



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
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August 25, 2009

Report Number: A-01-09-00509

Dr. Christopher Whelan, M.D.
Cape Cod Emergency Associates
8 Sankey Road
Cohasset, Massachusetts 02025

Dear Dr. Whelan:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Emergency Department Procedure Codes Billed by Cape Cod Emergency Associates." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG 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>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact David Lamir, Audit Manager, at (617) 565-2704 or through e-mail at david.lamir@oig.hhs.gov. Please refer to report number A-01-09-00509 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF EMERGENCY
DEPARTMENT PROCEDURE
CODES BILLED BY CAPE COD
EMERGENCY ASSOCIATES**



Daniel R. Levinson
Inspector General

August 2009
A-01-09-00509

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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

Physicians are required to bill for emergency department services provided to Medicare beneficiaries in accordance with the Centers for Medicare & Medicaid (CMS) 1995 and 1997 publications entitled “Documentation Guidelines for Evaluation and Management Services” which provide guidelines for documenting the three key elements of evaluation and management services: history, examination, and medical decision making. Physicians use Current Procedural Terminology (CPT) codes to bill emergency department services at one of five levels of service for the three key elements. Physicians are responsible for ensuring that the documentation supports the level of services billed and that the CPT codes selected reflect those services.

In addition, Medicare claim form instructions state that each physician is responsible for becoming familiar with Medicare coverage and billing requirements. One such billing requirement states that, for nurse practitioner services to be covered as incident to the service of a physician and payable as a physician service, the service must be performed under the direct supervision of the physician as an integral part of the physician’s personal in-office service.

The Medicare Part B carriers, under contract with CMS, process and pay claims submitted by physicians, clinical laboratories, and other suppliers. National Heritage Insurance Corporation (NHIC) is the carrier for Part B providers in Massachusetts, Maine, New Hampshire, Vermont, Oregon, Washington, Idaho, and Alaska.

Cape Cod Emergency Associates (CCEA) is a group of physicians located in Hyannis, Massachusetts, that provides emergency department services at Cape Cod Hospital. CCEA submits claims through a billing agent to NHIC for Medicare reimbursement.

OBJECTIVE

Our objective was to determine whether CCEA’s claims for emergency department services met certain Medicare requirements.

SUMMARY OF FINDINGS

CCEA’s claims for emergency department services did not always meet certain Medicare requirements. NHIC’s medical review of beneficiaries’ medical records for the 100 claims in our sample determined that 58 claims were for services that were medically necessary, correctly coded, and billed in compliance with Medicare requirements. Although the remaining 42 claims were for medically necessary services, the services were either incorrectly coded or incorrectly billed. As a result, these claims resulted in overpayments or underpayments to CCEA. Specifically:

- 20 incorrectly coded claims resulted in overpayments totaling \$888 because the emergency department procedure codes billed for the services were higher than the level of care provided,

- 19 incorrectly coded claims resulted in underpayments totaling \$979 because the procedure codes billed for the services were lower than the level of care provided, and
- 3 claims resulted in overpayments totaling \$235 because they were billed as physician services rather than as nurse practitioner services.

These incorrect payments occurred because CCEA's procedures were not always strong enough to ensure that claims for emergency department services were submitted in compliance with Medicare coding and billing requirements.

RECOMMENDATIONS

We recommend that CCEA:

- refund to the Medicare program \$235 in overpayments for the three incorrectly billed claims and
- strengthen its procedures to ensure that all claims for emergency department services are submitted in compliance with Medicare coding and billing requirements.

CAPE COD EMERGENCY ASSOCIATES COMMENTS

In comments on our draft report, CCEA agreed with our findings and recommendations. CCEA's comments are included in their entirety in the appendix.

