

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE CONTINUES TO MAKE
OVERPAYMENTS FOR CHRONIC CARE
MANAGEMENT SERVICES, COSTING THE
PROGRAM AND ITS BENEFICIARIES
MILLIONS OF DOLLARS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: August 2021

Report No. A-07-19-05122

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



Why OIG Did This Audit

Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established a policy for Medicare to pay under the Medicare Physician Fee Schedule for chronic care management (CCM) services rendered to beneficiaries whose medical conditions meet certain criteria. Effective January 1, 2017, CMS unbundled complex CCM from noncomplex CCM and began paying separately for complex CCM. Although scope of service and billing requirements are the same for noncomplex CCM as for complex CCM, the two types of services differ as to clinical staff time, medical decisionmaking, and care planning. CCM services are a relatively new category of Medicare-covered services and are at higher risk for overpayments. This audit expands on the findings of a previous OIG audit.

Our objective was to determine whether payments made by CMS to providers for noncomplex and complex CCM services rendered during calendar years (CYs) 2017 and 2018 complied with Federal requirements.

How OIG Did This Audit

Our audit covered over 7.8 million claims submitted by physicians and over 240,000 claims submitted by hospitals for noncomplex and complex CCM services provided in CYs 2017 and 2018. Paid physician and hospital claims for those services for CYs 2017 and 2018 totaled \$356 million. We reviewed CMS's internal controls specific to claims containing CCM services.

Medicare Continues To Make Overpayments for Chronic Care Management Services, Costing the Program and Its Beneficiaries Millions of Dollars

What OIG Found

Not all payments made by CMS to providers for noncomplex and complex CCM services rendered during CYs 2017 and 2018 complied with Federal requirements, resulting in \$1.9 million in overpayments associated with 50,192 claims. We identified 38,447 claims resulting in \$1.4 million in overpayments for instances in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period. We also identified 10,882 claims that resulted in \$438,262 in overpayments for instances in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods. Further, we identified 863 claims that resulted in \$52,086 in overpayments for incremental complex CCM services that were billed along with complex CCM services that we identified as overpayments. For these 50,192 claims, beneficiaries' cost sharing totaled up to \$540,680.

These errors occurred because CMS did not have claim system edits to prevent and detect overpayments.

What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to: (1) recover the \$1.9 million for claims that are within the reopening period, and instruct providers to refund up to \$540,680, which beneficiaries were required to pay; (2) based on the results of this audit, notify appropriate providers 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; and (3) implement claim system edits to prevent and detect overpayments for noncomplex and complex CCM services. We also recommend that CMS implement claim system edits at its level.

CMS concurred with all of our recommendations and described corrective actions for the recovery of the overpayments we identified and the refund of amounts overcharged to beneficiaries. CMS also stated that since our audit period, it has implemented claims processing controls, including system edits, to prevent and detect these types of overpayments. CMS added, though, that some providers may not be liable for the overpayments because they could be found to be without fault under the provisions of the Social Security Act. Our recommendations conform to CMS provisions that the Medicare contractors make determinations regarding the recovery of overpayments.

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INTRODUCTION

WHY WE DID THIS AUDIT

Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established a policy for Medicare to pay under the Medicare Physician Fee Schedule (PFS) for chronic care management (CCM) services rendered to beneficiaries whose medical conditions meet certain criteria. Before that effective date, physicians did not have the ability to bill separately for non-face-to-face care management services provided to these beneficiaries. Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Initially, CMS covered CCM services without distinguishing between: (1) those of lesser complexity and lower time consumption and (2) those of more complexity and time consumption. Under new Federal rules that became effective January 1, 2017, CMS unbundled complex CCM from noncomplex CCM and began paying separately for complex CCM under the Medicare PFS.¹ The effect of this change was to allow health care providers (including hospitals and physicians) to receive payments for the relatively more complex and time-consuming services rendered under complex CCM.

Although the scope of service and billing requirements are the same for noncomplex CCM as for complex CCM, the two types of services differ as to the amount of clinical staff service time provided, the complexity of medical decisionmaking, and the nature of care planning that was performed.

CCM services are still a relatively new category of Medicare-covered services and have multiple restrictions on when and how they can be billed. CCM payments are at higher risk for overpayments compared with payments for more established Medicare services because CMS generally needs time to conduct provider education and create and test controls to ensure that claims for new services conform to the restrictions. The recent unbundling of these services also means that sufficient controls may not be in place to ensure compliance with applicable requirements. A previous audit determined that CMS did not have sufficient controls in place to ensure that Medicare payments for noncomplex CCM services during calendar years (CYs) 2015 and 2016 complied with Federal requirements.² For this audit, we expanded on that

¹ Effective January 1, 2017, CMS specified the additional requirements for complex chronic care management services and split them out—that is, unbundled them—from the chronic care services that were initially effective January 1, 2015, to allow complex chronic care services to be billed separately (81 Fed. Reg. 80170, 80244-80245, 80349, 80364 (Nov. 15, 2016)).

