

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PAID MILLIONS MORE FOR  
PHYSICIAN SERVICES AT HIGHER  
NONFACILITY RATES RATHER THAN AT  
LOWER FACILITY RATES WHILE  
ENROLLEES WERE INPATIENTS OF  
FACILITIES**

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## Report in Brief

Date: May 2023

Report No. A-04-21-04084

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.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Medicare pays physicians and nonphysician practitioners (practitioners) for physician services separately from the payments it makes to inpatient facilities, such as skilled nursing facilities (SNFs) and hospitals.<sup>1</sup> Medicare usually pays practitioners a lower rate for services furnished to Part A inpatients to ensure that it does not make duplicate payments to the practitioner and the facility for certain expenses. 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 coding 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.

### OBJECTIVE

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.

### BACKGROUND

#### The Medicare Program

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for enrollees after they are discharged from the hospital. Medicare Part B provides supplementary medical insurance for medical and other health services, including physician services.

CMS administers Medicare and contracts with Medicare administrative contractors (Medicare contractors) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A inpatient claims submitted for hospital services, process and pay Medicare Part B claims submitted for physician services, safeguard against fraud and abuse, and educate providers and practitioners about Medicare billing requirements.

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<sup>1</sup> Physician services include surgery; consultation; and home, office, and institutional calls. Medicare Part B covers physician services furnished by various types of practitioners, including doctors of medicine, podiatrists, optometrists, physician assistants, nurse practitioners, clinical psychologists, and other health care practitioners.

## Medicare Part A Payments to SNFs and Hospitals

Medicare pays SNFs for covered services through a prospective payment system (PPS). Under the PPS, Medicare Part A pays SNFs through per diem rates that cover virtually all the costs of furnishing services to enrollees.<sup>2</sup>

However, CMS designates certain outpatient services as being beyond the general scope of a SNF, such that when an enrollee leaves the facility setting to receive a designated outpatient service, their status as a Part A SNF inpatient ends, as does the SNF's responsibility to furnish or make arrangements for any services.<sup>3, 4</sup> For example, if a SNF inpatient left to have a venous procedure as a hospital outpatient, the patient would not be considered a SNF inpatient during the procedure and the SNF would not be responsible for these services. When the patient returned to the SNF, they would resume their status as a SNF inpatient.

Similarly, Medicare Part A pays inpatient hospital services through a PPS. Payment rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which an enrollee's stay is assigned. The MS-DRG payment is primarily intended to be a payment in full to the hospital for all inpatient costs associated with the enrollee's stay.<sup>5</sup>

## Part B Payments for Physician Services

Generally, physician services are not paid under SNF or inpatient hospital PPS because they are excluded from the definition of covered SNF services and the definition of inpatient hospital services.<sup>6, 7</sup> Instead, Medicare Part B pays separately for physician services furnished during

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<sup>2</sup> The Social Security Act (the Act) § 1888(e).

<sup>3</sup> 42 CFR § 411.15(p)(3)(iii).

<sup>4</sup> CMS produces annual files that contain the list of services that CMS designates as within or beyond the scope of a SNF. A description of these designations can be found in CMS's *General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing*.

<sup>5</sup> The Act § 1886(d).

<sup>6</sup> The Act § 1888(e)(2)(A)(ii) excludes physician services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, and certain other services from payment under SNF PPS. The Act § 1861(b)(4) excludes medical or surgical services provided by a physician, resident, or intern, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, and certain other services from the definition of inpatient hospital services.

<sup>7</sup> Although physician services are already excluded from SNF consolidated billing requirements, CMS includes physician services in its annual files of services beyond the scope of the SNF. CMS's *General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing* and 68 Fed. Reg. 46036, 46061 (Aug. 4, 2003) indicate that practitioners should furnish these services only in a hospital setting for SNF inpatients. We excluded from the scope of our audit these services that practitioners coded as furnished in a nonfacility setting unless they used place-of-service code 32 (Nursing Facility or SNF with no Part A Coverage).

these SNF and hospital inpatient stays using amounts from the Medicare Physician Fee Schedule (fee schedule). Medicare enrollees are required to participate in cost sharing for physician services that are paid under Medicare Part B.<sup>8</sup> Cost sharing includes the payment of deductibles and coinsurance by the enrollee.

### **Physician Services Usually Have Different Payment Rates To Account for Practice Expenses**

Section 1861(q) of the Act defines physician services as services by physicians, including surgery; consultation; and home, office, and institutional calls. CMS bases Medicare reimbursement for physician services on a fee schedule, which has predetermined payment amounts. The fee schedule uses Current Procedural Terminology (CPT)<sup>9</sup> codes and standardized codes from the Healthcare Common Procedure Coding System (HCPCS) to assign payments for these services. The fee schedule payments for physician services are based on three major categories of physician costs: practice expense, physician work, and malpractice insurance.<sup>10</sup> Practice expenses reflect the overhead costs involved in maintaining a practice, such as renting office space, buying supplies, equipment, and staff costs.<sup>11</sup>

Medicare pays practitioners either a usually lower facility rate (facility rate) or a usually higher nonfacility rate (nonfacility rate) to account for the differences in practice expenses at different settings (see examples in Table 1 on the following page).<sup>12</sup>

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<sup>8</sup> 42 CFR § 410.3(b).

<sup>9</sup> The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2018–2019 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

<sup>10</sup> The Act § 1848(c) and 42 CFR § 414.22.

<sup>11</sup> The Act § 1848(c)(1)(B).

<sup>12</sup> The facility rate is usually lower than the nonfacility rate but for some services (e.g., nursing home evaluation and management services billed with HCPCS codes 99304 through 99318), the nonfacility rate and facility rate are the same.

**Table 1: Examples of Physician Services With Different Payment Rates**

HCPCS Code	HCPCS Code Description	Facility Rate*	Nonfacility Rate*	Difference
11043	Removal of skin and/or muscle, first 20 square centimeters or less	\$161.32	\$239.64	\$78.32
11720	Removal of tissue from 1 to 5 fingernails or toenails (nail debridement)	15.16	33.56	18.40
90791	Psychiatric diagnostic evaluation	127.76	145.44	17.68
92004	Eye and medical examination for diagnosis and treatment, new patient, 1 or more visits	99.97	152.66	52.69
99214	Established patient office or other outpatient, visit typically 25 minutes	80.48	110.43	29.95
*Rates shown are the national payment amounts for calendar year 2020.				

