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Dermatology Providers Generally Met Medicare Requirements for Evaluation and Management Services Performed on Same Day as Minor Surgical Procedures

REPORT HIGHLIGHTS

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Dermatology Providers Generally Met Medicare Requirements for Evaluation and Management Services Performed on Same Day as Minor Surgical Procedures

Why OIG Did This Audit

- An evaluation and management (E/M) service claimed on the same day as a minor surgical procedure is generally included in the cost of the surgery. Therefore, the provider should not be paid separately for an E/M service unless a significant, separately identifiable E/M service was performed.

- In 2019 and 2020, approximately 61.5 percent of Medicare paid dermatology claims for E/M services included a minor surgical procedure on the same day performed by the same dermatologist. In these cases, Medicare may be inappropriately paying for the E/M service.

What OIG Found

- Dermatologists met Medicare requirements for 90 of the 100 sampled E/M services but did not meet them for the remaining 10.
- On the basis of our sample results, we estimated that Medicare made overpayments totaling $62,915,655 to dermatologists for claims with E/M services that did not meet Medicare requirements.

- CMS' oversight of dermatologist claims for E/M services provided on the same day as a minor surgical procedure could be improved to reduce the risk of non-compliance with Medicare requirements.

What OIG Recommends

We made two recommendations to CMS to improve its oversight of dermatologists' compliance with Medicare requirements for E/M services provided on the same day as minor surgical procedures. CMS did not concur with our recommendations but described steps they have already taken to promote compliance with Medicare requirements.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare covers an evaluation and management (E/M) service when the service is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.[1, 2] An E/M service performed on the same day as a minor surgical procedure is subject to the Medicare global surgery rules and is generally included in the cost of the minor surgical procedure.[3, 4, 5] Therefore, the provider should not be paid separately for the E/M component unless a significant, separately identifiable E/M service was performed. The Office of Inspector General's (OIG) research identified that approximately 61.5 percent of Medicare paid dermatology claims for E/M services in 2019 and 2020 included a minor surgical procedure on the same day performed by the same dermatologist. In these cases, Medicare may be inappropriately paying for the E/M service. Therefore, we conducted this audit to determine whether these services met Medicare requirements.

OBJECTIVE

Our objective was to determine whether Medicare claims that dermatologists submitted for E/M services performed on the same day as minor surgical procedures complied with Medicare requirements.

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services when they are medically necessary, including coverage of E/M services

[1] Physicians and nonphysician practitioners perform E/M services to assess and manage a recipient's health.

[2] Social Security Act § 1862(a)(1)(A).

[3] A minor surgical procedure typically includes any procedure that can be safely performed in an outpatient setting without the use of general anesthesia or the need for respiratory assistance.

[4] Social Security Act § 1848(c)(1)(A)(ii); 2019 and 2020 National Correct Coding Initiative (NCCI), Chapter I, §§ D & E(1)(b).

[5] *The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare & Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.*

performed by dermatologists. When billing for covered services, medical providers must also comply with Medicare billing requirements.

Dermatology and Dermatology Services

Dermatology is the branch of medicine that specializes in the diagnosis, treatment, and prevention of diseases and conditions affecting the skin, hair, nails, and mucous membranes. Dermatologists are medical professionals who evaluate and manage patients' health relative to these conditions and have extensive training to perform dermatology services that include minor surgeries such as lesion removals, destructions, and biopsies.

Medicare Requirements for Evaluation and Management Services

E/M services are cognitive services in which physicians or other qualified healthcare professionals (providers) diagnose and treat illness or injury.[6] Medicare covers E/M services when they are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member and the services are documented in the patient's medical record.[7] Providers are required to bill Medicare for an E/M service using a Healthcare Common Procedure Coding System (HCPCS) code.[8] The HCPCS codes for E/M services are organized to distinguish between new and established patients and whether the physician performed the service in an inpatient or outpatient setting.[9, 10]

The E/M HCPCS codes are further organized into various categories and levels that represent the variations in skills, knowledge, and work required for different patient encounters. In general, the more complex the encounter, the higher the level of HCPCS code providers may bill. Providers must choose the HCPCS code that best represents the complexity of the relevant (1) clinical history, (2) physical examination, and (3) medical decision making (MDM), which are

[6] Cognitive services involve the application, based on relevant knowledge and experience, of such skills as data gathering and analysis, planning, management, decision making, and judgment relating to the prevention, diagnosis, and treatment of health problems, and communication of such information to the patient.

