



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

October 7, 2004

Report Number: A-05-04-00025

Mr. Ned Boston
Senior Vice President, Medicare Division
WPS Insurance Corporation
1717 West Broadway
Box 1787
Madison, Wisconsin 53701

Dear Mr. Boston:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final audit report entitled "Review of Place of Service Coding for Physician Services." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action 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.

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To facilitate identification, please refer to report number A-05-04-00025 in all correspondence relating to this report.

Sincerely,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF PLACE OF SERVICE CODING
FOR PHYSICIAN SERVICES**

**WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION
MADISON, WISCONSIN**



**October 2004
A-05-04-00025**

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Medicare Part B pays for services provided by physicians to program beneficiaries. Although physicians routinely perform many of these services in a facility setting, such as an outpatient hospital department or a freestanding ambulatory surgical center, certain of the same services may also be performed in non-facility settings, including a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting. Physicians are required to identify the place of service on the health insurance claim form submitted to Medicare Part B carriers for payment. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform the service.

OBJECTIVE

The objective of the audit was to determine the extent of Medicare Part B overpayments made to physicians by Wisconsin Physicians Service Insurance Corporation (WPS) for billings with an incorrect place of service code.

FINDINGS

Medicare overpaid physicians due to incorrect place of service coding. Seventy-nine of 100 sampled physician services, selected from a population of services identified as having a high potential for error, were performed in a facility but were billed by the physicians using the "office" place of service code. As a result of the incorrect coding, Medicare paid the physicians a higher amount for these services. Based on a statistical projection, we estimate that WPS overpaid physicians \$742,510 for incorrectly coded services provided during the 2-year period ended December 31, 2002.

We attribute the overpayments to control weaknesses at WPS and at the physician office level. Specifically:

- WPS had not established sufficient controls, due in part to vulnerabilities inherent in Medicare's claims processing system, to detect Medicare Part B place of service billing errors and to prevent, identify, or recover the program overpayments that resulted from these errors. (Under the Medicare claims processing system, Medicare Part B carriers do not have access to billing information from outpatient hospitals, whose claims are processed by the Medicare Part A fiscal intermediaries.)
- Many of the physicians had not implemented controls to prevent, or subsequently identify, billings with incorrect place of service codes.

RECOMMENDATIONS

We recommend that WPS:

- Recover the \$1,948 of overpayments for the sampled physician services that were performed in a facility setting but billed as if provided in the physician's office.
- Work with the physicians in the developed population of potential errors to reassess their billings and refund any overpayments estimated at \$742,510.
- Educate physicians about the importance of correctly reporting the place of service and encourage physicians to implement internal control systems to prevent Medicare billings with incorrectly coded place of service.
- Work with the Medicare Part A fiscal intermediary to perform a data match to identify physician services having a high potential for place of service miscoding and recover program overpayments that result from these errors.

WPS COMMENTS

In written comments to our draft report, WPS concurred with our findings and recommendations. WPS stated that it recognizes the potential risk for error and will implement measures designed to decrease the error rate associated with claims submitted with the incorrect place of service coding. WPS's written comments are attached as Appendix B.

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INTRODUCTION

BACKGROUND

Medicare Part B Procedures and Services

Medicare Part B pays for services provided by physicians to program beneficiaries. These services include medical and surgical procedures and other services such as office visits and medical consultations. Although physicians routinely perform many of these services in a facility setting, including an outpatient hospital department or a freestanding ambulatory surgical center, certain of the same services may also be performed in non-facility settings, including a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting.

Medicare Payment Regulations

Physicians are paid for services based on the Medicare physician fee schedule. The Centers for Medicare & Medicaid Services (CMS) established relative value units (RVU) for physician work, practice expense, and malpractice insurance. Each RVU has a corresponding geographic practice cost index based on the location where the service was performed. To calculate the physician payment, each of the RVUs is multiplied by the appropriate geographic practice cost index. The sum of these products is then multiplied by the nationally uniform conversion factor to determine the payment.