CMS designed the governing regulation and the different payment rates “to ensure that Medicare does not make a duplicate payment for any of the practice expenses incurred in providing a service for a Medicare patient. When the beneficiary is a hospital [or] SNF...patient, the facility is paid for the clinical staff, supplies and equipment needed to take care of that patient, and the lower facility rate should be paid to the practitioner. Therefore, if the patient is a facility patient or if a facility bills for the service, the practitioner must bill for a facility site-of-service [place-of-service] so that the practice expense accurately reflects the setting in which the service was furnished.”<sup>13</sup> Conversely, if a practitioner furnishes services in a nonfacility setting, the practitioner will generally use a nonfacility place-of-service code and Medicare pays the nonfacility rate to account for any increased practice expenses that practitioners incur in these nonfacility settings, like an office, independent clinic, or urgent care facility.<sup>14</sup>

### **Place-of-Service Codes Determine the Payment Rates for Physician Services**

Practitioners use a two-digit place-of-service code on a Medicare claim line. CMS designates each place-of-service code as either a facility setting or a nonfacility setting. Appendix B contains a list of the possible place-of-service codes and the designated rate (facility or nonfacility) associated with these codes. Table 2 on the following page shows the place-of-service codes frequently referenced in this report. The correct place-of-service code ensures

<sup>13</sup> 64 Fed. Reg. 59380, 59407 (Nov. 2, 1999).

<sup>14</sup> 42 CFR § 414.22(b)(5)(i).

that Medicare properly reimburses the practitioner the appropriate practice expenses at either the facility rate or the nonfacility rate.

**Table 2: Examples of Place-of-Service Codes and Their Designated Payment Rate**

Code	Code Name	Facility Rate	Nonfacility Rate
11	Office		✓
21	Hospital	✓	
31	Skilled Nursing Facility (SNF with Part A coverage)	✓	
32	Nursing Facility (NF or SNF with no Part A coverage)		✓

Generally, the place-of-service code represents where the practitioner furnished the services face-to-face (face-to-face standard), but CMS coding guidance provides an exception to this standard in its *Medicare Claims Processing Manual* (the Manual). CMS states that when an enrollee is a registered inpatient, the physician services should be coded with a facility place-of-service code, and the practitioner should be paid the facility rate “irrespective of the setting where the patient actually receives the face-to-face encounter.”<sup>15</sup> Practitioners should report a facility place-of-service code such as 21 (inpatient hospital), 31 (SNF with Part A coverage), or 51 (psychiatric inpatient facility) so that Medicare pays the practitioner the facility rate when services are furnished to a registered inpatient.<sup>16</sup>

Another exception to the face-to-face standard for place-of-service codes involves registered inpatients of a SNF. Federal regulations require physician services to be paid at the facility rate when furnished to patients in a SNF and at the nonfacility rate when furnished to patients in a nursing facility (NF).<sup>17</sup> Some facilities can include both NF and SNF settings. In addition, SNF patients may or may not have Part A coverage. CMS instructs practitioners to use place-of-service code 31 (SNF with Part A coverage) for patients who are inpatients of a SNF with Part A coverage. If the patient exhausts Part A benefits and Medicare is no longer making payments to the SNF for institutional services, CMS instructs practitioners to use place-of-service code 32 (NF or SNF with no Part A coverage), which is paid at the nonfacility rate. However, CMS always allows practitioners to forgo determining the patient’s Part A inpatient status and receive the usually lower facility rate by using the place-of-service code 31 (SNF with Part A coverage).<sup>18</sup> See Figure 1 on the following page for the different payment rate scenarios that can occur

<sup>15</sup> This is because payments to the facilities already include some of the practice expenses for the physician services furnished to their inpatients.

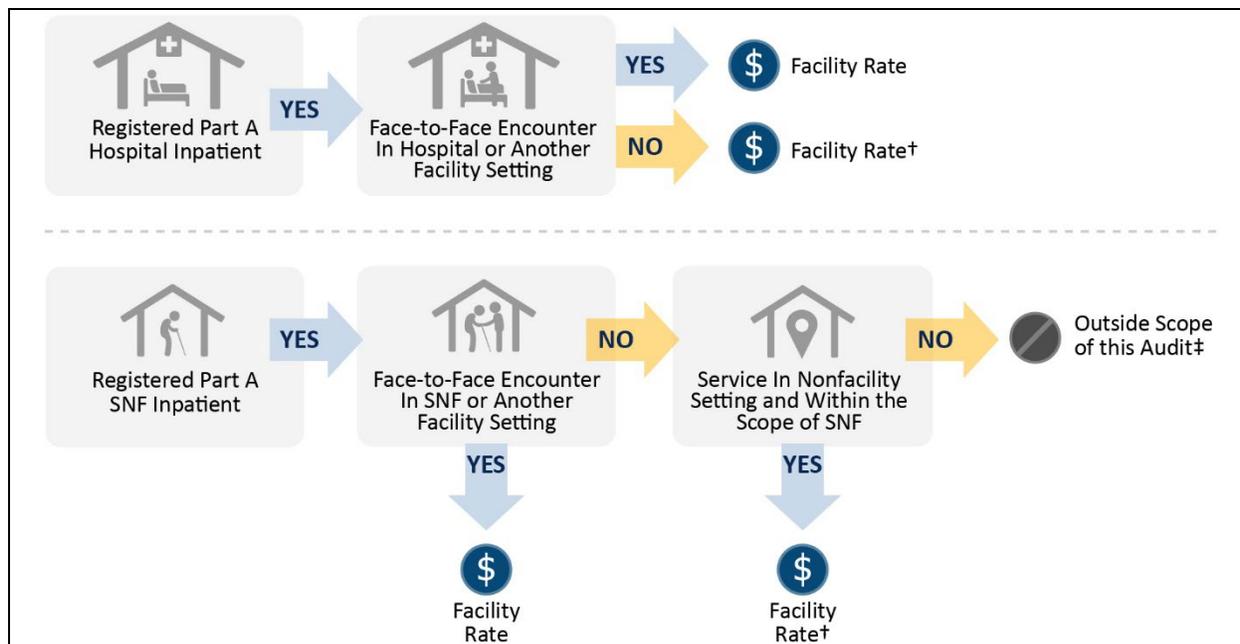
<sup>16</sup> The Manual, Chapter 26, section 10.5 (see paragraph titled “Special Considerations for Services Furnished to Registered Inpatients”).

<sup>17</sup> 42 CFR § 414.22(b)(5)(i)(A) and (B).

<sup>18</sup> 67 Fed. Reg. 79966, 79984 (Dec. 31, 2002).

during an inpatient stay for an enrollee with Part A coverage.

**Figure 1: Place-of-Service Scenarios for SNF and Hospital Inpatients with Part A Coverage\***



\*This figure is not intended to be a complete representation of all the place-of-service rules.

† Per the CMS coding guidance at Manual, Chapter 26, Section 10.5, physician services furnished to SNF and hospital inpatients should be paid the facility rate "irrespective of the setting where the patient actually receives the face-to-face encounter."