[7] Social Security Act §§ 1862(a)(1)(A) and 1833(e) and 42 CFR § 424.5(a)(6).

[8] HCPCS is a standardized coding system used to identify products, supplies, and services for claims submission to CMS. HCPCS is divided into 2 main subsystems – Level I and Level II. HCPCS Level I is comprised of American Medical Association's (AMA's), Current Procedural Terminology (CPT®). HCPCS Level II is used primarily to identify products, supplies, and services not included in the CPT.

[9] A new patient is an individual who has not received professional services from a provider of the same specialty within the same group practice in the past three years. An established patient has received such services within that period.

[10] Generally, an inpatient setting includes medical facilities such as hospitals where the patient stays overnight. An outpatient setting includes physician offices or other medical facilities where the patient does not stay overnight.

known as key components.[11] According to the American Medical Association's (AMA's), Current Procedural Terminology (CPT®) Professional Code Book, providers must address all three key components to bill a new patient E/M service and two of the three key components to bill an established patient E/M service.[12, 13, 14]

Medicare Requirements for Evaluation and Management Services Performed on Same Day as Minor Surgical Procedures

Medicare established global surgical packages that include payment for all the necessary services normally furnished by a surgeon before, during, and after a procedure (i.e., pre-operative, intra-operative, and post-operative services).[15] Global surgical packages are defined based on the number of post-operative days that the patient is expected to need to recover from the surgery. Procedures that have a zero to 10-day post-operative period are defined as minor surgical procedures.

An E/M service claimed on the same day as a minor surgical procedure is subject to the Medicare global surgery rules. That is, the decision to perform a minor surgical procedure (such as lesion removals,

The Global Surgery Payment for a Minor Surgery Includes:

- **Preoperative Services**
  The initial consultation or evaluation of the problem by the physician to determine the need for surgery made on the same day as the surgery
- **Intraoperative Services**
  Services that are normally a usual and necessary part of a surgical procedure
- **Postoperative Services**
  Followup services during the postoperative period of the surgery that are related to the recovery from the surgery

[11] The CPT codes for new patients in an outpatient setting, which range from 99201–99205, and for established patients in an outpatient setting, which range from 99211–99215, are Level I HCPCS codes.

[12] *CPT copyright 2019 and 2020 American Medical Association. All rights reserved.*

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[14] 45 CFR §§ 162.1002(c)(1) and (a)(5); 2019 and 2020 NCCI Chapter 1 §§ (D) and (E)(1)(b); 2019 and 2020 AMA/CPT Code Book definition and E/M Services Guidelines.

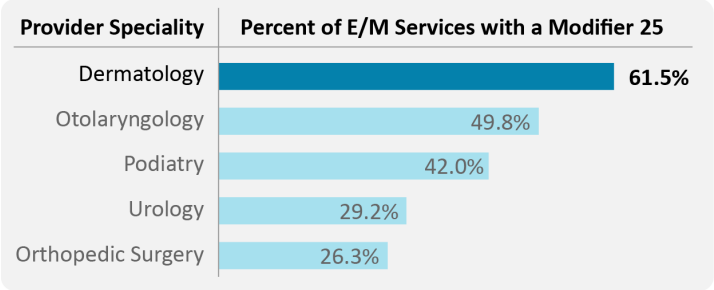
[15] Social Security Act § 1848(c)(1)(A)(ii).

destructions, and biopsies) is included in the payment for the procedure and must not be reported separately as an E/M service. An E/M service should only be billed on the same day if a significant and separately identifiable E/M service is rendered and clearly documented in the patient's medical record.[16]

