the services furnished.

Physicians provide E/M services to assess and manage patients' health. These services may be provided at a physician's office or in an outpatient or other ambulatory facility. Hospitals provide three types of outpatient E/M services: clinic visits, emergency department visits, and critical care services. The Medicare payment for clinic visits depends on the complexity of the visit and whether the patient is identified as "new" or "established" at the particular hospital.

To identify whether a patient is new or established, hospitals must determine whether the patient already has a hospital medical record. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient at the hospital. The same patient could be "new" to the physician but "established" at the hospital (73 Fed. Reg. 68502, 68677 (Nov. 18, 2008)).

WHAT WE FOUND

CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. Of the 110 randomly sampled line items for which CMS made Medicare payments to hospitals for clinic visits (HCPCS 99203 to 99205) during our audit period, 2 were correct. In addition, we treated six line items as non-errors (correct) because, for three line items, hospitals refunded incorrect payments totaling $54 prior to our fieldwork and, for three line items, hospitals were under investigation. CMS overpaid the remaining 102 line items by a total of $2,190. The hospitals had not refunded these overpayments by the beginning of our audit:

- For 80 line items, hospitals incorrectly used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $1,653.

- For 19 line items, in addition to incorrectly using new patient HCPCS codes for established patients, hospitals did not use correct HCPCS codes to describe the levels of services furnished, resulting in incorrect payments totaling $307.

- For three line items, hospital officials informed us that they billed for clinic visits without supporting documentation, resulting in incorrect payments totaling $230.

The hospitals attributed the incorrect payments to clerical errors, staff not fully understanding Medicare billing requirements for clinic visits, reliance on the code that the physician selected for the visit, or billing systems that could not identify established patients.

Also, CMS does not have edits in place to identify Medicare payments for patients who were already registered at a facility.

On the basis of our sample results, we estimated that CMS made incorrect payments to hospitals totaling $7,536,964 during CYs 2010 and 2011.

WHAT WE RECOMMEND

We recommend that CMS work with its MACs to:

- recover the $2,190 in incorrect payments identified in our sample;

- provide additional guidance to hospitals on billing clinic visits for new or established patients, which could result in savings totaling $7,536,964 over a 2-year period;

- resolve the remaining 378,376 line items and recover the overpayments to the extent feasible and allowed under the law; and

- direct MACs to instruct hospitals on the need for stronger compliance controls that ensure proper billing of clinic visits.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS concurred with our first recommendation and stated that it would instruct contractors to recover the $2,190 in incorrect payments to the extent allowed under the law.

CMS did not concur, however, with our second and fourth recommendations. CMS stated that it revised the hospital outpatient clinic visit codes for CY 2014. Effective January 1, 2014, CMS replaced the 10 HCPCS codes with a single HCPCS code that describes any and all hospital outpatient clinic visits. We agree that this recent change should address the new and existing coding issues.

CMS partially concurred with our third recommendation regarding the recovery of overpayments of the remaining 378,376 line items. However, CMS stated that it must consider return on investment when conducting medical review because of the limited resources associated with medical review activities. CMS also requested that we furnish the necessary data to follow up on these 378,376 line items.

After receiving the CMS comments regarding our third recommendation, we gave CMS detailed information regarding the 378,376 line items. Also, we do not consider medical review of these line items necessary. We questioned the payments in our audit solely on the basis of administrative criteria regarding whether the patient had been previously treated in the hospital, not on medical necessity. During the course of our audit, hospitals returned approximately $813,402 in incorrect established-clinic visit payments to Medicare. The return of these amounts leads us to conclude that, if CMS works with the hospitals and MACs, the recoupment benefit would outweigh the costs involved.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare payments to hospitals for evaluation and management (E/M) outpatient clinic visits vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a 3-year period. The Centers for Medicare & Medicaid Services (CMS) found in its improper payment reviews for 2008 through 2011[1] that E/M services were frequently miscoded. In addition, in 2009, two health care entities paid more than $10 million to settle allegations that they fraudulently billed Medicare for E/M services.[2] This is the first audit that we have conducted relating to E/M outpatient clinic visits (clinic visits).

OBJECTIVE

Our objective was to determine whether CMS correctly made selected outpatient payments to hospitals for established patients' clinic visits for calendar years (CYs) 2010 and 2011.