‡ We excluded these services from our audit. CMS produces annual files that contain the list of services that CMS designates as within or beyond the scope of a SNF. A description of these designations can be found in CMS's *General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing*. Although physician services are already excluded from SNF consolidated billing requirements, CMS includes physician services in its annual files of services beyond the scope of the SNF. CMS's *General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing and 68 Fed. Reg. 46036, 46061 (Aug. 4, 2003)* indicate that practitioners should furnish these services only in a hospital setting for SNF inpatients. Medicare would not likely have paid twice for the practice expenses for these services in a nonfacility setting. The applicable practice expenses are not likely included in a payment to the SNF because they are for services beyond the scope of the SNF and the practitioners coded the services as furnished outside of the SNF.

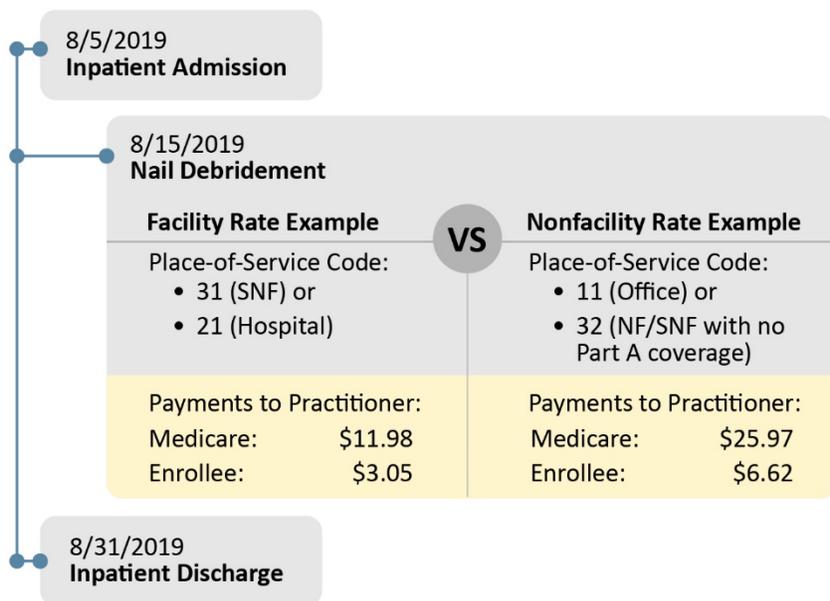
### **CMS's Claim Processing System Has Prepayment and Postpayment Edits**

Medicare contractors use the Fiscal Intermediary Standard System to process inpatient claims submitted by facilities and the Multi-Carrier System to process physician services submitted by practitioners. Before payment, claims processed by both systems move through CMS's Common Working File (CWF) system for verification, validation, and payment authorization.

The CWF system contains both prepayment and postpayment system edits that are intended to prevent or detect overpayments, including verifying that the services on a claim have not

already been paid on another claim.<sup>19</sup> However, the CWF system does not have edits that compare Part A inpatient claims (SNF and hospital inpatient services) to Part B claim lines (physician services) to assess the proper place-of service code on the Part B claim line and the corresponding payment rate to the practitioner while an enrollee is an inpatient (see Figure 2). In addition, CWF edits are limited to the fields available on a claim, which does not include fields indicating when a patient leaves and returns on the same day.

**Figure 2: Example of a Part A Claim and a Part B Claim Line Not Compared By CWF Edits To Assess the Proper Payment Rate to the Practitioner**



### The 60-Day Rule and 6-Year Lookback Period

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after

<sup>19</sup> For additional detail on prepayment and postpayment edits see *CMS's System Edits Significantly Reduced Improper Payments to Acute-Care Hospitals After May 2019 for Outpatient Services Provided to Beneficiaries Who Were Inpatients of Other Facilities* ([A-09-22-03007](#)), issued Sept. 22, 2022.

identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>20</sup>

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>21</sup>

## HOW WE CONDUCTED THIS AUDIT

Our audit covered \$171,241,491 in Medicare Part B payments for 2,142,385 physician service claim lines with dates of service between January 1, 2019, and December 31, 2020. Those claim lines were for enrollees who were Part A inpatients of either a SNF or hospital and whose practitioners used a nonfacility place-of-service code.<sup>22</sup> We only included physician services when the facility rate on the physician fee schedule was lower than the nonfacility rate.

We identified the 2,142,385 claim lines through a claims analysis that compared Part A inpatient SNF and hospital claims to the corresponding Part B physician service claim lines for the same patient to determine whether Medicare paid the proper rate for physician services while an enrollee was an inpatient of a SNF or hospital. We did not review medical records to determine where the practitioners actually furnished the services for all 2,142,385 claim lines. We selected 34 claim lines on a judgmental basis to discuss coding and billing practices with the practitioners, to review the practitioners' records of the enrollee, or to review the records of the SNF or hospital where the enrollee was inpatient.

We categorized the 2,142,385 claim lines based on the corresponding inpatient facility, the place-of-service code on the claim line, and the HCPCS code on the claim line or other HCPCS codes for the enrollee that directly related to the claim line. When a practitioner used any nonfacility place-of-service code, other than place-of-service code 32 (NF or SNF with no Part A coverage), during a SNF inpatient stay, we categorized the service as furnished in a nonfacility setting. We grouped the claim lines into the following three categories:

- claim lines for enrollees who were inpatients during a Part A SNF stay and the Part B practitioners coded the services with the nonfacility place-of-service code 32 (NF or SNF with no Part A coverage) (1,130,182 claim lines);

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<sup>20</sup> The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>21</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual—Part 1*, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. 7654, 7670 (Feb. 12, 2016).

<sup>22</sup> See Appendix B for a list of place-of-service codes designated as nonfacility.

- claim lines for enrollees who were inpatients during a Part A SNF stay, the Part B practitioners coded the services as furnished in a nonfacility setting, and the services or services directly related to these claim lines were not designated by CMS as beyond the scope of the SNF (986,932 claim lines);<sup>23, 24</sup> and
- claim lines for enrollees who were inpatients during a Part A hospital stay (25,271 claim lines).

We calculated the differences between the facility rates and nonfacility rates for each claim line after matching the relevant fields on those lines to the respective fee schedule lines. We also calculated the difference between the enrollee’s cost-sharing payment at the two different rates. Appendix A contains the details of our scope and methodology.

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.