Providers should append modifier 25 to the appropriate E/M code to indicate the patient's condition required a significant, separately identifiable E/M service that was above and beyond the other service performed or beyond the usual pre- and post-operative care associated with the procedure performed.[17] A significant, separately identifiable E/M service is substantiated by documentation that supports the E/M service reported. Providers should not use modifier 25 to report E/M services that resulted in a decision to perform a minor surgical procedure, nor should they use the modifier solely to bypass automated prepayment edits[18] in the Medicare administrative contractors' (MACs') claims processing system.[19]

Our analysis of claims data for calendar years (CYs) 2019 and 2020 (audit period) showed that about 61.5 percent of dermatologists' claims for an E/M service included a modifier 25, which indicated that the E/M service was significant and separately identifiable from the minor surgical procedure performed on the same day by the same dermatologist.[20] This is the highest usage rate among the top 20 provider specialties with the most E/M claims. Figure 1 shows the provider specialties with highest modifier 25 usage rate.

Figure 1: Provider Specialties with Highest Modifier 25 Usage Rates During the Audit Period



[16] 45 CFR §§ 162.1002(c)(1) and (a)(5); 2019 and 2020 NCCI, Chapter I, §§ D & E(1)(b).

[17] A modifier is a two-character code reported with an HCPCS code and is used to give Medicare additional information needed to process a claim. The modifier 25 allows Medicare claims to bypass automated prepayment edits in a MAC's claims processing system that were designed to prevent improper payments for E/M services performed on the same day as minor surgical procedures (NCCI Policy Manual, chapter I, §§ E(1) & E(1)(b)).

[18] An edit is programming within the standard claim processing system that: (1) selects certain claims; (2) evaluates or compares information on the selected claims or other accessible sources; and (3) acts on the claims – depending on the evaluation – such as paying claims in full or in part, denying payments, or suspending claims for manual review.

[19] AMA, CPT Manual (modifier 25). NCCI, Chapter I, § D; §§ E(1) & E(1)(b).

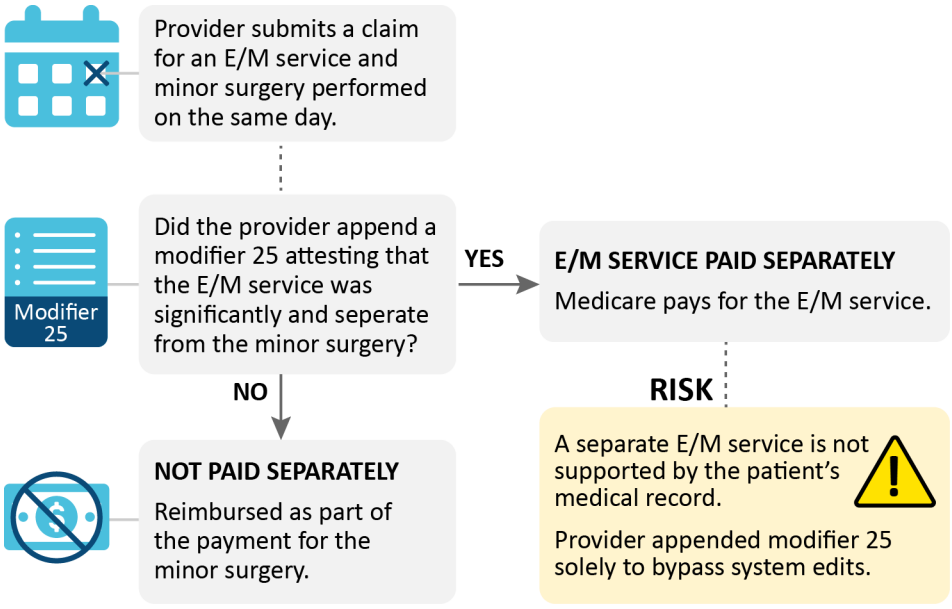
[20] CYs 2019 and 2020 were the most recent data available at the start of the audit.