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program and contracts with Medicare Administrative Contractors (MACs) to, among other things, process and pay hospital claims.

Hospital Outpatient Prospective Payment System

Section 4523 of the Balanced Budget Act of 1997 (BBA)[3] mandated CMS to implement a Medicare outpatient prospective payment system (OPPS) for hospital outpatient services. Sections 201 and 202 of the Balanced Budget Refinement Act of 1999[4] further modified section 4523 of the BBA. OPPS became effective for services furnished on or after August 1, 2000. Under OPPS, CMS uses Healthcare Common Procedure Coding System (HCPCS) codes to identify outpatient services. To determine the rate per service, CMS assigns these HCPCS codes to an ambulatory payment classification (APC). Services in each APC are similar clinically and in terms of the resources they require.

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[1] CMS performed these reviews under the Comprehensive Error Rate Testing program. The objectives of the improper payment reviews were to evaluate claims to determine whether the items and services were covered, correctly coded, and medically necessary.

[2] *Coding Trends of Medicare Evaluation and Management Services* (OEI 04-10-00180).

[3] P. L. No. 105-33.

[4] P. L. No. 106-113.

Hospitals are required to submit accurate claims for outpatient services. Each Medicare claim should contain details regarding each provided service (called a line item in this report). When billing for services, hospitals should select the HCPCS codes that best represent the services furnished.

Outpatient Evaluation and Management Services

Physicians provide E/M services to assess and manage patients' health. These services may be provided at a physician's office or in an outpatient or other ambulatory facility. Hospitals provide three types of outpatient E/M services: clinic visits,[5] emergency department visits, and critical care services. The Medicare payment for clinic visits depends on the complexity of the visit and whether the patient is identified as "new" or "established" at the particular hospital. A hospital should bill a clinic visit with a *new patient* using one of five HCPCS codes, from 99201 (the lowest complexity level code (Level 1)) to 99205 (the highest complexity level code (Level 5)). Likewise, a hospital should bill a clinic visit with an *established patient* using one of five different HCPCS codes, from 99211 (the lowest complexity level code (Level 1)) to 99215 (the highest complexity level code (Level 5)). (See examples in Table 1.)

To identify whether a patient is new or established, hospitals must determine whether the patient already has a hospital medical record. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient at the hospital. The same patient could be "new" to the physician but "established" at the hospital (73 Fed. Reg. 68502, 68677 (Nov. 18, 2008)). Table 1 on the next page compares the January 2010 Addendum B[6] Medicare clinic visit OPPS payment rates for new and established patients using different complexity level HCPCS codes.

[5] We reviewed only HCPCS codes 99203, 99204, and 99205 related to clinic visits. HCPCS codes 99201 and 99202 are paid the same whether new or established.

[6] Addendum B gives a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates that are in effect at the beginning of each quarter. The quarterly update of Addendum B reflects the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals. Updates of Addendum B are posted quarterly to the OPPS Web site.

Table 1: Medicare Clinic Visits Outpatient Prospective Payment System Payment Rates

Description	Clinic Visit HCPCS Codes	Payment Amount
Outpatient visit, new (problem focused)	99201	$57.92
Outpatient visit, new (expanded problem focused)	99202	69.68
Outpatient visit, new (detailed)	99203	89.12
Outpatient visit, new (comprehensive, moderate)	99204	113.44
Outpatient visit, new (comprehensive, high)	99205	167.52
Outpatient visit, established (minimal)	99211	57.92
Outpatient visit, established (problem focused)	99212	69.68
Outpatient visit, established (expanded)	99213	69.68
Outpatient visit, established (detailed)	99214	89.12
Outpatient visit, established (comprehensive high)	99215	113.44

HOW WE CONDUCTED THIS REVIEW

Our audit covered $37,102,649 in Medicare payments to hospitals for clinic visits with dates of services from CY 2010 through 2011. We limited our review to HCPCS 99203 to 99205 on outpatient claims (referred to as line items in this report). We eliminated HCPCS codes 99201 and 99202 because the payment amounts for new and established patients are identical. We randomly selected 110 line items totaling $9,798 for review.

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

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the Federal requirements.