## FINDINGS

Medicare did not always pay the proper rate for physician services coded with the nonfacility place-of-service code for a NF or SNF without Part A coverage while enrollees were Part A inpatients of a SNF. During the 2-year audit period, Medicare made overpayments totaling \$22,463,193 for 1,130,182 claim lines at the nonfacility rate for these physician services. Medicare paid twice for the practice expenses for these services in its payments to the SNFs and the practitioners. In addition, the enrollees incurred additional cost sharing for deductibles and coinsurances of as much as \$5,706,079.<sup>25</sup> Medicare improperly paid these claim lines at the nonfacility rate because practitioners incorrectly used the nonfacility place-of-service code

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<sup>23</sup> CMS defines “directly related” as occurring on the same date of service with the same place-of-service code. For example, if a patient received a service that CMS designated as outside the scope of the SNF with an office place-of-service code the same patient received another service and on the same day that was within the scope of a SNF with an office place-of-service code, we excluded both services from our audit.

<sup>24</sup> We excluded from our audit the claim lines for which (1) enrollees were inpatient during a Part A SNF stay; (2) the Part B practitioners used a nonfacility place-of-service code (excluding place-of-service code 32); and (3) the services or directly related additional services were designated by CMS as beyond the scope of the SNF. Medicare would not likely have paid twice for the practice expenses for these services. The applicable practice expenses are not likely included in a payment to the SNF because they are for services beyond the scope of the SNF and the practitioners coded the services as furnished outside of the SNF.

<sup>25</sup> We did not determine if practitioners received all the enrollee cost-sharing payments that they had charged. In addition, \$20,198 of the overpayments was attributed to deductibles that may still be owed by the enrollees for future services.

32 (NF or SNF with no Part A coverage) rather than the facility place-of-service code 31 (SNF with Part A coverage). In addition, CMS did not have CWF system edits to detect the coding errors.

Similarly, while enrollees were Part A inpatients of a SNF or hospital, Medicare sometimes paid the nonfacility rate for physician services coded as furnished in a nonfacility setting.<sup>26</sup> By paying for these services at the nonfacility rate, Medicare paid an additional \$22,142,489 for 1,012,203 physician service claim lines. The enrollees may have incurred additional cost sharing for these claim lines of as much as \$5,609,125.<sup>27</sup> These additional payments represent practice expense payments paid to the practitioners that the separate payments to the SNFs or hospitals are intended to cover. 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 (e.g., a physician's office) while remaining an inpatient. However, in the Manual, CMS coding guidance states that when a practitioner furnishes services to a registered SNF or hospital inpatient, Medicare pays the facility rate, irrespective of the setting where the patient actually receives the face-to-face encounter. CMS has expressed reluctance to take enforcement action based on this Manual provision because there is no identifiable support for it in statute or regulation. Therefore, we are reporting these payments for the practice expenses that Medicare included in its payments to both a practitioner and a SNF or hospital as cost savings that CMS could have achieved with revised regulations.

#### **MEDICARE IMPROPERLY PAID THE HIGHER NONFACILITY RATE FOR PHYSICIAN SERVICES CODED AS FURNISHED IN A NF OR SNF SETTING WITHOUT PART A COVERAGE WHILE ENROLLEES WERE PART A SNF INPATIENTS**

Federal regulations require physician services to be paid at the facility rate when furnished to patients in a SNF and at the nonfacility rate when furnished to patients in a NF.<sup>28</sup> When services are furnished to patients in settings that have a combination of NF and SNF patients, practitioners should designate their services as facility services payable at the facility rate, unless they verify that no Part A claim will be submitted for the service (i.e., that the patient is a NF patient or a SNF inpatient with no Part A coverage).<sup>29</sup> Therefore, if a practitioner appropriately verifies the enrollee's Part A SNF inpatient status for the date of service, the practitioner should not assign the nonfacility place-of-service code 32 (NF or SNF with no Part A coverage) to a claim line.

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<sup>26</sup> See Appendix B for a list of place-of-service codes designated as nonfacility.

<sup>27</sup> We did not determine if practitioners received all the enrollee cost-sharing payments that they had charged. In addition, \$53,995 of the potential overpayments was attributed to deductibles that may still be owed by the enrollees for future services.

<sup>28</sup> 42 CFR § 414.22(b)(5)(i)(A) and (B).

<sup>29</sup> 65 Fed. Reg. 65376, 65401 (Nov. 1, 2000).

Medicare improperly paid 1,130,182 physician service claim lines coded as furnished in a NF or SNF setting at nonfacility rates while the enrollees were Part A inpatients. Medicare overpaid the claim lines by \$22,463,193. The enrollees incurred additional cost sharing for as much as \$5,706,079. The overpayments are the difference between the incorrectly used nonfacility rate and the facility rate that should have been used. The difference in rates reflects practice expenses. SNFs receive separate Part A payments for comparable practice expenses so Medicare pays twice for practice expenses when it pays practitioners the nonfacility rate for furnishing services to Part A SNF inpatients in a facility setting. Table 3 shows the Medicare and enrollee overpayments associated with incorrectly using the nonfacility rate.

**Table 3: Overpayments for Physician Services Coded as Furnished in a NF or SNF Setting Without Part A Coverage While Enrollees Were Part A SNF Inpatients**

	Medicare Payment	Enrollees Payment
<b>Actual Payments at Nonfacility Rate</b>	\$89,820,440	\$23,026,956
<b>Revised Payments at Facility Rate</b>	67,357,247	17,320,877
<b>Overpayment</b>	<b>\$22,463,193</b>	<b>\$5,706,079</b>

By using place-of-service code 32 (NF or SNF with no Part A coverage) on the claims, the practitioners indicated that services were provided in a NF or SNF setting to an enrollee with no Part A coverage. However, to the contrary, those enrollees were inpatients in Part A covered SNF stay, and the practitioners should have used place-of-service code 31 (SNF with Part A coverage). Therefore, the practitioners' use of place-of-service code 32 was incorrect, and Medicare made improper payments to those practitioners at the nonfacility rate, causing both the SNF and the practitioner to be compensated for the practice expenses associated with furnishing the service.

According to the practitioners that we had discussions with, they used the wrong place-of-service code on the claim line either because of a coding mistake, such as an incorrect setting in their coding software, or that they incorrectly determined the patient's Part A inpatient status. Practitioners noted that keeping track of each patient's coverage can be complicated, especially for outside practitioners visiting facilities that have patients receiving a variety of services. In addition, their patients can have a variety of insurance coverages, such as Medicare, private insurance, or Medicaid and that Part A SNF inpatients may exhaust or lose their Part A coverage during their stay. Further complicating the determination of the patient's Part A inpatient status is that some facilities may transport a variety of patients, including SNF inpatients, from various parts of their facility to a designated room for treatment. Practitioners noted that all these factors cause confusion about the Part A inpatient status of their patients.

