U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Why OIG Did This Audit

Recovery Audit Contractors (RACs) assist the Centers for Medicare & Medicaid Services (CMS) by performing audits of monthly capitation payments (MCPs) for end-stage renal disease (ESRD) patients receiving four or more visits per month; these audits have identified claims with improper payments. An MCP is a monthly payment made to physicians for dialysis-related physician services provided to Medicare ESRD patients. Only one physician may receive an MCP for all ESRD-related services provided to a Medicare beneficiary during a calendar month. The RAC audits found that this was not always the case: some of these audits identified claims that were improperly paid, because they reflected more than one MCP for ESRD-related services provided to the same beneficiary for the same calendar month.

Our objective was to determine whether CMS made Medicare MCPs to physicians for monthly ESRD-related services provided in calendar years (CYs) 2016 through 2018 in accordance with Federal requirements.

How OIG Did This Audit

Our audit covered $12.2 million in Medicare MCPs to physicians for 53,608 claims for monthly ESRD-related services with dates of service in CY 2016, CY 2017, or CY 2018 that we identified as at risk for noncompliance with Federal requirements.

Medicare Made Millions of Dollars in Overpayments for End-Stage Renal Disease Monthly Capitation Payments

What OIG Found

CMS did not always make Medicare MCPs to physicians for monthly ESRD-related services provided in CYs 2016 through 2018 in accordance with Federal requirements. Specifically, 23,695 claims were for services for which physicians reported monthly ESRD-related billing codes more than once for the same beneficiary for the same month. These claims consisted of 21,763 claims that resulted in $4 million in overpayments for instances in which different physicians reported codes for services and 1,932 claims that resulted in $291,813 in overpayments for instances in which the same physician reported codes for services. Beneficiaries were responsible for up to $1.1 million in cost sharing related to these 23,695 claims. We are setting aside potential overpayments related to an additional 1,598 claims totaling $289,169 and $74,563 in beneficiary cost sharing for CMS's review and determination. CMS did not have adequate claims processing controls in place, to include system edits, to identify and prevent these overpayments.

What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to: (1) recover the $4 million for claims that are within the reopening period; (2) recover the $291,813 for claims that are within the reopening period; (3) instruct the physicians to refund the $1.1 million in beneficiary cost-sharing amounts; (4) review the 1,598 claims for potentially duplicate claims, determine which should have been denied, and take followup actions; (5) based on the results of this audit, notify physicians so that they can exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule and identify any returned overpayments as according with this recommendation; and (6) implement improved claims processing controls, including improved system edits, to prevent and detect overpayments.

CMS did not concur with our first recommendation (because, it said, some physicians may not be liable for overpayments because they could be found to be without fault under the provisions of the Social Security Act) but concurred with all of our other recommendations and described actions taken or planned. We revised our first recommendation for this final report by deleting the reference to physicians that had been in the draft report's first recommendation. This revision conforms to CMS provisions that the Medicare contractors make determinations regarding the recovery of overpayments. The actions that CMS described, when fully executed, should resolve the other recommendations.