CMS Oversight

During our audit period, CMS contracted with seven MACs to process and pay Medicare Part B claims for services provided to Medicare patients who resided in 1 of 12 geographical jurisdictions. CMS requires MACs to conduct provider oversight in their respective jurisdictions. This includes educating providers about Medicare coverage and billing requirements through training and published articles. The MACs are also required to review selected claims and implement claim processing edits and to ensure compliance with Medicare requirements. The MACs should coordinate their oversight efforts with CMS and other CMS contractors.[21]

Medicare's claim processing system contains edits designed to detect and reject claims for E/M services performed on the same day as a minor surgical procedure. When a modifier 25 is appended to a claimed E/M service, the provider is attesting that the E/M service is significant and separately identifiable from the minor surgical procedure. The claim then bypasses the system edits and is processed for payment. Figure 2 illustrates the claims process when a E/M service and minor surgery are performed on the same day.

Figure 2: Claims Process—Evaluation and Management Service and Minor Surgical Procedure Performed on the Same Day



[21] Other CMS contractors include Recovery Audit Contractors, Supplemental Medical Review Contractors (SMRC), and Unified Program Integrity Contractors, all of whom support CMS' audit, oversight, and efforts to combat fraud, waste, and abuse.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 10,434,812 paid E/M claim lines totaling $677,518,078 for outpatient services dermatologists provided on the same day as a minor procedure during the audit period.[22] This included E/M services not previously reviewed by a CMS contractor, for which Medicare was the primary payor. From these E/M services, we selected a simple random sample of 100 E/M services with payments totaling $6,682 for review.

We obtained copies of medical records from the dermatologists who received reimbursement for the E/M services in our sample to support the sampled E/M service. We then provided those records to an independent medical review contractor to determine whether the E/M services complied with Medicare requirements.

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.

Appendix A contains our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Dermatologists generally met Medicare requirements for E/M services performed on the same day as minor surgical procedures. Dermatologists met Medicare requirements for 90 of the 100 sampled E/M services but did not meet them for the remaining 10, for which Medicare paid $603. Table 1 below contains a description and number of errors for the sampled E/M services.

Table 1: Description and Number of Errors for Sampled Evaluation and Management Services

Description of Error	Number of Errors
Dermatologists Did Not Submit Medical Records to Support E/M Service	5
E/M Service Level Not Supported by Medical Records	3
Key Components For E/M Service Not Supported	1
E/M Service Not Significant and Separate from Minor Surgical Procedure	1

CMS' oversight of dermatologist claims for E/M services performed on the same day as a minor surgical procedure could be improved to reduce the risk of non-compliance with Medicare requirements. CMS' contractors did not identify these dermatologists' claims as at risk for

[22] To identify the claim lines, we performed a data match of outpatient E/M HCPCS codes and minor surgical procedure HCPCS codes with the same patient, same date of service, and same dermatologists.

potential improper payments. As such, most of the MACs did not focus their education and detection efforts on these claims.

On the basis of our sample results, we estimated that Medicare made overpayments totaling $62,915,655 to dermatologists for E/M services that did not meet Medicare requirements.[23, 24]

DERMATOLOGISTS RECEIVED MEDICARE REIMBURSEMENT FOR SOME SERVICES THAT DID NOT MEET MEDICARE REQUIRMENTS

Dermatologists received Medicare reimbursement for 10 sampled E/M services that did not meet Medicare requirements. Specifically, dermatologists did not submit medical records to support the E/M service (5 services), the E/M service level was not supported by the medical record (3 services), key components for the E/M service were not supported (1 service), and the E/M service was not significant and separate from the minor surgical procedure (1 service).

No Medical Records to Support Evaluation and Management Service

Medicare makes no payment to any provider of services unless there is sufficient information to determine whether a payment is due and the amount of the payment.[25] A significant, separately identifiable E/M service is substantiated by documentation that supports the E/M service reported. [26]

For five E/M services, the dermatologists did not provide supporting documentation. For four of these services, we contacted the dermatologists and requested the patients' medical records several times, but they did not respond. For the remaining E/M service, the dermatologist issued an attestation letter stating that the patient had no medical records for the date of service under review. Therefore, the dermatologists are not entitled to payment for the services.