To compensate physicians for the practice expense differences for certain services, Medicare has established two different RVUs for services performed in a facility versus a non-facility setting. Physicians are required to identify the place of service on the health insurance claim form submitted to Medicare Part B carriers for payment. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service.

Carrier Responsibility

The Medicare Part B carriers, under contract with CMS, process and pay claims submitted by physicians, clinical laboratories, suppliers, and ambulatory surgical centers. WPS is the Medicare Part B carrier that processes and pays claims submitted by Part B providers in Wisconsin, Michigan, Illinois, and Minnesota.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of the audit was to determine the extent of Medicare Part B overpayments made to physicians by WPS for billings with an incorrect place of service code.

Scope and Methodology

Our audit covered physician services provided during the period from January 1, 2001 through December 31, 2002. For this 2-year period, we analyzed a stratified random sample of 100 services selected from a population of 62,420 physician services paid by WPS that had been identified through a computer match as having a high potential for error. The services, although coded by the physicians as being performed in non-facility settings, were matched with data that indicated the services may have been performed in a facility setting (outpatient hospital department or ambulatory surgical center).

To accomplish the objective of the audit, we:

- reviewed paid claims data to determine the place of service for which the sampled services were paid;
- discussed the billings with physician office personnel, reviewed medical and billing records to determine whether the place of service was incorrectly coded, and identified the underlying causes contributing to incorrect coding;
- calculated the amounts of any Medicare overpayments; and
- discussed the results of the review with WPS officials and provided additional data needed to implement our recommendations.

Our review of internal controls was limited to discussions with WPS officials and physician employees and representatives. The discussions were intended to establish whether internal controls had been developed to prevent program overpayments resulting from place of service billing errors. The adequacy of any existing controls was not evaluated.

Our audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

PAYMENTS BASED ON INCORRECT PLACE OF SERVICE

Medicare overpaid physicians due to incorrect place of service coding. Seventy-nine of 100 sampled physician services, selected from a population of services identified as having a high potential for error, were performed in a facility but were billed by the physicians using the “office” place of service code. As a result of the incorrect coding, Medicare paid the physicians a higher amount for these services. We attribute the overpayments to control weaknesses at the carrier and physician office level. Based on a statistical projection, we estimate that WPS overpaid physicians \$742,510 for incorrectly coded services provided during the 2-year period ended December 31, 2002.

Medicare Requirements

The Medicare physician fee schedule includes two payment amounts depending on whether a service is performed in a facility setting, such as an outpatient hospital department or ambulatory surgical center, or in a non-facility setting, such as a physician's office. The payments to physicians are higher when the services are performed in non-facility settings. The higher payments are designed to compensate physicians for the additional costs incurred to provide the service at an office location as opposed to a facility location.

In order for the physician to receive the higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B), as follows:

. . . The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC [ambulatory surgical center] if the physician is performing a procedure not on the ASC approved procedure 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

Services Billed with Incorrect Place of Service Codes

The place of service for 79 of 100 sampled services had been incorrectly coded on the physicians' billings. Although each of the 79 services was coded as if it was performed in the physician's office, 55 of the services were actually performed in outpatient hospital settings, and 24 of the services were performed in ambulatory surgical centers.

By re-pricing the claims using the correct place of service code, we determined that claims for 75¹ of the 79 services were overpaid by WPS in the amount of \$1,948. Even though the place of service had been miscoded, overpayments did not result for 4 of the 79 services because the physicians' billings did not otherwise exceed the Medicare fee schedule amount for the correct facility setting.

Estimate of Overpayments

We estimate that WPS overpaid physicians \$742,510 for services that were billed using incorrect "non-facility" place of service codes for services provided during the period from January 1, 2001 through December 31, 2002. Our estimate is based on the point estimate of a statistical projection as described in the appendix.