Medicare improperly paid these 1,130,182 claim lines because CMS had no CWF edits in place to detect when practitioners billed claim lines with nonfacility place-of-service code 32 (NF or

SNF with no Part A coverage) while the enrollees were Part A SNF inpatients. Practitioners should have billed these claim lines with a facility place-of-service code and Medicare should have paid for these claim lines at the facility rate.

### **MEDICARE PAID THE HIGHER NONFACILITY RATE FOR PHYSICIAN SERVICES CODED AS FURNISHED IN A NONFACILITY SETTING WHILE ENROLLEES WERE PART A SNF OR HOSPITAL INPATIENTS**

Federal regulations provide two levels of payment based on the amount of practice expenses attributable to the service: facility or nonfacility. The facility rate applies to physician services furnished to patients in a hospital, skilled nursing facility, or certain other listed facilities.<sup>30</sup> The nonfacility rate applies to physician services furnished to patients in all other locations, including a physician's office, the patient's home, or a nursing facility.<sup>31</sup> According to CMS, the major purpose for having two rates is to ensure that Medicare does not pay twice for any of the practice expenses of a service furnished to a Medicare patient.<sup>32</sup>

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 while remaining an inpatient. However, in the Manual, CMS coding guidance states that when a practitioner furnishes services to a registered SNF or hospital inpatient, Medicare pays the facility rate, "irrespective of the setting where the patient actually receives the face-to-face encounter."<sup>33</sup>

While enrollees were Part A inpatients of a SNF or hospital, Medicare paid 1,130,182 physician service claim lines coded as furnished in a nonfacility setting at the nonfacility rates. By paying the nonfacility rate, Medicare paid an additional \$22,142,489 more than it would have paid at the facility rate. These potential overpayments represent practice expenses that the separate payments to the SNF or hospital were intended to cover.

Of these 1,130,182 claim lines, 986,932 claim lines were for services during a Part A inpatient SNF stay where the Part B practitioner used a nonfacility place-of-service code (excluding place-of-service code 32) and the service or directly related additional services were not designated by CMS as beyond the scope of a SNF.<sup>34</sup> The remaining 25,271 claim lines were for services during a Part A hospital stay where the practitioner used any nonfacility place-of-service

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<sup>30</sup> 42 CFR § 414.22(b)(5)(i)(A).

<sup>31</sup> 42 CFR § 414.22(b)(5)(i)(B).

<sup>32</sup> 65 Fed. Reg. 65376, 65400 (Nov. 1, 2000).

<sup>33</sup> The Manual, Chapter 26, section 10.5, under the heading of "Special Considerations for Services Furnished to Registered Inpatients."

<sup>34</sup> We discuss services coded with a nonfacility place-of-service 32 (NF or SNF with no Part A coverage) and furnished to a Part A SNF inpatient earlier in this section of the report.

code.<sup>35</sup> On the following page, table 4 shows the additional payments that Medicare and the enrollees made by paying the nonfacility rates during inpatient SNF stays and table 5 shows those payments for hospital stays.

**Table 4: Payments for Physician Services Coded as Furnished in a Nonfacility Setting While Enrollees Were Part A SNF Inpatients**

	Medicare Payment	Enrollees Payment
<b>Actual Payments at Nonfacility Rate</b>	\$78,987,263	\$20,602,389
<b>Revised Payments at Facility Rate</b>	57,547,245	15,167,794
<b>Difference</b>	<b>\$21,440,018</b>	<b>\$5,434,595</b>

**Table 5: Payments for Physician Services Coded as Furnished in a Nonfacility Setting While Enrollees Were Part A Hospital Inpatients**

	Medicare Payment	Enrollees Payment
<b>Actual Payments at Nonfacility Rate</b>	\$2,433,788	\$603,956
<b>Revised Payments at Facility Rate</b>	1,731,317	429,426
<b>Difference</b>	<b>\$702,471</b>	<b>\$174,530</b>

According to the practitioners that we had discussions with, when a patient visits their office, they use the office place-of-service code irrespective of the inpatient status of the patient. CMS has expressed reluctance to take enforcement action against this sort of billing because CMS regulations do not include language that specifically addresses when a Part A SNF or hospital inpatient receives services in a nonfacility setting.<sup>36</sup>

In addition, Medicare may have made some of these payments at the nonfacility rate because CMS lacked controls to detect when practitioners billed for services to Part A inpatients furnished in a facility setting using nonfacility place-of-service codes. Through our claims analysis, we identified that some of these services were possibly furnished in a SNF or hospital setting while patients were Part A inpatients. For example, practitioners coded 22,526 of the services furnished to Part A SNF inpatients with a nonfacility place-of-service code 13 (assisted living facility) or 33 (custodial care facility) (i.e., settings where Medicare does not make Part A payments). In addition, practitioners coded 8,712 of the services furnished to Part A hospital

<sup>35</sup> See Appendix B for a list of place-of-service codes designated as nonfacility.

<sup>36</sup> CMS's position is based on *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019), in which the Supreme Court held that, under section 1871(a)(2) of the Act, any Medicare issuance that establishes or changes a "substantive legal standard" governing the scope of benefits, payment for services, eligibility of individuals to receive benefits, or eligibility of individuals, entities, or organizations to furnish services, must go through notice-and-comment rulemaking.

inpatients with a nonfacility place-of-service code 32 (NF or SNF with no Part A coverage). No mechanism exists for hospitals and SNFs to denote on an inpatient claim when a patient leaves a facility and returns the same day. CMS does not consider this type of same-day return as a leave of absence.<sup>37</sup> If facilities could indicate this type of same-day return on an inpatient claim, CMS would be better able to assess whether the patient had been seen in a nonfacility setting.

## RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct its Medicare contractors to reprocess the physician service claim lines during our audit period for which enrollees were Part A SNF inpatients but the services were incorrectly coded with the nonfacility place-of-services 32 (NF or SNF with no part A coverage) to recover \$22,463,193;
- notify appropriate practitioners (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) 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;
- establish CWF system edits to detect instances in which practitioners incorrectly use the nonfacility place-of-service code 32 (NF or SNF with no Part A coverage) while an enrollee is a Part A SNF inpatient and the nonfacility place-of-service-code causes a higher payment rate, and direct its Medicare contractors to apply these recommended CWF system edits retroactively or otherwise reprocess the claim lines for similarly coded physician services furnished after our audit period and before CMS establishes these edits;
- take the necessary steps, including seeking legislative authority, if necessary, to revise its regulations to ensure that Medicare pays the facility rate for physician services furnished while enrollees are Part A SNF or hospital inpatients irrespective of where the services are actually furnished or otherwise ensure that Medicare does not pay twice for any of the practice expenses incurred for physician services furnished while enrollees were Part A SNF or hospital inpatients, which could have resulted in the Medicare program paying up to \$22,142,489 less and enrollees paying up to \$5,609,125 less in cost-sharing during our 2-year audit period;

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<sup>37</sup> CMS uses the midnight-to-midnight method for counting days of care for Medicare reporting purposes. If a patient is not in the facility at midnight, CMS considers that day as a leave of absence or the day of discharge. If a patient returns on the same day that they depart, CMS considers it a full day (*Medicare Benefit Policy Manual*, Chapter 3, section 20.1 and 20.1.2).