² *Medicare Made Hundreds of Thousands of Dollars in Overpayments for Chronic Care Services* (A-07-17-05101), Nov. 7, 2019. Available online at <https://oig.hhs.gov/oas/reports/region7/71705101.asp>.

previous work to review both noncomplex and complex CCM services paid after CMS unbundled them.

OBJECTIVE

Our objective was to determine whether payments made by CMS to physicians and hospitals (providers) for noncomplex and complex CCM services rendered during CYs 2017 and 2018 complied with Federal requirements.

BACKGROUND

Under the provisions of Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by providers.

Payment Differences Based on Setting

Under the provisions of section 1848 of the Act, CMS is required to establish a fee schedule for physicians' services based on national uniform relative value units that account for the relative resources used in furnishing a service to a beneficiary. Under its Federal rulemaking authority, CMS established the Medicare PFS and publishes changes and revisions to the PFS annually, in the form of a final rule, in the Federal Register.

This report focuses on two different types of settings under which Medicare makes payments to health care providers. The first type of setting is a physician's office. The second type is a hospital outpatient department. Hospital outpatient departments include off-campus provider-based departments that are subsidiary to and under the operational control of the hospitals that own them and are integrated into those hospitals for accounting purposes.

The differences between these two types of settings are reflected in the amounts paid through the PFS, which consists of three main components: the physician's work, the practice expense, and the malpractice insurance expense. Physicians are paid under this fee schedule regardless of setting, and two of the three components—the physician's work and the malpractice insurance expense—remain constant irrespective of setting. However, for some types of services, the practice expense component is reduced when these services are rendered in certain facilities such as a hospital (42 CFR § 414.22(b)).³ This is done because it is assumed

³ The practice expense component reflects the costs of maintaining a physician's office practice: rental of office space, purchase of supplies and equipment, staff salaries and benefits, and similar types of costs.

that the practice expense component reflects the operating costs of the physician's office—and these costs are included in the facility payment when services are rendered in a facility.

Physicians' claims must include a Place of Service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician. Physicians providing non-face-to-face CCM services must use the POS code to indicate where the physician would furnish a face-to-face visit (*e.g.*, an office or a hospital outpatient department). When a physician renders health care services in a hospital outpatient department, he or she bills for those services using the PFS and must indicate on the Medicare claim that the service was rendered at a hospital outpatient department. In turn, the hospital where the physician rendered the service can submit a corresponding claim under the outpatient prospective payment system (OPPS), which CMS implemented effective for hospital outpatient department services rendered on or after August 1, 2000. Therefore, when a physician renders a service in a hospital outpatient department, there are generally two claims: one claim submitted by the physician under the PFS and one submitted by the hospital under the OPPS.⁴

Under the OPPS, Medicare pays the hospital for outpatient services on a rate per service basis that varies according to the assigned ambulatory payment classification (APC) (42 CFR § 419.31)). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group (42 CFR § 419.2(a)).⁵ The HCPCS includes the American Medical Association's Current Procedural Terminology (CPT) codes⁶ for physician services and CMS-developed codes for certain nonphysician services.⁷ All services and items within an APC group are comparable clinically and require comparable resources.

Beneficiaries are required to participate in cost sharing for CCM services provided under Medicare Part B (42 CFR §§ 410.3(b) and 419.40)). Cost sharing includes the payment of deductibles and coinsurance by the beneficiary. CMS has stated that it cannot waive coinsurance for CCM services (79 Fed. Reg. 67548, 67718 (Nov. 13, 2014) and 81 Fed. Reg. 80170, 80240 (Nov. 15, 2016)).

⁴ Critical access hospitals are excluded from the OPPS (42 CFR § 419.20(b)(2)) and can elect to bill the facility and professional service on the same claim (42 CFR § 413.70(b)(3)).

⁵ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

⁶ **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2017 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 document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

⁷ 45 CFR § 162.1002(c)(1); *The Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 4, § 20.1.