FINDINGS

CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. Of the 110 randomly sampled line items for which CMS made Medicare payments to hospitals for clinic visits (HCPCS 99203 to 99205) during our audit period, 2 were correct. In addition, we treated six line items as non-errors (correct) because, for three line items, hospitals refunded incorrect payments totaling $54 prior to our fieldwork and, for three line items, hospitals were under investigation. CMS overpaid the remaining 102 line items by a total of $2,190. The hospitals had not refunded these overpayments by the beginning of our audit:

- For 80 line items, hospitals incorrectly used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $1,653.

- For 19 line items, in addition to incorrectly using new patient HCPCS codes for established patients, hospitals did not use correct HCPCS codes to describe the levels of services furnished, resulting in incorrect payments totaling $307.

- For three line items, hospital officials informed us that they billed for clinic visits without supporting documentation, resulting in incorrect payments totaling $230.

The hospitals attributed the incorrect payments to clerical errors, staff not fully understanding Medicare billing requirements for clinic visits, reliance on the code that the physician selected for the visit, or billing systems that could not identify established patients.

Also, CMS does not have edits in place to identify Medicare payments for patients that were already registered at a facility.

On the basis of our sample results, we estimated that CMS made incorrect payments to hospitals totaling $7,536,964 during CYs 2010 and 2011.

HOSPITALS DID NOT USE CORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS

Federal regulations required hospitals to report the correct HCPCS codes, depending on whether the hospital had registered the patient within the preceding 3 years: codes 99201 to 99205 for new patients and codes 99211 to 99215 for established patients (73 Fed. Reg. 68502, 68676, 68679 (Nov. 18, 2008)).[7] A Medicare claim submitted for payments contains details regarding each provided service.

For 80 line items, hospitals used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $1,653. Appendix E contains the incorrect line item detail for the 80 line items.

[7] CMS continued these definitions of new and established patients in CYs 2010 and 2011 (74 Fed. Reg. 60316, 60547 (Nov. 20, 2009) and 75 Fed. Reg. 71800, 71986 (Nov. 24, 2010)).

HOSPITALS DID NOT USE CORRECT CODES REPRESENTING SERVICES FURNISHED

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. For 19 line items, hospitals, in addition to incorrectly reporting the clinic visit for an established patient, did not use the correct HCPCS code that represented the level of service furnished, resulting in inappropriate payments totaling $307.

- For eight line items, hospitals identified that they had incorrectly used new patient HCPCS codes for established patients and used higher complexity level HCPCS codes to describe the services, resulting in incorrect payments totaling $332. Appendix F contains the incorrect line item detail for the eight line items.

- For 11 line items, hospitals identified that they had incorrectly used new patient HCPCS codes for established patients and used lower complexity level HCPCS codes to describe the services, resulting in incorrect underpayments totaling $25.[8] Appendix G contains the incorrect line item detail for the 11 line items.

HOSPITALS BILLED FOR CLINIC VISITS WITHOUT SUPPORTING DOCUMENTATION

Chapter 1, section 80.3.2.2, of the Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. For three line items, three hospitals stated that they had incorrectly billed for clinic visits because the medical records did not contain supporting documentation. The hospitals agreed to adjust the claims associated with these line items and to refund the combined incorrect payments totaling $230. Appendix E contains the incorrect line item detail for the three line items.[9]

CAUSES OF INCORRECT PAYMENTS FOR CLINIC VISITS

The hospitals attributed the incorrect payments to clerical errors, staff application of physician Medicare billing requirements in a hospital setting, reliance on the code that the physician selected for the visit, and automated hospital billing systems that did not always interface effectively to indicate that a patient had been previously registered in that hospital.

Also, CMS does not have edits in place to identify Medicare payments for patients who were already registered at a facility.

[8] Ten of the eleven line items resulted in no incorrect payments because the payment for the higher level of complexity equaled the difference between the HCPCS code rate for new and established patients.

[9] Sample numbers 40, 71, and 100.

ESTIMATE OF INCORRECT PAYMENTS FOR CLINIC VISITS

On the basis of our sample results, we estimated that CMS made incorrect payments to hospitals for clinic visits totaling $7,536,964 during CYs 2010 and 2011.