- consider developing a mechanism for SNFs and hospitals to indicate on the claim when a Part A inpatient leaves the facility and returns on the same day to help ensure that Medicare does not pay twice for any of the practice expenses incurred for physician services furnished while enrollees were Part A SNF or hospital inpatients; and
- provide additional education to practitioners on the appropriate use of place-of-service codes while an enrollee is a Part A inpatient.

## **CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, 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. CMS’s comments regarding those recommendations are summarized below. Our response follows. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS’s entire comments, excluding the technical comments, are included as Appendix D.

### **CMS Comments Regarding OIG’s Fourth and Fifth Recommendations**

For our fourth recommendation, CMS stated it will consider OIG’s findings and recommendation, along with other available information, to determine if it should update its regulations or seek legislative change to ensure that Medicare pays the facility rate for physician services furnished while enrollees are Part A SNF or hospital inpatients.

For our fifth recommendation, CMS stated it will consider OIG’s findings and recommendation, along with other available information, to determine if it should submit a request to the National Uniform Billing Committee (NUBC) to add a field to the inpatient claim form.<sup>38</sup> CMS also noted that modifications to a claim form are a significant undertaking and require industry consensus.

### **Office of Inspector General Response**

With regards to our first, second, third, and sixth recommendation, we appreciate CMS’s concurrence and the actions CMS indicated that it would take.

With regards to our fourth recommendation, we appreciate CMS’s willingness to consider updating its regulations or seeking legislative change. We maintain that sufficient evidence exists to warrant action by CMS to ensure that Medicare is not paying twice for any of the

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<sup>38</sup> The NUBC develop and maintain a single billing form and standard data set to be used nationwide by institutional, private, and public providers and payers for handling health care claims.

practice expenses incurred for physician services furnished while enrollees are Part A SNF or hospital inpatients. Without action, no enforceable criteria will exist that specifically addresses how practitioners should bill when a Part A SNF or hospital inpatient receives services in a nonfacility setting.

With regards to our fifth recommendation, we appreciate CMS's willingness to consider submitting a request to the NUBC to add a new field on the inpatient claim form indicating when an inpatient leaves the facility and returns on the same day. We note that there may be alternative mechanisms that could also indicate this information, such as creating a new occurrence code.<sup>39</sup>

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<sup>39</sup> Occurrence codes can already be reported on the inpatient claim form to describe a specific event and are associated with a specific date (e.g., occurrence code 26 indicates the date that a SNF bed became available to a hospital inpatient who required only SNF level of care).

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$171,241,491 in Medicare Part B payments for 2,142,385 physician service claim lines with dates of service between January 1, 2019, and December 31, 2020. These claim lines were for enrollees who were Part A inpatients of either a SNF or hospital and whose practitioners used a nonfacility place-of-service code.<sup>40</sup> We only included physician services when the facility rate on the physician fee schedule was lower than the nonfacility rate.<sup>41</sup>

We identified the 2,142,385 claim lines through a claims analysis that compared Part A inpatient claims to the corresponding Part B physician service claim lines to determine whether Medicare paid the proper rate for physician services while an enrollee was an inpatient of a SNF or hospital. We did not review medical records to determine where the practitioners actually furnished the services for all 2,142,385 claim lines. We selected 34 claim lines on a judgmental basis to discuss coding and billing practices with the practitioners, to review the practitioners' records of the enrollee, or to review the records of the SNF or hospital where the enrollee was inpatient.

We categorized the 2,142,385 claim lines based on the corresponding inpatient facility, the place-of-service code on the claim line, and the HCPCS code on the claim line or other HCPCS codes for the enrollee that directly related to the claim line. When a practitioner used any nonfacility place-of-service code, other than place-of-service code 32 (NF or SNF with no Part A coverage), during a SNF inpatient stay, we categorized the service as furnished in a nonfacility setting.<sup>42</sup> We grouped the claim lines into the following three categories:

- claim lines for enrollees who were inpatient during a Part A SNF stay and the Part B practitioners coded the services with the nonfacility place-of-service code 32 (NF or SNF with no Part A coverage) (1,130,182 claim lines);
- claim lines for enrollees who were inpatient during a Part A SNF stay, the Part B practitioners coded the services as furnished in a nonfacility setting, and the services or services directly related to these services were not designated by CMS as beyond the

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<sup>40</sup> See Appendix B for a list of place-of-service codes designated as nonfacility.

<sup>41</sup> When we conducted a data match of Part B physician service claim lines and Part A inpatient claims, we included claim lines only for services for which the face-to-face encounter must have occurred while the enrollee was a Part A inpatient. Also, we included data matches only for which the facility billed services for everyday between the from and through date (i.e., there was no leave of absence) on the applicable Part A claim and when the physician service was for a single date. For example, we included services only when the date of the Part B service was between, but not on, the date of admission and the date of discharge of the applicable Part A claim.

<sup>42</sup> If a practitioner established a separate practice within a SNF, services furnished here would likely be coded with place-of-service code 11 (office) and therefore categorized as furnished inside a nonfacility setting.

scope of the SNF (986,932 claim lines);<sup>43, 44, 45</sup> and

- claim lines for enrollees who were inpatient during a Part A hospital stay (25,271 claim lines).<sup>46</sup>

We calculated the differences between the facility rates and nonfacility rates for each claim line after matching the relevant fields on those lines to the respective fee schedule lines. We also calculated the difference between the enrollee's cost-sharing payment at the two different rates.

Our audit objective required that we obtain an understanding of internal controls. However, we did not assess the overall internal control structure of CMS. Rather, we limited our review to CMS's internal controls for compliance with place-of-service requirements and adherence to appropriate physician service rates. To evaluate these internal controls, we discussed with CMS officials their understanding of the place-of-service requirements, their applicable claims processing controls, and their guidance to practitioners for place-of-service coding. Of the five components of internal controls, three of them – risk assessment, control activities, and information and communication were significant to our audit objective.<sup>47</sup> Within these components, the following underlying principles were significant:

- management should define objectives clearly to enable the identification of risks and define risk tolerances;

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<sup>43</sup> CMS produces annual files that contain the list of services that CMS designates as within or beyond the scope of a SNF. A description of these designations can be found in CMS's *General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing*. To determine if services went beyond the scope of a SNF, we used CMS's annual files that contain the list of HCPCS codes that CMS designates as beyond the scope of a SNF.