Noncomplex Chronic Care Management

Noncomplex CCM involves the provision of at least 20 minutes per month of non-face-to-face services, such as developing a comprehensive care plan or coordinating services with other providers, to Medicare beneficiaries who have two or more chronic conditions expected to last at least 12 months, or until the death of the beneficiary, that place the beneficiary at significant risk of death, acute exacerbation or decompensation, or functional decline. Some examples of chronic conditions are arthritis, cancer, cardiovascular disease, and diabetes. Effective January 1, 2015, Medicare began allowing physicians and nonphysician practitioners (NPPs) (collectively referred to as “physicians” for this report) to bill for CCM services under the Medicare PFS using CPT code 99490.

Federal rules and coding requirements state that CCM services are provided by a physician on a per calendar month basis.⁸ When CCM services are not provided personally by the physician, they may be provided by clinical staff at the direction of the physician.⁹

CMS requirements provide that a physician may bill for noncomplex CCM services only once per calendar month (service period) for a beneficiary, and that only one physician may do so per service period for that beneficiary. CMS requirements also state that if the noncomplex CCM services were provided in a hospital outpatient department, then only one hospital per service period may bill for those services provided to a beneficiary. In addition, some of the noncomplex CCM scope of service/billing requirements and certified electronic health record (EHR) requirements include that:

- the clinical staff furnishes at least 20 minutes of care management services under the direction of the physician during the service period,
- the physician obtains beneficiary consent to provide CCM services and bill Medicare for those services,
- the physician meets all scope-of-service elements contained in the PFS,¹⁰ and
- the physician uses a certified EHR system.¹¹

⁸ 79 Fed. Reg. 67548, 67651, 67716 (Nov. 13, 2014); *HCPCS and CPT Codebook*, CPT Code 99490. See also CMS’s *Frequently Asked Questions about Billing Medicare for CCM Services* (Mar. 17, 2016).

⁹ “Clinical staff” refers to clinical staff employed by either the physician’s practice or the outpatient facility.

¹⁰ “Scope-of-service elements” refer to specific standards set forth in the PFS that a physician must meet to be qualified to bill for CCM services (79 Fed. Reg. 67548, 67728 (Nov. 13, 2014)).

¹¹ EHR technology is approved by a certifying body authorized by the National Coordinator for Health Information Technology.

Physicians may submit a claim to CMS for payment of CCM services once the minimum 20-minute time threshold has been met; however, physicians should continue to provide the CCM services after the minimum threshold has been met.

Complex Chronic Care Management

Effective January 1, 2017, Medicare unbundled complex CCM from noncomplex CCM. This allowed physicians to bill for complex CCM under the Medicare PFS using CPT codes 99487 (initial 60 minutes of services) and 99489 (each additional 30-minute increment). For this report, we define these CPT codes as “complex CCM” (CPT code 99487) and “incremental complex CCM” (CPT code 99489). Complex CCM involves the provision of at least 60 minutes per month of non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions expected to last at least 12 months, or until the death of the beneficiary, that place the beneficiary at significant risk of death, acute exacerbation or decompensation, or functional decline. Although scope of service and billing requirements and certified EHR requirements are the same for complex CCM as they are for noncomplex CCM, the services differ in the following ways:

- the amount of clinical staff service time provided, i.e.:
 - noncomplex CCM requires 20 minutes of non-face-to-face services per month and
 - complex CCM requires an initial 60 minutes of non-face-to-face services per month and additional increments of 30 minutes;
- the complexity of medical decisionmaking as described in CMS rules and coding requirements (determined by the problems addressed by the reporting provider during the month); and
- the nature of care planning that was performed (establishment or substantial revision of the care plan for complex CCM as opposed to establishment, implementation, revision, or monitoring of the care plan for noncomplex CCM).

Further, a claim for incremental complex CCM can be submitted only after the physician completed the initial 60 minutes for complex CCM and submitted a claim. Additionally, incremental complex CCM cannot be submitted if a physician has submitted a claim for noncomplex CCM. Thus, physicians may submit a claim to CMS for payment of the initial complex CCM services once the minimum 60-minute time threshold has been met, and for each full 30-minute increment after the initial complex CCM during the month.

Overlapping Care Management Services

Both noncomplex and complex CCM services include care management services that are also an integral part of home health care supervision (HCPCS code G0181), hospice care supervision (HCPCS code G0182), and certain end-stage renal disease (ESRD) services (CPT codes 90951 through 90970). Therefore, these codes include overlapping care management services, and no physician may bill for CCM during the same month for which he or she bills for these other services.

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 identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.¹²

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.¹³

HOW WE CONDUCTED THIS AUDIT

Our audit covered 7,820,899 claims submitted by physicians and 240,673 claims submitted by hospitals for noncomplex and complex CCM services provided in CYs 2017 and 2018 (audit period). Physicians were paid \$343,312,325 and hospitals were paid \$12,646,100 for these 8,061,572 claims. For our audit period, we reviewed the Federal requirements for noncomplex and complex CCM services and CMS's internal controls specific to claims containing CCM services. To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments and overlapping services.