RECOMMENDATIONS

We recommend that CMS work with its MACs to:

- recover the $2,190 in incorrect payments identified in our sample;
- provide additional guidance to hospitals on billing clinic visits for new or established patients, which could result in savings totaling $7,536,964 over a 2-year period;
- resolve the remaining 378,376 line items and recover the overpayments to the extent feasible and allowed under the law; and
- direct MACs to instruct hospitals on the need for stronger compliance controls that ensure proper billing of clinic visits.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Centers for Medicare & Medicaid Services Comments

In written comments on our draft report, CMS concurred with our first recommendation and stated that it would instruct contractors to recover the $2,190 in incorrect payments to the extent allowed under the law.

CMS did not concur, however, with our second and fourth recommendations. CMS stated that it revised the hospital outpatient clinic visit codes for CY 2014. Effective January 1, 2014, CMS replaced the 10 HCPCS codes with a single HCPCS code that describes any and all hospital outpatient clinic visits.

CMS partially concurred with our third recommendation regarding the recovery of overpayments of the remaining 378,376 line items. However, CMS stated that it must consider return on investment when conducting medical review because of the limited resources associated with medical review activities. CMS also requested that we furnish the necessary data to follow up on these 378,376 line items.

CMS's comments are included in their entirety as Appendix H.

Office of Inspector General Response

With regards to our second and fourth recommendations, we agree with CMS that its January 1, 2014, regulatory changes should address the new and existing coding issues.

After receiving the CMS comments regarding our third recommendation, we gave CMS detailed information regarding the 378,376 line items. Also, we do not consider medical review of these line items necessary. We questioned the payments in our audit solely on the basis of administrative criteria regarding whether the patient had been previously treated in the hospital, not on medical necessity. During the course of our audit, hospitals returned approximately $813,402 in incorrect established-clinic visit payments to Medicare. The return of these amounts leads us to conclude that, if CMS works with the hospitals and MACs, the recoupment benefit would outweigh the costs involved.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 378,486 line items with payments to hospitals totaling $37,102,649 for clinic visits from January 1, 2010, through December 31, 2011. We randomly selected 110 line items totaling $9,798 for review.

We did not review the overall internal control structure of the hospitals or the Medicare program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether selected Medicare outpatient payments made to hospitals for clinic visits at the new patient rate were correctly paid. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We did not review the medical necessity of any of the services rendered.

We conducted our audit fieldwork from August 2012 to April 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- gained an understanding of CMS's internal controls over identifying, preventing, and correcting improper payments;
- using the National Claims History file, extracted 5,883,230 outpatient line items totaling $411,926,303 containing the new patient HCPCS codes for clinic visits (99201 through 99205) and 67,060,086 inpatient claims paid during CYs 2007 through 2011;
- identified 378,486 outpatient line items totaling $37,102,649 containing the new patient HCPCS codes (99203 through 99205) for clinic visits for the audit period that had another inpatient or outpatient line item for the same patient and for which the hospital had received payment within the prior 3-year period—HCPCS codes 99201 and 99202 were excluded because the payment amounts for new and established patients are identical;
- randomly selected for review 110 line items totaling $9,798;
- sent letters to the 84 hospitals related to the sampled line items requesting documentation to determine whether the sampled items were correctly paid;
- reviewed documentation provided by hospitals to support:

    - whether, for the sampled line items' dates of service, the patient was a new or established patient,
    - the correct coding that represents services furnished, and
    - the reason(s) the error occurred;

- for each sampled line item's dates of service, obtained information from CMS's Common Working File to support:
    - that a prior registration occurred within 3 years,
    - an adjustment to the sampled line item, and
    - the accuracy of the paid amount and completeness test;

- calculated the difference between the originally paid amount of the line item at the new patient HCPCS code rate and the correct payment amount at the established patient HCPCS code rate; and

- estimated the incorrect payment amount for the sampling frame.

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

POPULATION

The population consisted of 5,883,230 outpatient line item payments totaling $411,926,303 that Medicare made to hospitals using the new patient HCPCS codes 99201 through 99205 and 67,060,086 inpatient[10] claims paid during CYs 2007 through 2011.