Control Weaknesses at the Carrier and Physician Office Level

We attribute the overpayments to control weaknesses at the Medicare Part B carrier and at the physician office level.

¹ Physician providers informed us that 9 of the 75 overpayments had recently been self-disclosed or otherwise uncovered through a Medicare provider audit. They indicated that repayments have been, or will be, initiated.

At the carrier level, WPS had not established sufficient controls, due in part to vulnerabilities in Medicare's claims processing system, to detect place of service billing errors and to prevent, identify, or recover the program overpayments that resulted from these errors. Under the Medicare claims processing system, Medicare Part B carriers do not have access to billing information from outpatient hospitals because hospital claims are processed by the Medicare Part A fiscal intermediaries. In addition, although carriers have access to claims data for freestanding ambulatory surgical centers, the centers have up to 27 months to submit their claims for processing. Therefore, a physician could submit a bill and receive payment well before the ambulatory surgical center submits its claim, making the identification of these cases more difficult.

At the physician office level, we found that many physicians had not implemented controls to prevent, or subsequently identify, billings with incorrect place of service codes. Specifically, we found that incorrect place of service coding often occurred for one or more of the following reasons:

- Billing personnel were inadequately trained, new to their jobs, or temporarily substituting for more experienced employees and did not correctly assign the place of service code for a particular location.
- Physician office personnel were not aware that an incorrect place of service code could change the Medicare payment amount for a specific service.
- Physician office personnel were unsure about the precise definition of a physician's office, or had not adequately considered whether the "office" place of service code for a particular location was appropriate.
- Undetected flaws in the design or implementation of some billing systems allowed the systems to assign an incorrect place of service code to specific physical locations or groups of services.
- Default settings within some billing systems for place of service codes for specific service locations were incorrectly set and not manually over-ridden or were correctly set but inappropriately over-ridden by personnel who did not fully understand the default settings.
- Inadvertent data entry errors occurred when apparently well-trained billing personnel made isolated mistakes.

RECOMMENDATIONS

We recommend that WPS:

- Recover the \$1,948 of overpayments for the sampled physician services that were performed in a facility setting but billed as if provided in the physician's office.

- Work with the physicians in the developed population of potential errors to reassess their billings and refund any overpayments estimated at \$742,510.
- Educate physicians about the importance of correctly reporting the place of service and encourage physicians to implement internal control systems to prevent Medicare billings with incorrectly coded place of service.
- Work with the Medicare Part A fiscal intermediary to perform a data match to identify physician services having a high potential for place of service miscoding and recover program overpayments that result from these errors.

WPS COMMENTS

In written comments to our draft report, WPS concurred with our findings and recommendations. It stated that it recognizes the potential risk for error and will implement measures designed to decrease the error rate associated with claims submitted with incorrect place of service coding.

Addressing our recommendations, WPS stated that it requested refunds of the overpayments made to the sampled providers and developed an education plan to instruct providers about the appropriate use of place of service codes. WPS indicated that it will encourage providers to self-assess their billings and to refund overpayments as part of its educational effort. WPS also said that it would evaluate the feasibility of exchanging information with Medicare fiscal intermediaries to help identify those services that may be highly susceptible to place of service coding errors.

WPS's written comments are attached in their entirety as Appendix B.

APPENDICES

SAMPLING METHODOLOGY

POPULATION

The population included 62,420 services that were provided during the period from January 1, 2001 through December 31, 2002 and were billed to Medicare Part B by physicians who may have used incorrect “non-facility” place of service codes. Claims for the services were processed and paid by WPS. Through a computer match, we identified the services as having a high potential for error. These services, although coded by the physicians as being performed in non-facility settings, were matched with data that indicated the services may have been performed in an outpatient hospital setting or in an ambulatory surgical center.