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.

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

¹³ 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. at 7670.

Appendix A contains details of our audit scope and methodology.

FINDINGS

Not all payments made by CMS to providers for noncomplex and complex CCM services rendered during CYs 2017 and 2018 complied with Federal requirements. Of the 8,061,572 claims we reviewed, 50,192 claims did not comply with Federal requirements, resulting in \$1,918,278 in overpayments.

Specifically, of the 50,192 claims totaling \$1,918,278, we identified the following:

- 38,447 claims that resulted in \$1,427,930 in overpayments for instances in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period. The 38,447 claims included instances in which a single provider billed more than once (21,327 claims) as well as instances in which more than one provider billed for the same beneficiary (17,120 claims).
- 10,882 claims that resulted in \$438,262 in overpayments for instances in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods.
- 863 claims that resulted in \$52,086 in overpayments for incremental complex CCM services that were billed along with complex CCM services that we identified as overpayments. Because the payments for the complex CCM services represented overpayments, these incremental complex CCM claims should have been denied just as the complex CCM claims should have been.

For these 50,192 claims, beneficiaries' cost sharing totaled up to \$540,680.¹⁴

Table 1 on the following page summarizes these findings and breaks out, for each finding, the amount of overpayments made by CMS and the amount of overpayments made by beneficiaries.

¹⁴ We did not determine whether providers received all of the beneficiary cost-sharing payments that they had charged.

Table 1: Claims Questioned			
	Number of Claims	Medicare Payments	Beneficiary Cost Sharing
Multiple claims by single provider	21,327	\$816,810	\$236,472
Claims by more than one provider	17,120	611,120	169,608
Subtotal of Multiple Claims	38,447	1,427,930	406,080
Overlapping care management claims	10,882	438,262	121,166
Incremental complex CCM services associated with overpayments for complex CCM services identified by OIG	863	52,086	13,434
Total of Questioned Claims	50,192	\$1,918,278	\$540,680

The errors we identified occurred because CMS did not have claim system edits to prevent and detect overpayments. Additionally, as noted in our previous audit (footnote 2), CMS did not have CCM-specific claim system edits in place.

PAYMENTS FOR MULTIPLE CLAIMS FOR THE SAME BENEFICIARY

CMS requirements provide that physicians may bill for only one claim for CCM services for an individual beneficiary for each calendar month (service period). In addition, only one physician and one facility may bill for CCM services provided to a beneficiary during a service period (79 Fed. Reg. 67548, 67651 (Nov. 13, 2014); 81 Fed. Reg. 80170, 80364 (Nov. 15, 2016); *HCPCS and CPT Codebook*, CPT Codes 99490 and 99487)).

Under new Federal rules that were effective January 1, 2017, CMS unbundled complex CCM from noncomplex CCM and began paying separately for complex CCM under the Medicare PFS (81 Fed. Reg. 80170, 80244 (Nov. 15, 2016)). Although CMS unbundled complex CCM from noncomplex CCM, CMS requirements limit physicians to billing for either noncomplex or complex CCM services (but not both) for an individual beneficiary for a service period.

CMS's claim processing guidance states that Medicare contractors must establish controls to prevent and detect payments for the same service. Additionally, if a claim (for the same service period for the same beneficiary) is received after a claim has been paid, this guidance instructs Medicare contractors not to pay the subsequent claims (*Medicare Claims Processing Manual*, ch. 1, §§ 30.3.9 and 120).

We identified 38,447 claims totaling \$1,427,930 in overpayments for instances in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period. The 38,447 claims included instances in which a single provider billed more than once (21,327 claims) as well as instances in which more than one provider billed for the same beneficiary (17,120 claims). Specifically:

- a single provider submitted more than 1 claim for either a noncomplex or complex CCM service (18,486 claims totaling \$667,896) or both noncomplex and complex CCM

services (2,841 claims totaling \$148,913) rendered in the same service period to the same beneficiary (these 2 types of errors totaled 21,327 claims; Table 1); and

- two or more providers submitted a claim for either a noncomplex or complex CCM service (14,764 claims totaling \$479,250) or both noncomplex and complex CCM services (2,356 claims totaling \$131,870) rendered in the same service period to the same beneficiary (these 2 types of errors totaled 17,120 claims; Table 1).

