

Report in Brief

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



Why OIG Did This Audit

Medicare pays practitioners for physician services separately from the payments it makes to inpatient facilities, such as skilled nursing facilities (SNFs) and hospitals.

Practitioners report a two-digit place-of-service code on a Medicare claim line that generally reflects where the practitioner furnished the service. Medicare uses the place-of-service code to determine the payment to the practitioner. We conducted this audit because our analysis of claims indicated that practitioners may not always follow the Centers for Medicare & Medicaid (CMS) regulations and guidance when reporting the place-of-service code on a claim line, thereby increasing the risk of Medicare making an overpayment for physician services furnished to inpatients of a SNF or hospital.

Our objective was to determine whether Medicare paid the proper rate for physician services furnished to enrollees while they were inpatients of a SNF or hospital.

How OIG Did This Audit

For calendar years 2019 and 2020, we identified 2.1 million physician service claim lines at risk of overpayment because of non-compliance with the place-of-service policy. We conducted claims analysis and calculated the overpayments and potential overpayments. We also discussed coding with CMS and practitioners and reviewed a sample of medical records.

Medicare Paid Millions More for Physician Services at Higher Nonfacility Rates Rather Than at Lower Facility Rates While Enrollees Were Inpatients of Facilities

What OIG Found

Medicare sometimes paid higher nonfacility rates rather than lower facility rates for physician services while enrollees were Part A SNF or hospital inpatients. During the 2-year audit period, Medicare made overpayments totaling \$22,463,193 for 1,130,182 claim lines by paying the nonfacility rate for services coded as furnished in a nursing facility or SNF setting without Part A coverage while enrollees were a Part A SNF inpatients. CMS did not have Common Working File (CWF) system edits to detect these coding errors. Similarly, while enrollees were Part A SNF or hospital inpatients, Medicare paid an additional \$22,142,489 for 1,012,203 physician service claim lines coded as furnished in a nonfacility setting. CMS has expressed reluctance to take enforcement action for these claim lines because neither statute nor CMS's regulation specifically addresses situations in which a SNF or hospital inpatient leaves to receive a physician service in a nonfacility setting.

What OIG Recommends and CMS Comments

We recommend that CMS 1) direct its Medicare contractors to recover the \$22.5 million in overpayments identified in our audit; 2) notify the appropriate practitioners so that they can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; 3) establish and apply CWF edits to detect instances in which practitioners incorrectly use the nonfacility place-of-service code for a SNF while an enrollee is a Part A SNF inpatient; 4) take the necessary steps, including seeking legislative authority, if necessary, to revise its regulations, to ensure that Medicare appropriately pays for the physician services, which could have resulted in the Medicare program paying up to \$22.1 million less; 5) consider developing a mechanism for facilities to indicate when an inpatient leaves a facility and returns the same day; and 6) provide additional education to practitioners on the appropriate use of place-of-service codes.

CMS concurred with recommendations one, two, three, and six and described actions that it plans to take to address those recommendations. For recommendations four and five, CMS stated it will consider OIG's findings and recommendations, along with other available information, to determine if it should take action.