SAMPLING FRAME

From the population, we removed 5,504,744 outpatient line items totaling $374,823,654. Specifically, we removed:

- 360,161 line items with a zero paid amount;
- 1,512,615 line items paid to nonhospitals or hospitals not using OPPS totaling $101,755,243;
- 1,799,920 line items that did not contain an inpatient or outpatient line match (same patient, same hospital) totaling $137,392,848;
- 72,635 line items containing matches to more than 20 other line items totaling $6,392,621;
- 842,583 line items deemed allowable totaling $63,715,953;
- 905,818 line items totaling $61,986,447 with HCPCS codes 99201 and 99202 (because the payment amounts for new and established patients are identical) and with a date of service during CYs 2007 through 2009 (except for use as evidence of a prior hospital registration);
- 235 line items that were under a Recovery Audit Contractor[11] review totaling $25,891; and
- 10,777 line items paid for State of Maryland hospitals and Indian Health claims (because these did not use OPPS) totaling $3,554,651.

[10] We used inpatient claims only as evidence of a prior hospital registration. We did not calculate the total paid amount for these claims.

[11] As required by the Tax Relief and Health Care Act of 2006, CMS implemented Medicare recovery auditing in all States. CMS awarded contracts to four regional Recovery Audit Contractors.

After we removed these line items, the sampling frame consisted of 378,486 outpatient line items totaling $37,102,649 for Medicare clinic visits matched to other outpatient line items or inpatient claims for the same patient and hospital paid within 3 years of the matching outpatient line item.

SAMPLE UNIT

The sample unit was an individual Medicare paid line item for a registered, established patient billed as a new patient for the date of service reviewed.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 110 line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS), Statistical Software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sampling frame from 1 through 378,486. After generating 110 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of incorrect payments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Number of Line Items	Value	Sample Size	Value of Sample	Number of Incorrect Line Items	Value of Incorrect Line Items
378,486	$37,102,649	110	$9,798	102[12]	$2,190

Table 3: Estimated Value of Incorrect Line Items
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount
Point estimate	$7,536,964
Lower limit	6,590,512
Upper limit	8,483,415

[12] Of the 102 incorrect line items, 10 resulted in no incorrect payments because the payment for the higher level of complexity equaled the difference between the HCPCS code rate for new and established patients. As a result, we used only 92 of the incorrect line items to estimate the value of the incorrect line items.

APPENDIX D: FEDERAL REQUIREMENTS

Federal regulations require hospitals to report the HCPCS[13] codes that describe new and established clinic visits (74 Fed. Reg. 60316, 60547 (Nov. 20, 2009) and 75 Fed. Reg. 71800, 71986 (Nov. 24, 2010)). Furthermore, as published in 73 Fed. Reg. 68677 (Nov. 18, 2008):

> [T]he meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital. The same patient could be "new" to the physician but an ''established'' patient to the hospital.

CMS continued this definition of a new or established patient into CYs 2010 and 2011 (74 Fed. Reg. 60316, 60547 (Nov. 20, 2009) and 75 Fed. Reg. 71800, 71986 (Nov. 24, 2010)).

In addition, the Manual, Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

[13] The Federal regulation cited actually states that hospitals must report Current Procedural Terminology (CPT) codes. We substituted the term HCPCS for CPT to reduce confusion because the CPT code is included as part of every HCPCS code. For our purposes, the codes are interchangeable.

APPENDIX E: INCORRECT LINE ITEM DETAIL – HOSPITALS USED INCORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS

Sample Order[14]	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
1	99204	$107.43	99214	$83.37	$24.06
2	99203	94.70	99213	71.36	23.34
3	99203	75.76	99213	57.09	18.67
4	99204	92.94	99214	72.14	20.80
5	99203	78.40	99213	59.14	19.26
6	99203	90.59	99213	68.26	22.33
7	99203	78.94	99213	61.70	17.24
8	99204	94.39	99214	74.15	20.24
9	99203	77.32	99213	58.26	19.06
10	99203	77.85	99213	60.87	16.98
11	99203	14.97	99213	0.00*	14.97
12	99205	127.43	99215	96.93	30.50
14	99203	77.09	99213	58.09	19.00
16	99203	80.86	99213	63.06	17.80
17	99203	75.02	99213	56.54	18.48
20	99203	87.56	99213	65.98	21.58
21	99203	76.19	99213	57.42	18.77
22	99204	122.04	99214	94.70	27.34
23	99203	84.56	99213	63.72	20.84
25	99203	66.69	99213	52.14	14.55
28	99203	71.79	99213	56.13	15.66
29	99203	77.66	99213	53.96	23.70
30	99203	81.32	99213	61.28	20.04
31	99203	64.02	99213	50.21	13.81
32	99204	116.74	99214	90.59	26.15
33	99204	99.64	99214	77.33	22.31
34	99203	70.83	99213	54.95	15.88
35	99203	82.18	99213	61.93	20.25
36	99204	82.11	99214	64.51	17.60
37	99203	84.94	99213	66.24	18.70
38	99203	94.70	99213	71.36	23.34
39	99203	72.94	99213	56.89	16.05
40	99203	72.89	N/A†	0.00	72.89