Of these 38,447 claims, 33,250 claims (18,486 + 14,764) totaling \$1,147,147 were the result of providers submitting more than 1 claim for either a noncomplex or complex CCM service and 5,197 claims (2,841 + 2,356) totaling \$280,783 were the result of providers submitting more than 1 claim for both noncomplex and complex CCM services rendered in the same service period to the same beneficiary.

In addition to the \$1,427,930 in overpayments made by CMS, beneficiaries were required to pay more in coinsurance and deductibles for these noncomplex and complex CCM services than they should have. For these 38,447 claims, beneficiaries were required to pay a total of \$406,079 in cost sharing.

Table 2 below depicts an example of a provider submitting two claims for complex CCM services rendered to the same beneficiary for the same service period. In this example, Provider 1 submitted two different claims to CMS for December 2018 complex CCM services for Beneficiary A.

Beneficiary	Provider	Service Period	Date of Submission	Type of CCM Service	Payment to Provider	Beneficiary Cost Sharing	Status
A	1	December 2018	December 12, 2018	Complex	\$64.86	\$16.55	First Payment
A	1	December 2018	December 28, 2018	Complex	\$64.86	\$16.55	Overpayment

The second payment that CMS made, in the amount of \$64.86, was an overpayment. In addition, Beneficiary A should not have been required to pay \$16.55 in cost sharing for the second claim.

Table 3 on the following page depicts an example of two providers submitting claims for complex CCM services rendered to the same beneficiary for the same service period. In this case, both Provider 2 and Provider 3 submitted claims for December 2018 complex CCM services for Beneficiary B.

Table 3: Example of Two Providers Submitting Claims for Same Month for Same Beneficiary							
Beneficiary	Provider	Service Period	Date of Submission	Type of CCM Service	Payment to Provider	Beneficiary Cost Sharing	Status
B	2	December 2018	January 10, 2019	Complex	\$70.72	\$18.04	First Payment
B	3	December 2018	January 17, 2019	Complex	\$83.20	\$21.22	Overpayment

CMS's second payment (to Provider 3 in the amount of \$83.20) was an overpayment because Provider 3 submitted its claim after Provider 2 did. In addition, Beneficiary B should not have been required to pay \$21.22 in cost sharing to Provider 3.

Table 4 below depicts an example of a provider submitting a claim for complex CCM services and a claim for noncomplex CCM services rendered to the same beneficiary for the same service period. In this case, Provider 4 submitted two different claims to CMS for December 2018 noncomplex and complex CCM services for Beneficiary C.

Table 4: Example of One Provider Submitting Both Noncomplex and Complex CCM Claims for Same Month for Same Beneficiary							
Beneficiary	Provider	Service Period	Date of Submission	Type of CCM Service	Payment to Provider	Beneficiary Cost Sharing	Status
C	4	December 2018	December 13, 2018	Complex	\$78.16	\$19.94	First Payment
C	4	December 2018	January 11, 2019	Non-complex	\$34.67	\$8.84	Overpayment

The second payment that CMS made, in the amount of \$34.67, was an overpayment. In addition, Beneficiary C should not have been required to pay \$8.84 in cost sharing for the second claim.

Table 5 on the following page depicts an example of one provider submitting a claim for a noncomplex CCM service and a second provider submitting a claim for a complex CCM service, both rendered to the same beneficiary for the same service period. In this example, Provider 5 submitted a claim for December 2018 noncomplex CCM services for Beneficiary D, and Provider 6 submitted a claim for December 2018 complex CCM services for Beneficiary D.

Table 5: Example of Two Providers in Which One Submitted a Noncomplex CCM Claim and the Other Submitted a Complex CCM Claim for Same Month for Same Beneficiary

Beneficiary	Provider	Service Period	Date of Submission	Type of CCM Service	Payment to Provider	Beneficiary Cost Sharing	Status
D	5	December 2018	December 5, 2018	Non-complex	\$34.05	\$8.68	First Payment
D	6	December 2018	December 19, 2018	Complex	\$75.21	\$19.19	Overpayment

CMS's second payment (to Provider 6 in the amount of \$75.21) was an overpayment because the second claim was submitted to CMS (by Provider 6) after Provider 5 had submitted its claim. Under CMS requirements, this second claim should not have been paid. In addition, Beneficiary D should not have been required to pay \$19.19 in cost sharing to Provider 6.