<sup>44</sup> We identified services as directly related when the enrollee received an allowable, excluded service with the same date of service and the same place-of-service code as a service that CMS designates as beyond the scope of a SNF.

<sup>45</sup> We excluded from our audit the claim lines for which (1) enrollees were inpatient during a Part A SNF stay; (2) the Part B practitioners used a nonfacility place-of-service code (excluding place-of-service code 32); and (3) the services or directly related additional services were designated by CMS as beyond the scope of the SNF. Medicare would not likely have paid twice for the practice expenses for these services. The applicable practice expenses are not likely included in a payment to the SNF because they are for services beyond the scope of the SNF and the practitioners coded the services as furnished outside of the SNF.

<sup>46</sup> If a claim line overlapped both a hospital and SNF stay, we categorized the claim line as occurring during a hospital stay. We did not distinguish between services furnished inside a hospital or outside (based on the place-of-service code) as we did for the services during a SNF inpatient stay.

<sup>47</sup> Standards for Internal Control in the Federal Government (GAO-14-704G), Section OV2.09, Figure 3.

- management should design the entity’s information system and related control activities to achieve objectives and respond to risks; and
- management should externally communicate the necessary quality information to achieve the entity’s objectives.

We conducted our audit from June 2021 to January 2023.

## **METHODOLOGY**

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- used CMS’s National Claims History file and data analysis techniques to identify 2,142,385 claim lines described in the Scope section above;
- matched these claim lines to the applicable physician fee-service-schedule line using the applicable calendar year, procedure code, carrier code, and locality code on the claim line;<sup>48</sup>
- repriced the claim lines using the facility rate instead of the nonfacility rate, holding all other variables constant;
- calculated the difference between the facility rate and the nonfacility rate for Medicare’s payment and the enrollees’ cost-sharing payment;
- reviewed a random sample of 30 claim lines, using the CWF and the physician fee schedule, to verify that:
  - the enrollee was a Part A inpatient on the date of the Part B service,
  - the Part A claim was paid and not canceled,
  - the Part B service was paid the nonfacility rate and not canceled, and
  - our calculations of the payments at the facility rate were materially accurate;
- further validated our calculations of the payments at the facility rate by comparing them to claim lines that:
  - Medicare paid at the facility rate for the same services, by the same practitioners, for the same month of service, and

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<sup>48</sup> We included claim lines only when the carrier code or the locality code on a claim line matched a line of the physician fee schedule.

- Medicare initially paid at a nonfacility rate while an enrollee was inpatient but subsequently adjusted to be paid at a facility rate;<sup>49</sup>
- categorized the Part B claim lines based on the corresponding inpatient facility, the place-of-service code used by the practitioner, and the HCPCS code on the claim line or other HCPCS code for the same enrollee that directly related to the claim line;
- selected 34 claim lines on a judgmental basis for review where we:
  - discussed coding and billing practices with the practitioners;
  - reviewed medical records of the practitioners; or
  - reviewed the medical records of the SNF or hospital where the enrollee was inpatient; and
- discussed our results with CMS 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 objectives.

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<sup>49</sup> These adjusted claim lines are not included in the numbers discussed in this report.

## APPENDIX B: PLACE-OF-SERVICE CODES AND THEIR DESIGNATED PAYMENT RATE

The table below shows the place-of-service codes that a practitioner is required to use on the claim line to generally indicate the setting in which the practitioner furnished the service. For each place-of-service code, CMS assigns a corresponding rate designation to indicate whether the payment should be made at the facility rate or the nonfacility rate. The information in this table is sourced from the Manual, Chapter 26, section 10.5.

Code	Code Name	Facility Rate	Nonfacility Rate
01	Pharmacy		✓
02	Telehealth	✓	
03	School		✓
04	Homeless Shelter		✓
05	Indian Health Service Free-Standing Facility*		
06	Indian Health Service Provider-Based Facility*		
07	Tribal 638 Free-Standing Facility*		
08	Tribal 638 Provider-Based Facility*		
09	Prison/Correctional Facility		✓
10	Unassigned		
11	Office		✓
12	Home		✓
13	Assisted Living Facility		✓
14	Group Home		✓
15	Mobile Unit		✓
16	Temporary Lodging		✓
17	Walk-in Retail Health Clinic		✓
18	Place of Employment/Worksite*		
19	Off Campus—Outpatient Hospital	✓	
20	Urgent Care Facility		✓
21	Inpatient Hospital	✓	
22	On Campus—Outpatient Hospital	✓	
23	Emergency Room-Hospital	✓	
24	Ambulatory Surgical Center	✓	
25	Birth Center		✓
26	Military Treatment Facility	✓	
27–30	Unassigned		
31	Skilled Nursing Facility (SNF with Part A coverage)	✓	
32	Nursing Facility (NF or SNF with no Part A coverage)		✓
33	Custodial Care Facility		✓
34	Hospice	✓	
35–40	Unassigned		

Code	Code Name	Facility Rate	Nonfacility Rate
41	Ambulance—Land	✓	
42	Ambulance—Air or Water	✓	
43–48	Unassigned		
49	Independent Clinic		✓
50	Federally Qualified Health Center		✓
51	Inpatient Psychiatric Facility	✓	
52	Psychiatric Facility—Partial Hospitalization	✓	
53	Community Mental Health Facility	✓	
54	Intermediate Care Facility		✓
55	Residential Substance Abuse Treatment Facility		✓
56	Psychiatric Residential Treatment Center	✓	
57	Non-residential Substance Abuse Treatment Facility		✓
58–59	Unassigned		
60	Mass Immunization Center		✓
61	Comprehensive Inpatient Rehabilitation Facility	✓	
62	Comprehensive Outpatient Rehabilitation Facility		✓
63–64	Unassigned		
65	End Stage Renal Disease Treatment Facility		✓
66–70	Unassigned		
71	State or Local Public Health Clinic		✓
72	Rural Health Clinic		✓
73–80	Unassigned		
81	Independent Laboratory		✓
82–98	Unassigned		
99	Other Place of Service		✓
* Code assigned to a setting but is not applicable for Medicare processing.			

**APPENDIX C: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Incorrect Place-of-Service Claims Resulted in Potential Medicare Overpayments Costing Millions</i>	<a href="#">A-01-13-00506</a>	5/6/2015
<i>Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009</i>	<a href="#">A-01-10-00516</a>	9/7/2011
<i>Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2008</i>	<a href="#">A-01-10-00513</a>	9/7/2011
<i>Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007</i>	<a href="#">A-01-09-00503</a>	7/28/2010
<i>Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006</i>	<a href="#">A-01-08-00528</a>	6/17/2009



## APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*

Washington, DC 20201

**DATE:** May 8, 2023

**TO:** Amy J. Frontz  
Deputy Inspector General for Audit Services

**FROM:** Chiquita Brooks-LaSure *Chiq B LaS*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Paid Millions More for Physician Services at Higher Nonfacility Rates Rather Than at Lower Facility Rates While Enrollees Were Inpatients of Facilities (A-04-21-04084)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS recognizes the importance of providing people with Medicare access to medically necessary services and, at the same time, protecting the Medicare Trust Funds from improper payments.