[14] We did not review eight line items from our sample (sample numbers 13, 18, 46, 51, 55, 73, 98, and 109) or include them in any of the line item detail appendixes for one of the following reasons: they were correct, they were incorrect but the hospitals had refunded the incorrect payments prior to our audit, or they were from hospitals under investigation.

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
41	99203	74.86	99213	56.42	18.44
42	99204	122.04	99214	94.71	27.33
43	99204	90.92	99214	71.26	19.66
44	99203	77.85	99213	60.86	16.99
45	99204	102.99	99214	80.90	22.09
48	99204	103.44	99214	80.27	23.17
49	99204	84.47	99214	66.35	18.12
52	99203	89.40	99213	67.37	22.03
54	99204	83.45	99214	65.57	17.88
56	99204	108.97	99214	84.57	24.40
57	99203	64.02	99213	50.06	13.96
59	99203	84.94	99213	66.25	18.69
60	99204	135.79	99214	105.38	30.41
61	99203	66.17	99213	51.73	14.44
62	99205	160.44	99215	122.04	38.40
63	99203	105.37	99213	79.41	25.96
65	99203	62.42	99213	48.81	13.61
66	99205	155.63	99215	118.21	37.42
68	99203	86.10	99213	64.88	21.22
69	99204	79.65	99214	67.27	12.38
70	99204	97.40	99214	76.33	21.07
71	99203	74.69	N/A†	0.00	74.69
72	99204	82.95	99214	65.17	17.78
74	99205	121.14	99215	92.14	29.00
75	99204	99.10	99214	77.86	21.24
77	99204	85.00	99214	66.77	18.23
79	99204	106.15	99214	78.82	27.33
80	99203	64.95	99213	50.78	14.17
81	99203	94.70	99213	71.36	23.34
82	99203	68.17	99213	53.30	14.87
83	99203	94.39	99213	73.78	20.61
84	99203	76.30	99213	53.02	23.28
85	99204	100.59	99214	78.06	22.53
88	99204	94.55	99214	73.37	21.18
89	99203	74.36	99213	56.04	18.32
90	99204	93.67	99214	72.70	20.97
92	99204	116.74	99214	90.59	26.15
93	99205	150.29	99215	114.32	35.97
94	99203	74.36	99213	56.04	18.32

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
95	99204	0.46	99214	0.00*	0.46
96	99203	79.18	99213	61.90	17.28
97	99203	94.70	99213	71.36	23.34
99	99204	107.86	99214	84.74	23.12
100	99203	82.72	N/A†	0.00	82.72
101	99204	79.11	99214	62.15	16.96
102	99203	33.11	99213	18.42	14.69
103	99203	107.77	99213	81.21	26.56
104	99203	79.14	99213	61.90	17.24
108	99204	104.55	99214	82.14	22.41
110	99203	85.34	99213	64.31	21.03
	Total[15]	**$7,315**		**$5,431**	**$1,884**

* For these line items, although the patients received services, the hospital reimbursement was zero because, at the scheduled payment date, the Medicare cash deductible for these patients was greater than the established patient payment rate. As a result, the total paid amount was incorrect.

† For these line items, hospitals stated that they had incorrectly billed for the clinic visits because the medical records did not contain supporting documentation. As a result, the total paid amount was incorrect.

[15] Totals are rounded.

APPENDIX F: INCORRECT LINE ITEM DETAIL – HOSPITALS USED INCORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS AND USED HIGHER COMPLEXITY LEVEL CODES TO DESCRIBE SERVICES

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
15	99203	$110.28	99212	$83.11	$27.17
19	99203	82.18	99211	43.16	39.02
24	99205	153.48	99214	90.59	62.89
26	99203	72.98	99211	47.32	25.66
47	99204	138.87	99213	81.21	57.66
86	99205	135.68	99214	80.09	55.59
105	99204	123.74	99213	75.81	47.93
107	99203	71.79	99212	56.13	15.66
	Total[16]	**$889**		**$557**	**$332**

[16] Totals are rounded.