Evaluation and Management Service Level Not Supported by Medical Records

The E/M HCPCS codes are organized into various categories and levels that represent the variations in skill, knowledge, and work required for different patient encounters. In general, the more complex the encounter, the higher the level of HCPCS code providers may bill. Providers must choose the HCPCS code that best represents the complexity of the relevant

[23] The 90-percent confidence interval for the total Medicare overpayment amount in the sampling frame ranged from $27,157,826 to $98,673,485.

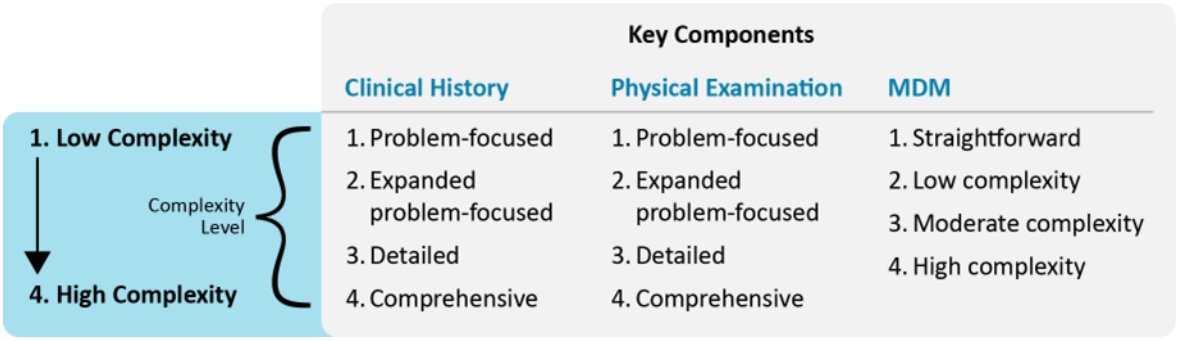
[24] These overpayments are related to claims that are now outside of the 4-year reopening period (42 CFR § 405.980(b)(2)) (permitting a contractor to reopen within 4 years for good cause).

[25] Social Security Act § 1833(e), 42 CFR § 424.5(a)(6).

[26] AMA, CPT Manual (modifier 25).

clinical history, physical examination, and MDM. Providers must address all three of these key components to bill a new patient E/M service and two of the three key components to bill an established patient E/M service. See Figure 3 for the complexity levels of the key components.

Figure 3: Complexity Levels of Clinical History, Physical Examination and MDM* (Lowest to Highest)



* AMA, CPT Manual, Evaluation and Management (E/M) Services Guidelines. Also see the 1995 and 1997 editions of the *CMS Documentation Guidelines for Evaluation and Management Services* for the specific medical elements required for each type of clinical history, physical examination, and MDM.

For three E/M services, our independent medical review contractor found that the patients' medical records did not support the level of E/M service billed. For example, a dermatologist billed an established patient E/M service that required two of the following three key components at the required levels: a detailed clinical history, a detailed physical examination, and a moderate complexity of MDM. However, the medical record only supported the MDM key component at the required level. We only considered the difference in the Medicare payment for the level of E/M service billed and the level of E/M service that was supported by the medical record to be unallowable.

Key Components for Evaluation and Management Service Not Supported

Physicians must address two of three key components for an established patient E/M service: the patient's clinical history, a physical examination, and the physician's MDM.[27]

For one E/M service, our independent medical review contractor found that the provider did not address two of the three key components required for an established patient. Therefore, the dermatologist should not have received payment for this service.

[27] See Figure 3 above. MDM refers to the complexity of establishing a diagnosis and/or selecting a management option.