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INTRODUCTION

BACKGROUND

Physician Billing for Emergency Department Services

Physicians who provide emergency department services to Medicare beneficiaries are required to bill for these services in accordance with the Centers for Medicare & Medicaid (CMS) 1995 and 1997 publications entitled “Documentation Guidelines for Evaluation and Management Services.” These publications provide guidelines for documenting the three key elements of evaluation and management services: history, examination, and medical decision making. Physicians use Current Procedural Terminology (CPT) codes to bill emergency department evaluation and management services at one of five levels of service for the three key elements. Physicians are responsible for ensuring that the documentation supports the level of services billed and that the CPT codes selected reflect those services.

In addition, Medicare claim form instructions state that each physician is responsible for becoming familiar with Medicare coverage and billing requirements. One such billing requirement states that, for nurse practitioner services to be covered as incident to the service of a physician and payable as a physician service, the service must be performed under the direct supervision of the physician as an integral part of the physician’s personal in-office service.

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.

Carrier Responsibilities

The Medicare Part B carriers, under contract with CMS, process and pay claims submitted by physicians, clinical laboratories, and other suppliers. National Heritage Insurance Corporation (NHIC) is the carrier for Part B providers in Massachusetts, Maine, New Hampshire, Vermont, Oregon, Washington, Idaho, and Alaska.

Cape Cod Emergency Associates

Cape Cod Emergency Associates (CCEA) is a group of physicians in Hyannis, Massachusetts, that provides emergency department services at Cape Cod Hospital. CCEA submits claims through a billing agent to NHIC for Medicare reimbursement.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether CCEA’s claims for emergency department services met certain Medicare requirements.

Scope

Our review covered 20,121 claims for emergency department services provided in calendar year (CY) 2007 for which CCEA received Medicare Part B payments totaling \$2,314,131.

We limited our review to obtaining an understanding of CCEA's controls related to developing and submitting Medicare claims for emergency department services.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare requirements and CMS guidance regarding physician billing for emergency department services;
- extracted CCEA's paid claims data for CY 2007 emergency department services from CMS's National Claims History file;
- selected a random sample of 100 claims totaling \$10,969 from the population of 20,121 claims totaling \$2,314,131;
- requested and obtained supporting medical records for each sampled claim;
- reviewed the applicable Common Working File records for the selected claims to verify that the claims had not been canceled;
- used medical reviewers from NHIC to review all medical records obtained for the 100 sampled claims to determine whether the services were medically necessary, correctly coded, and billed in compliance with Medicare requirements;
- calculated the payment effect of NHIC's review determinations; and
- discussed the results of our review with CCEA 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 objective.

FINDINGS AND RECOMMENDATIONS

CCEA's claims for emergency department services did not always meet certain Medicare requirements. NHIC's medical review of beneficiaries' medical records for the 100 claims in our sample determined that 58 claims were for services that were medically necessary, correctly coded, and billed in compliance with Medicare requirements. Although the remaining 42 claims

were for medically necessary services, the services were either incorrectly coded or incorrectly billed. As a result, these 42 claims resulted in overpayments or underpayments to CCEA. Specifically:

- 20 incorrectly coded claims resulted in overpayments totaling \$888 because the emergency department procedure codes billed for the services were higher than the level of care provided,
- 19 incorrectly coded claims resulted in underpayments totaling \$979 because the procedure codes billed for the services were lower than the level of care provided, and
- 3 claims resulted in overpayments totaling \$235 because they were billed as physician services rather than as nurse practitioner services.

These incorrect payments occurred because CCEA's procedures were not always strong enough to ensure that claims for emergency department services were submitted in compliance with Medicare coding and billing requirements.

PROGRAM REQUIREMENTS

Coding Emergency Department Services

CMS's "Medicare Contractor Beneficiary and Provider Communications Manual," chapter 5, section 20.12.1.b, states: "Only the single CPT code most accurately describing the procedure performed or service rendered should be reported." In addition, CMS's Medicare Claims Processing Transmittal 178, Pub. No. 100-04, states: "Documentation should support the level of service reported."