Since 1992, Medicare payment has been made under the Physician Fee Schedule (PFS) for the services of physicians and other billing professionals. Physicians' services paid under the PFS are furnished in various settings, and payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs), defined in regulation at 42 CFR § 414.22, are applied to each physicians' service for their work, practice expense, and malpractice expense. Different practice expense RVUs are applied depending on the setting in which the physicians' service is furnished; these are known as the facility or nonfacility practice expense RVUs. For example, for physicians' services furnished in a hospital or Skilled Nursing Facility (SNF) the facility practice expense RVUs are applied. The nonfacility practice expense RVUs are applied to physicians' services furnished in all locations other than those listed in 42 CFR § 414.22 (b)(5)(i)(A), which include, but are not limited to, a physician's office, the beneficiaries' home, or a Nursing Facility (NF).

Place of service (POS) codes are used to identify the setting in which a beneficiary receives a physicians' service. POS codes are two-digit codes placed on health care professional claims, and CMS currently maintains the National POS code set that is used throughout the health care industry.<sup>1</sup> The National POS code set contains a series of individual codes that encompass the variety of different settings in which beneficiaries can receive care. For example, as described in the OIG's report, POS code 31 is used for services furnished in SNFs for beneficiaries with Part A coverage. Alternatively, POS code 32 is used for all services furnished in NFs, and for services furnished in SNFs when beneficiaries have exhausted their Part A coverage. For services furnished in facilities that includes both

<sup>1</sup> CMS, Place of Service Code Set. Accessed at: [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set)

## APPENDIX D: CMS COMMENTS

NF and SNF settings, also known as mixed facilities, POS code 31 is used unless the physician can verify that no Part A claim will be made for the service.<sup>2</sup>

As noted above, CMS recognizes the importance of preventing improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system. As part of this strategy, CMS recovers identified improper payments in accordance with relevant law and agency policies and procedures. Additionally, CMS educates providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters.<sup>3</sup> CMS appreciates the OIG's review in this area, and the opportunity to comment on the draft report.

OIG's recommendations and CMS's responses are below.

### **OIG Recommendation 1**

Direct its Medicare contractors to reprocess the physician service claim lines during our audit period for which enrollees were Part A SNF inpatients but the services were incorrectly coded with the nonfacility place-of-services 32 (NF or SNF with no part A coverage) to recover \$22,463,193.

### **CMS Response**

CMS concurs with this recommendation. CMS will direct the Medicare Administrative Contractors (MACs) to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

### **OIG Recommendation 2**

Notify appropriate practitioners (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) 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.

### **CMS Response**

CMS concurs with this recommendation. CMS will analyze the OIG's data to identify appropriate physicians to notify of potential overpayments. Within CMS's policies and procedures, CMS will then instruct the MACs to notify the identified physicians of OIG's audit findings. CMS will track any returned overpayments made in accordance with this recommendation and the 60-day rule.

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<sup>2</sup> *Federal Register*: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2000; Final Rule with Comment Period (64 FR 59380) (November 2, 1999)

<sup>3</sup> CMS, New/Modifications to the Place of Service (POS) Codes for Telehealth. Accessed at: <https://www.cms.gov/files/document/mm12427-newmodifications-place-service-pos-codes-telehealth.pdf>  
CMS, Frequently Asked Questions Related to Change Request 7631 (Revised and Clarified Place of Service Coding Instructions). Accessed at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQs-CR7631-4-25-13.pdf>

**OIG Recommendation 3**

Establish CWF system edits to detect instances in which practitioners incorrectly use the nonfacility place-of-service code 32 (NF or SNF with no Part A coverage) while an enrollee is a Part A SNF inpatient and the nonfacility place-of-service-code causes a higher payment rate, and direct its Medicare contractors to apply these recommended CWF system edits retroactively or otherwise reprocess the claim lines for similarly coded physician services furnished after our audit period and before CMS establishes these edits.

**CMS Response**

CMS concurs with this recommendation. CMS will explore opportunities to establish Common Working File (CWF) system edits that could identify instances in which physicians incorrectly use Place of Service (POS) code 32, Nursing Facility (NF) or Skilled Nursing Facility (SNF) with no Part A coverage, while a beneficiary is a Part A SNF inpatient. To the extent it is consistent with relevant law, and the agency's policies and procedures, CMS then will direct the MACs to apply any newly established CWF system edits retroactively.

**OIG Recommendation 4**

Take the necessary steps, including seeking legislative authority, if necessary, to revise its regulations to ensure that Medicare pays the facility rate for physician services furnished while enrollees are Part A SNF or hospital inpatients irrespective of where the services are actually furnished or otherwise ensure that Medicare does not pay twice for any of the practice expenses incurred for physician services furnished while enrollees were Part A SNF or hospital inpatients, which could have resulted in the Medicare program paying up to \$22,142,489 less and enrollees paying up to \$5,609,125 less in cost-sharing during our 2-year audit period.

**CMS Response**

CMS will consider the OIG's findings and recommendation, along with other available information, to determine if it should update its regulations or seek a legislative change, if necessary to ensure that Medicare pays the facility rate for physician services furnished while enrollees are Part A SNF or hospital inpatients. The policy developed during the notice and comment rulemaking period would ultimately determine any potential savings.

**OIG Recommendation 5**

Consider developing a mechanism for SNFs and hospitals to indicate on the claim when a Part A inpatient leaves the facility and returns on the same day to help ensure that Medicare does not pay twice for any of the practice expenses incurred for physician services furnished while enrollees were Part A SNF or hospital inpatients.

**CMS Response**

CMS will consider the OIG's findings and recommendation, along with other available information, to determine whether to submit a request to the National Uniform Billing Committee (NUBC), as modifying the claim form to add a new field is not within CMS's control. Modifications to the claim form are a significant undertaking and require extensive system changes that impact the entire healthcare system. Therefore, this process requires industry consensus.

## APPENDIX D: CMS COMMENTS

### **OIG Recommendation 6**

Provide additional education to practitioners on the appropriate use of place-of-service codes while an enrollee is a Part A inpatient.

### **CMS Response**

CMS concurs with this recommendation. CMS will educate providers on the appropriate use of POS Codes.