Evaluation and Management Service Not Significant and Separate from Minor Surgical Procedure

The physician's decision to perform a minor surgical procedure (such as lesion removals, destructions, and biopsies) is included in the payment for the procedure and shall not be reported separately as an E/M service.[28] An E/M service should only be billed on the same day if a significant and separately identifiable E/M service is rendered and clearly documented in the patient's medical record.[29]

Providers should append modifier 25 to the appropriate E/M code when billing Medicare to indicate the patient's condition required a significant, separately identifiable E/M service.[30] Providers should not use modifier 25 to report E/M services that resulted in a decision to perform the minor surgical procedure, nor should they use the modifier solely to bypass automated prepayment edits in the MAC's claims processing system.[31]

For one E/M service, our independent medical review contractor found that the medical record did not support the dermatologist's use of modifier 25. Specifically, based on the signs, symptoms, and conditions documented in the patient's medical record, our independent medical review contractor found that the E/M service was not significant and separately identifiable from the minor surgical procedure performed on the same day. The focus of the patient's visit was the management and destruction of a lesion, and the dermatologist did not address any other skin conditions. Therefore, the dermatologist should not have billed and received payment for a separate E/M service.

CMS Oversight of Dermatologist Claims for Evaluation and Management Services Could Be Improved to Reduce the Risk of Non-Compliance with Medicare Requirements

CMS' oversight of dermatologist claims for E/M services performed on the same day as a minor surgical procedure could be improved to reduce the risk of non-compliance with Medicare requirements. Medicare's claims reimbursement process for E/M services performed on the same day as a minor surgical procedure puts Medicare at risk of making overpayments to dermatologists who may (1) improperly bill for E/M services that should be considered part of a minor surgical procedure and (2) append a modifier 25 solely to bypass Medicare claims processing system edits. Because of these risks, provider education and claim reviews are essential to reduce these risks and prevent improper payments.

[28] NCCI, Chapter I, §§ D & E(1)(b).

[29] Social Security Act § 1833(e), 42 CFR § 424.5(a)(6), NCCI, Chapter I, § D; §§ E(1) & E(1)(b).

[30] AMA, CPT Manual (modifier 25).

[31] NCCI, Chapter I, § D; §§ E(1) & E(1)(b).

The MACs stated that they provided guidance and education to all Medicare Part B providers on how to properly document E/M services and the proper use of modifier 25 through a variety of sources, including webinars, newsletters, bulletins, and other information published on their websites. However, only one MAC stated that they provided additional guidance and education to some dermatology providers on E/M services and the use of modifier 25.

In addition, the MACs' and other CMS contractors' reviews of dermatologists' claims for E/M services on the same day as a minor surgical procedure were minimal. When we initiated our audit, only one MAC stated they had reviewed any of these claims during our audit period and none of the other CMS contractors had performed reviews in this area. After we notified CMS of our audit, CMS directed its SMRC to conduct a review of these claims with dates of service during calendar year 2019.[32]

ESTIMATE OF OVERPAYMENT

On the basis of our sample results, we estimated that Medicare could have saved approximately $62,915,655 in payments to dermatologists for E/M services performed on the same day as a minor surgical procedure that did not meet Medicare requirements.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- work with the MACs and other CMS contractors to continue reviews of dermatologists' claims for E/M services performed on the same day as a minor surgical procedure, which could have resulted in an estimated cost savings of $62,915,655; and

- work with the MACs and other CMS contractors to continue to educate dermatologists on Medicare requirements for billing E/M services, including maintaining sufficient information to support that the E/M services were performed and billed at the appropriate service level and using modifier 25 appropriately when billing E/M services performed on the same day as a minor surgical procedure.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not concur with our recommendations. CMS described steps they have already taken to promote provider compliance with Medicare requirements and requested that we remove both recommendations. CMS stated that they employ a robust program integrity strategy to reduce and prevent improper Medicare

[32] CMS contracts with a SMRC to conduct nationwide medical reviews of Medicare claims to determine whether claims follow coverage, coding, payment, and billing requirements. The SMRC found a 48 percent error rate because modifier 25 was not supported, documentation was not submitted or not submitted timely, or the E/M service level was not supported.

payments. This strategy includes automated system edits within the claims processing systems and prepayment and post-payment reviews. CMS also noted that, after being notified of OIG's audit, the SMRC completed a review of claims for Medicare Part B E/M dermatology services that were billed on the same day as a minor surgical procedure. It also conducted educational sessions that covered topics such as the documentation needed to support the procedure performed, the separate E/M visit billed by the same provider on the same day to justify modifier 25, and the specific leveling of E/M codes with procedures. CMS's comments are included in their entirety as Appendix D.