APPENDIX G: INCORRECT LINE ITEM DETAIL – HOSPITALS USED INCORRECT CODES TO IDENTIFY ESTABLISHED PATIENTS AND USED LOWER COMPLEXITY LEVEL CODES TO DESCRIBE SERVICES

Sample Order	New Patient HCPCS Code	New Patient Payment Amount	Established Patient HCPCS Code	Established Patient Payment Rate	Line Item Incorrect Payment Calculation
27	99203	$91.86	99214	$91.86	$0.00
50	99204	93.10	99215	93.10	0.00
53	99203	85.72	99215	110.47	(24.75)
58	99203	73.92	99214	73.92	0.00
64	99203	77.85	99214	77.85	0.00
67	99203	66.57	99214	66.57	0.00
76	99203	77.88	99214	77.88	0.00
78	99203	66.73	99214	66.73	0.00
87	99203	72.57	99214	72.57	0.00
91	99203	66.73	99214	66.73	0.00
106	99204	95.26	99215	95.26	0.00
	Total[17]	**$868**		**$893**	**($25)**

[17] Totals are rounded.

APPENDIX H: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 28 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: The Centers for Medicare & Medicaid Services (CMS) Did Not Always Correctly Make Clinic Visit Payments to Hospitals (A-04-12-06154)

Thank you for the opportunity to review and comment on the OIG draft report titled above. OIG stated that the objective of its audit was to determine whether CMS correctly made selected outpatient payments to hospitals for established payments' clinic visits for calendar years (CYs) 2010 and 2011.

According to OIG, CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. On the basis of OIG's sample results, it estimated that CMS made incorrect payments to hospitals totaling $7,536,964 during CYs 2010 and 2011.

OIG Recommendation

The OIG recommends CMS recover the $2,190 in incorrect payments identified in our sample.

CMS Response

The CMS concurs with the recommendation. CMS will instruct its contractors to recover the $2,190 in incorrect payments to the extent allowed under the law.

OIG Recommendation

The OIG recommends CMS provide additional guidance to hospitals on billing clinic visits for new or established patients, which could result in savings totaling $7,536,964 over a 2-year period.

CMS Response

The CMS does not concur with this recommendation. CMS recently revised the hospital outpatient clinic codes in the CY 2014 Hospital Outpatient Prospective Payment System final rule. Effective January 1, 2014, the ten hospital outpatient clinic visit codes (five codes for new patient visits, and five codes for established patient visits) used in prior years are replaced with a single Healthcare Common Procedure Coding System (HCPCS) code (G0463) that describes any and all hospital outpatient clinic visits.

OIG Recommendation

The OIG recommends CMS resolve the remaining 378,376 line items and recover the overpayments to the extent feasible and allowed under the law.

CMS Response

The CMS partially concurs with this recommendation. CMS must always consider return on investment when conducting medical review due to the limited resources associated with medical review activities. CMS requests that OIG furnish the necessary data (e.g. Medicare contractor number, provider number, claims information including the paid data, claim number, Health Insurance Claim Number, overpaid amount, etc.) to follow-up on the 378,376 line items. In addition, CMS requests that current Medicare contractor-specific data be sent through a secure portal to better facilitate the transfer of information to the appropriate contractor.

Upon receipt of the files from OIG, CMS will conduct an analysis to determine return on investment. Based on analysis and contractor resources, CMS will determine an appropriate number of claims to review, and if appropriate, CMS will instruct the contractor to review the claims and take appropriate action.

OIG Recommendation

The OIG recommends CMS direct Medicare Administrative Contractors to instruct hospitals on the need for stronger compliance controls that ensure proper billing of clinic visits.

CMS Response

The CMS does not concur with this recommendation. CMS recently revised the hospital outpatient clinic codes in the CY 2014 Hospital Outpatient Prospective Payment System final rule. Effective January 1, 2014, the ten hospital outpatient clinic visit codes (five codes for new patient visits, and five codes for established patient visits) used in prior years are replaced with a single HCPCS code (G0463) that describes any and all hospital outpatient clinic visits.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.