PAYMENTS FOR CLAIMS CONTAINING CHRONIC CARE MANAGEMENT SERVICES THAT OVERLAPPED WITH OTHER CARE MANAGEMENT SERVICES

The CMS final rule for the 2014 PFS states that a physician cannot bill for CCM services rendered during the same service period in which the same physician billed for care management services that overlap with those CCM services. Care management services that overlap with CCM services include home health care supervision (HCPCS code G0181), hospice care supervision (HCPCS code G0182), and certain ESRD services (CPT codes 90951 through 90970) (78 Fed. Reg. 74230, 74423 (Dec. 10, 2013)). CMS repeats this requirement in Medicare Learning Network Fact Sheet ICN 909188, Dec. 2016. CMS requirements state that if a provider submits a claim containing a CCM service and an overlapping care management service during the same service period for a beneficiary, the CCM payment is disallowed.

We identified 10,882 claims with overpayments totaling \$438,262 for instances in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods. Neither a noncomplex CCM service nor a complex CCM service may be claimed during the same service period as an overlapping care management service.

In addition to the \$438,262 in overpayments made by CMS, providers charged beneficiaries more in coinsurance and deductibles for these noncomplex and complex CCM services than they should have. For these 10,882 claims, beneficiaries' cost sharing totaled \$121,166.

Table 6 on the following page depicts an example of a provider submitting a claim for a complex CCM service and a claim for an overlapping service (home health care supervision (CPT code G0181)), both of which were rendered to Beneficiary E for the same service period—December 2018.

Table 6: Example of One Provider Submitting Claims for CCM Services and an Overlapping Service for Same Month for Same Beneficiary							
Beneficiary	Provider	Service Period	Date of Submission	Type of CCM Service	Payment to Provider	Beneficiary Cost Sharing	Status
E	7	December 2018	February 22, 2019	Home Health care Supervision	\$73.05	\$18.63	Pre-empts Billing for CCM
E	7	December 2018	January 14, 2019	Complex CCM	\$61.80	\$15.77	Overpayment ¹⁵

According to the PFS, home health care supervision is a service for which a physician should not submit a claim (or bill) if that physician has submitted a claim for complex CCM services rendered to the same beneficiary for the same service period. However, if a provider submits a claim containing an overlapping care management service, such as home health care supervision, during the same service period for a beneficiary, the CCM payment is disallowed. Because a claim for home health care services was submitted and included an overlapping service, the payment that CMS made for complex CCM services, in the amount of \$61.80, was an overpayment. Furthermore, Beneficiary C should not have been required to pay \$15.77 in cost sharing for the complex CCM services.¹⁶

PAYMENTS FOR INCREMENTAL COMPLEX CHRONIC CARE MANAGEMENT SERVICES ASSOCIATED WITH OVERPAYMENTS FOR COMPLEX CHRONIC CARE MANAGEMENT SERVICES IDENTIFIED BY OFFICE OF INSPECTOR GENERAL

CMS requirements provide that physicians can submit claims for additional complex CCM (incremental complex CCM) services in 30-minute increments once the physician has provided 60 minutes of complex CCM services in the same service period (81 Fed. Reg. 80170, 80364 (Nov. 15, 2016)).

Under new Federal rules that were effective January 1, 2017, CMS unbundled complex CCM from noncomplex CCM and began paying separately for complex CCM under the Medicare PFS (81 Fed. Reg. 80170, 80244 (Nov. 15, 2016)). Although CMS unbundled complex CCM from noncomplex CCM, CMS requirements limit physicians to billing for either noncomplex or complex CCM services (incremental complex CCM services can be billed only by the physician who billed for the complex CCM services) for an individual beneficiary for each calendar month.

In its January 1, 2019, *Frequently Asked Questions about Physician Billing for Chronic Care Management Services*, CMS clarified that: “[Complex and incremental complex CCM services]

¹⁵ This claim is also included in the example in our next finding (Table 7).

¹⁶ Because CMS already paid the provider for the CCM services, remedial action would involve notifying the provider of its intent to collect the overpayment and instructing the provider to refund any cost-sharing payment made by the beneficiary that was associated with the overpayment.

may be reported for the same calendar month as each other if the time requirement for reporting both codes (the [complex] and the [incremental complex] code) is met.”

We identified 863 claims totaling \$52,086 for incremental complex CCM services that were overpayments because they were billed along with complex CCM services that we have identified as overpayments. The complex CCM services were overpayments because they were submitted after other claims for noncomplex CCM services or during the same service periods as claims for other overlapping care management services. Because the payments for the complex CCM services were overpayments, these incremental complex CCM claims associated with the complex CCM claims should have been denied just as the complex CCM claims should have been.

In addition to the \$52,086 in overpayments made by CMS, providers charged beneficiaries more in coinsurance and deductibles for these incremental complex CCM services than they should have. For these 863 claims, beneficiaries were required to pay a total of \$13,434 in cost sharing.