After reviewing CMS's comments, we revised our first recommendation from the draft report to state that CMS should work with the MACs and other CMS contractors to continue, rather than increase, reviews of dermatologist claims. For our second recommendation, we revised the language to state that CMS should continue working with the MACs and other CMS contractors to provide ongoing education to dermatologists regarding billing requirements for E/M services.

CMS COMMENTS

Regarding our first recommendation, CMS stated that its contractors target their efforts on services that pose the greatest financial risk to the Medicare program and offer the best return on investment of resources. CMS stated that our findings, along with data from the Comprehensive Error Rate Testing (CERT) program—which reported an improper payment rate of 1.8 percent for dermatology office visits—do not support increasing reviews of these claims at this time.

Regarding our second recommendation, CMS stated that both CMS and the MACs provide ongoing education to physicians on Medicare requirements. This includes resources such as the Medicare Learning Network booklets and other materials covering documentation principles, appropriate code selection for E/M services, and proper use of modifier 25. CMS also stated that the SMRC conducted education as part of its review. CMS stated that our findings and the previously mentioned CERT rate do not suggest a widespread misunderstanding of the requirements and therefore do not support the need for additional education at this time.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to believe that CMS can do more to reduce improper payments to dermatologists for E/M services billed on the same day as minor surgical procedures. Our audit identified a 10 percent error rate for these services—approximately 5 times higher than the 1.8 percent error rate reported by the CERT program for all dermatological services. Furthermore, the SMRC review, initiated by CMS after the start of our audit and referenced in its response, revealed a substantially higher error rate of 48 percent for claims with dates of service in CY 2019.[33]

[33] Noridian Healthcare Solutions, "01-071 E&M Dermatology Services: Findings of Medical Review – Supplemental Medical Review Contractor (SMRC) for Centers for Medicare & Medicaid Services," (n.d.).

We recognize that CMS must prioritize its resources and agree that focusing on services that pose the greatest financial risk is an appropriate strategy. However, we maintain that dermatologists' claims for E/M services on the same day as a minor surgical procedure represent one such service, as evidenced by the findings of our audit and the results of the SMRC's review. Accordingly, we revised our first recommendation to support continued reviews like the one CMS directed its SMRC to conduct after we initiated our audit.

Regarding our second recommendation, we appreciate the educational efforts CMS has undertaken since the start of our audit through its MACs and the SMRC reviews. However, based on the results of this audit and the SMRC review, we maintain that CMS should work with the MACs and other CMS contractors to continue educating dermatologists on Medicare requirements for billing E/M services. Accordingly, we revised our second recommendation to support continued efforts to educate dermatologists on Medicare requirements for billing E/M services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified 10,434,812 paid claim lines for E/M services totaling $677,518,078 in Medicare payments to dermatologists performed in an outpatient setting by the same dermatologist on the same day as a minor surgical procedure during our audit period. This included E/M services with dates of service within our audit period that were not previously reviewed by a CMS contractor and for which Medicare was the primary payor. From these E/M services, we selected a simple random sample of 100 E/M services with payments totaling $6,682 for review.

We did not review the Medicare program's overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective. This includes reviewing CMS' management oversight structure and its established policies, procedures, and processes for controlling and assessing risks related to providers' compliance with Medicare requirements for E/M services performed on the same day as minor surgical procedures.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and Medicare contractor guidance;

- held discussions with dermatologists to obtain an understanding of their procedures for the patient intake process and the process of documenting, coding, and billing services provided to Medicare patients;

- completed an internal control assessment to document CMS' internal control structure related to E/M services and E/M services performed on the same day as minor surgical procedures;

- held discussions with MAC officials to obtain an understanding of their efforts to (1) educate and train dermatologists on billing for E/M services and (2) review dermatologists' claims for E/M service performed on the same day as a minor surgical procedure;