SAMPLE DESIGN

We designed a stratified random sample of 100 services selected from two strata. The first stratum consisted of 61,444 services that were billed by physicians using a “non-facility” place of service code, but may have been performed in an outpatient hospital setting. The second stratum consisted of 976 services that were billed by physicians under the “non-facility” place of service code, but may have been performed in an ambulatory surgical center. We selected a random sample of 70 services from the first stratum and 30 services from the second stratum.

Stratum Number	Description of Stratum	Number of Services in Population	Number of Services in Sample
1	Physician - Outpatient Hospital Setting	61,444	70
2	Physician - Ambulatory Surgical Center	<u>976</u>	<u>30</u>
		62,420	100

RESULTS OF SAMPLE

The results of the sample review follow:

Stratum Number	Size of Population	Size of Sample	Number with Incorrect Coding	Number with Overpayments	Value of Overpayments
1	61,444	70	55	54	\$ 803
2	<u>976</u>	<u>30</u>	<u>24</u>	<u>21</u>	<u>1,145</u>
	62,420	100	79	75	\$1,948

The point estimate of the projection was \$742,510, with a precision of plus-or-minus \$205,404 at the 90 percent confidence level.

August 24, 2004

Appendix B
Page 1 of 2

Report No. A-05-04-00025

Paul Swanson
Regional Inspector General
Department of Health & Human Services
Office of Audit Services
233 N. Michigan Avenue
Chicago, IL 60601

Dear Mr. Swanson,

We received your letter informing us you have completed the U.S. Department of Health & Human Services, Office of Inspector General draft audit, "Review of Place of Service Coding for Physician Services," and we have reviewed the findings of this audit. We thank you for the opportunity to prepare a response to this draft and for your recommendations.

WPS recognizes the potential risk for error in reimbursing physicians for claims submitted with the incorrect place of service. We are determined to take the necessary measures to decrease the error rate of claims processed with incorrect place of service codes. Our Claims Processing System has internal controls designed to issue specific edits based on the place of service and procedure codes submitted on claims. WPS also has quality controls in place, with each processor receiving audits on a monthly basis, both in the front-end and post-pay claims environment. Based on the OIG draft audit, "Review of Place of Service Coding for Physician Services," and the recommendations contained within the audit, we developed a proposed educational plan to instruct providers regarding the use of the proper place of service code when billing claims. This educational plan is designed to supplement the internal controls and quality reviews we currently have in place.

WPS agrees that many providers are unclear on the precise definition of a physician's office and are unaware that an incorrect place of service code could cause an overpayment. We also believe some confusion among providers is due in part to the misconceptions they have regarding billing procedures performed in Ambulance Surgical Centers. WPS will implement our educational plan re-emphasizing the importance of accurate claims submission including place of service.

Educational Methods	Description of Educational Message
<ul style="list-style-type: none"> - Teleconference - Seminar 	<p>WPS will: Promote the importance of reporting the correct place of service on claims through various educational activities.</p>
<ul style="list-style-type: none"> - Computer Based Training - Medicare Update Programs - Communiqué articles 	<p>WPS will: Educate providers on the precise definition of an office setting specifically addressing an office in an institutional setting.</p>
<ul style="list-style-type: none"> - Web site articles - Mass E-mailing Lists 	<p>WPS will: Inform providers of the guidelines in billing place of service codes for procedures performed in an Ambulatory Surgical Center.</p>

WPS currently does not have access to claims processing information handled by Medicare Fiscal Intermediaries, however, WPS will explore the feasibility of exchanging data match tapes with Medicare Part A Fiscal Intermediaries to identify physician services having a high potential for place of service miscoding.

WPS reviewed the overpayments received for physician services provided in a facility setting, but billed as if performed in the physician's office, as determined by the findings of this audit. WPS requested a refund of these overpayments on June 4, 2004 and June 9, 2004. As part of our education effort we will encourage providers to self assess and submit any overpayments.

If you have any further questions, you may contact me at (608) 301-2603.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ned Boston', with a long horizontal stroke extending to the right.

Ned Boston
Senior Vice President
Medicare Division

NB:lp