Table 7 below depicts an example of a provider submitting a claim for a complex CCM service (which was an overpayment) and a claim for an incremental complex CCM service (CPT code 99489), both of which were rendered to Beneficiary E for the same service period—December 2018—and both of which were overpayments.

Table 7: Example of One Provider Submitting Claims for a Complex CCM Service and an Incremental Complex CCM Service, Both of Which Should Have Been Denied							
Beneficiary	Provider	Service Period	Date of Submission	Type of CCM Service	Payment to Provider	Beneficiary Cost Sharing	Status
E	7	December 2018	January 14, 2019	Complex CCM	\$61.80	\$15.77	Overpayment (Table 6)
E	7	December 2018	January 14, 2019	Incremental Complex CCM	\$30.79	\$7.85	Overpayment

As identified in Table 6 earlier in this report, the complex CCM claim (\$61.80) was an overpayment because the same provider had submitted a claim for an overlapping service (home health care supervision). Because the incremental complex CCM service can be billed only after the provider has rendered the initial 60 minutes of complex CCM services in the same service period, the payment of \$30.79 for incremental complex CCM services was also an overpayment. Further, Beneficiary E should not have been required to pay \$7.85 in cost sharing for the incremental complex CCM service.

LACK OF CLAIM SYSTEM EDITS FOR CHRONIC CARE MANAGEMENT SERVICES

These errors occurred because CMS did not have claim system edits to prevent and detect overpayments. Additionally, as noted in our previous audit (footnote 2), CMS did not have CCM-specific claim system edits in place.

As a result of these errors, for CYs 2017 and 2018, providers billed for and received overpayments totaling \$1,918,278, and beneficiaries were required to pay a total of up to \$540,680 in Medicare cost sharing.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services direct the Medicare contractors to:

- recover the \$1,918,278 for claims that are within the reopening period, and instruct providers to refund up to \$540,680, which beneficiaries were required to pay;¹⁷ these amounts consist of:
 - \$1,427,930 in overpayments to providers that billed noncomplex or complex CCM services more than once for the same beneficiaries for the same service periods and up to \$406,080 in cost-sharing overcharges to these beneficiaries,
 - \$438,262 in overpayments to providers that billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods and up to \$121,166 in cost-sharing overcharges to these beneficiaries, and
 - \$52,086 in overpayments to providers that billed for incremental complex CCM services associated with overpayments for complex CCM services that we identified and up to \$13,434 in cost-sharing overcharges to these beneficiaries;
- based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify

¹⁷ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare administrative contractor or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Physicians have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a physician exercises his or her right to an appeal, the physician does not need to return overpayments until after the second level of appeal.

any of those returned overpayments as having been made in accordance with this recommendation; and

- implement claim system edits to prevent and detect overpayments for noncomplex and complex CCM services.

We also recommend that the Centers for Medicare & Medicaid Services implement claim system edits at its level to prevent and detect overpayments for noncomplex and complex CCM services.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with all of our recommendations and described corrective actions that it had taken or planned to take. Specifically, with respect to our first and second recommendations, CMS described steps it would take for the recovery of the overpayments we identified and the refund of coinsurance and deductible amounts overcharged to beneficiaries. With respect to our first recommendation, CMS added that it recognizes that multiple physicians or NPPs could have fulfilled the billing requirements for the care management services for the same beneficiary without knowledge of the specific billing of another physician or NPP, and, as a result, may not be liable for the overpayments because they could be found to be without fault under section 1870(b) of the Act. Furthermore, CMS stated, with respect to our third recommendation, that “[w]hile CMS has not observed substantial rates of chronic care management overpayments, we continue to evaluate opportunities to implement claims processing controls to prevent and detect overpayments” for these services. In this context, CMS also stated that since our audit period, it has implemented claims processing controls, including system edits, to prevent and detect these types of overpayments.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS’s comments, excluding the technical comments, are included as Appendix B.