Billing Nonphysician Practitioner Services as Incident to Physician Services

According to CMS's "Medicare Benefit Policy Manual," Pub. 100-02, chapter 15, section 60.1, services or supplies that are furnished as an integral but incidental part of the physician's personal professional services are considered incident to a physician's professional services and are covered by Medicare as physician services. For nonphysician practitioner services such as nurse practitioner services to be billable as incident to the services of a physician and payable as a physician service, they must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service. This requirement applies even to those services provided by nonphysician practitioners who are licensed under State law to perform specific medical procedures without physician supervision. Such services are separately covered and paid for by Medicare as nonphysician practitioners' services rather than as physician services.

NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

Miscoded Claims

Our medical review indicated that, for 39 of the 100 claims in our sample, CCEA submitted claims for emergency department services that were medically necessary but were based on procedure codes that did not accurately reflect the services provided. Specifically, for 20 claims, CCEA's documentation supported a lower code than the code submitted for reimbursement, resulting in an overpayment from Medicare Part B. Conversely, for 19 claims, CCEA's documentation supported a higher code than the code submitted for reimbursement, resulting in an underpayment.

On a scale of five coding levels for emergency department services, 38 of the 39 claims were miscoded by one level. For example:

- CCEA submitted one claim for emergency department services using procedure code 99285, which represents a comprehensive history, a comprehensive examination, and high medical decision making. The medical records, however, supported procedure code 99284, which represents a detailed history, detailed examination, and moderate medical decision making. Accordingly, the claim should have been coded one level lower, and CCEA thus received an overpayment.
- CCEA submitted one claim for emergency department services using procedure code 99283, which represents an expanded problem-focused history, comprehensive examination, and moderate medical decision making. The medical records, however, support procedure code 99284, which represents a detailed history, detailed examination, and moderate medical decision making. Accordingly, the claim should have been coded one level higher, and CCEA thus received an underpayment.

Incorrectly Billed Claims

For 3 of the 100 claims in our sample, CCEA submitted claims for emergency department services that, although medically necessary, did not meet Medicare billing requirements. Specifically, a nurse practitioner provided the services in the hospital's emergency department and the physician billed the services as incident to physician services. However, these services did not meet the requirements for billed services to be incident to a physician's professional services because they were performed in a hospital emergency department setting rather than in a physician's office. As a result, the services should have been billed as nurse practitioner services rather than as physician services.

MEDICARE OVERPAYMENTS

For the 39 miscoded claims, CCEA received overpayments totaling \$888 and underpayments totaling \$979 that, when netted, were immaterial. For the three incorrectly billed claims, CCEA received overpayments totaling \$235.

INADEQUATE PROCEDURES

These incorrect payments occurred because CCEA's procedures were not always strong enough to ensure that claims for emergency department services were submitted in compliance with Medicare coding and billing requirements.

RECOMMENDATIONS

We recommend that CCEA:

- refund to the Medicare program \$235 in overpayments for the three incorrectly billed claims and
- strengthen its procedures to ensure that all claims for emergency department services are submitted in compliance with Medicare coding and billing requirements.

CAPE COD EMERGENCY ASSOCIATES COMMENTS

In comments on our draft report, CCEA agreed with our findings and recommendations. CCEA's comments are included in their entirety in the appendix.

APPENDIX

Chris Whelan MD
CCEA 8 Sankey Rd
Cohasset, MA 02025

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region 1
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

Re: Report No. A-01-09-00509

Dear Mr. Armstrong:

Thank you for providing me with the draft report entitled "Review of Emergency Department Procedure Codes Billed by Cape Cod Emergency Associates."

We have not reviewed the detailed basis for the NHIC analyst's conclusions, however, as you suggest we will take steps to ensure the integrity of our coding, and we will refund to the Medicare program the \$235 in purported overpayments for the three claims in which NHIC believed Cape Cod Emergency Associates should have billed for nurse practitioner services instead of physician services.

Please do not hesitate to contact me if you would like to discuss this matter further.

Sincerely,

A handwritten signature in black ink, appearing to read "Ch Whelan". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Christopher Whelan, M.D.