After reviewing CMS’s comments, we revised our first recommendation for this final report by deleting language contained in the draft report specifically recommending that CMS recoup overpayments from providers and replacing it with language recommending that CMS direct the Medicare contractors to recover the \$1,918,278 in improper payments. In so doing, we took into account the provisions of the *Medicare Financial Management Manual*, Pub. No. 100-06, which states that the Medicare contractor will make the determination that the provider is liable or without fault after reviewing all of the material facts (chapter 3, § 90). Further, this recommendation is not limited to recouping improper payments from providers. If a Medicare contractor determines that a contractor is without fault under the provisions of section 1870(b) of the Act, there are potential consequences for the beneficiary. Specifically, the *Medicare Financial Management Manual* states: “If the [Medicare contractor] determines that an overpaid [provider] was without fault and therefore not liable for the overpayment, it relieves the [provider] of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault.” However, “recovery from the beneficiary

may be waived if [the Medicare contractor] determine[s] the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience” (chapter 3, § 70).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the Federal requirements for noncomplex and complex CCM services and CMS's internal controls specific to claims containing CCM services in effect for CYs 2017 and 2018 (audit period). We reviewed all paid claims for noncomplex and complex CCM services during the audit period to determine whether CMS's controls prevented overpayments by denying unallowable payments.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the control activities designed and implemented to prevent and detect overpayments. However, because our review was limited to this internal control component and underlying principles, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

To conduct our audit, we used computer matching, data mining, and other data analysis techniques to identify overpayments and overlapping services. Our audit covered 7,820,899 claims submitted by physicians and 240,673 claims submitted by outpatient facilities for noncomplex and complex CCM services provided during the audit period. Physicians were paid \$343,312,325 and outpatient facilities were paid \$12,646,100 for these 8,061,572 claims.

We performed our audit work from January 2020 to May 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and guidelines;
- obtained noncomplex and complex CCM claims with dates of service during CYs 2017 and 2018;
- used computer matching, data mining, and other data analysis techniques to identify overpayments for CCM services and claims containing overlapping services;
- calculated the amount of overpayments for CCM services and the amount that beneficiaries were required to pay in Medicare cost sharing;
- interviewed CMS officials to obtain an understanding of CMS's oversight of CCM claims;

- provided CMS officials with data supporting the overpayments that we identified and solicited CMS's input on these findings to determine their causes; and discussed our findings with CMS officials on January 12, 2021.

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.



Administrator

Washington, DC 20201

DATE: June 25, 2021

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

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

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Continues to Make Overpayments for Chronic Care Management Services, Costing the Program and Its Beneficiaries Millions of Dollars (A-07-19-05122)

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 is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars.

CMS recognizes chronic care management as a critical component of primary care that contributes to better health and care for beneficiaries. In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule for chronic care management services furnished to Medicare beneficiaries with multiple chronic conditions. In 2017, Medicare began paying separately under the Medicare Physician Fee Schedule for complex chronic care management services furnished to Medicare beneficiaries who require not only more clinical staff time, but also complex medical decision-making. CMS has monitored chronic care management utilization since 2015, and similar to OIG's audit finding that less than one percent of claims for chronic care management services did not comply with billing requirement, CMS has not observed substantial rates of chronic care management overpayments. Additionally, early data show that, in general, chronic care management services are increasing patient and practitioner satisfaction, saving costs and enabling solo practitioners to remain in independent practice.¹

CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. Since the OIG's audit period, CMS has implemented edits to prevent and detect improper payments for both chronic care management and complex chronic care management services.

Additionally, CMS educates providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, a booklet detailing the Medicare billing requirements for chronic care management services was published in July 2019.²

¹ <https://innovation.cms.gov/files/reports/chronic-care-mnngmt-finalevalrpt.pdf>

² <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

CMS continues to update Physician Fee Schedule payment policies to improve payment for care management and care coordination and appreciates OIG's review in this area.

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

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services recoup \$1,918,278 for claims that are within the reopening period, and instruct providers to refund up to \$540,680, which beneficiaries were required to pay.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures. As part of this process, the Medicare Administrative Contractors will instruct providers to refund any deductible or coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

However, CMS recognizes the possibility that multiple physicians or nonphysician practitioners could have fulfilled the billing requirements for the care management services for the same beneficiary without knowledge of the specific billing of another physician or nonphysician practitioner. These physicians or nonphysician practitioners may not be liable because they could be found without fault under section 1870(b) of the Social Security Act. Since the OIG's audit period, CMS has implemented claims processing controls, including system edits, to prevent and detect these types of overpayments.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services, based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers 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 OIG's data to identify appropriate providers and suppliers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers and suppliers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services implement claim system edits to prevent and detect overpayments for noncomplex and complex CCM services.

CMS Response

CMS concurs with this recommendation. While CMS has not observed substantial rates of chronic care management overpayments, we continue to evaluate opportunities to implement claims processing controls to prevent and detect overpayments for both complex and noncomplex chronic care management services. CMS has also evaluated the feasibility and cost effectiveness of system edits in the context of overall access to chronic care management services and has implemented

system edits to prevent and detect overpayments for both noncomplex and complex chronic care management services.