- used the CMS National Claims History (NCH) file to match outpatient E/M and minor surgical HCPCS codes by patient, date of service, and dermatologist, identifying Medicare-paid claim lines for E/M services provided on the same day as a minor surgical procedure during CYs 2019 and 2020;

- identified a sampling frame of 10,434,812 Medicare paid claim lines for E/M services from the NCH data and selected a simple random sample of 100 claim lines for E/M services totaling $6,682 for review (see Appendix B);

- reviewed data from CMS's Common Working File for the claim lines for E/M services included in the sample to determine whether the claim lines had been canceled or adjusted;

- reviewed data from the Recovery Audit Contractor Data Warehouse for the claim lines for E/M services included in the sample to determine whether the claim lines had been previously reviewed;

- obtained medical records from the dermatologists who submitted the claim lines for the E/M services in our sample and provided the documentation to an independent medical review contractor who determined whether each sample item complied with Medicare requirements;

- reviewed and summarized the independent medical review contractor's results;

- estimated the amount in the sampling frame that Medicare overpaid dermatologists during our audit period for E/M services performed on the same day as minor surgical procedures that did not comply with Medicare requirements (see Appendix C); and

- shared the results of our audit 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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 10,434,812 paid claim lines totaling $677,518,078 in Medicare payments to dermatologists for E/M services performed on the same day as a minor surgical procedure during CYs 2019 and 2020. The frame included claim lines with dates of service within our audit period that were not previously reviewed by a CMS contractor and for which Medicare was the primary payor.

SAMPLE UNIT

The sample unit was a claim line.

SAMPLE DESIGN AND SAMPLE SIZE

We used a simple random sample of 100 claim lines.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the claim lines by a unique identifier and then consecutively numbered the claim lines in the sampling frame. After generating the random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total improper payment amount in the sampling frame that Medicare made to dermatologists for E/M services performed on the same day as a minor surgical procedure during CYs 2019 and 2020. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Improper Payments in Sample	Value of Improper Payments in Sample
10,434,812	$677,518,078	100	$6,682	10	$603

Table 3: Estimated Value of Improper Payments in the Sampling Frame (Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$62,915,655
Lower limit	$27,157,826
Upper limit	$98,673,485

APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 3, 2025

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Dermatology Providers Generally Met Medicare Requirements for Evaluation and Management Services Performed on Same Day as Minor Surgical Procedures (A-04-21-04083)

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 Medicare beneficiaries with access to medically necessary services, while also working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing systems, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

As stated in the OIG's report, after CMS was notified of OIG's audit, the Supplemental Medical Review Contractor (SMRC) completed a review of claims for Medicare Part B evaluation and management dermatology services that also included a minor surgical procedure. As part of this review, the SMRC conducted voluntary discussion and education sessions that included such topics as the documentation needed to support the procedure performed, the separate evaluation and management visit billed by the same provider on the same day as the procedure to support modifier 25, and the specific leveling of evaluation and management codes with procedures.

Additionally, CMS has taken action to educate health care providers on the proper billing of Medicare services. For example, CMS maintains a Medicare Learning Network (MLN) booklet for evaluation and management services that includes information about the principles of documentation and choosing the code that characterizes the service (including the level of service).[1] CMS also maintains a booklet for global surgery that includes information about billing a separately identifiable evaluation and management service on the same day as a procedure, including appropriate use of modifier 25.[2]

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

[1] MLN Booklet – Evaluation and Management Services. Available at: https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf
[2] MLN Booklet: Global Surgery. Available at: https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with the MACs and other CMS contractors to increase reviews of dermatologists' claims for E/M services performed on the same day as minor surgical procedures, which could have resulted in an estimated cost savings of $62,915,655.

CMS Response

CMS does not concur with this recommendation. CMS contracts with various types of contractors in its effort to fight improper payments and promote provider compliance in the Medicare FFS program. Generally, the contractors target their efforts to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources.

The OIG's findings, along with CMS's improper payment data, do not support increasing reviews of these claims at this time. The OIG's audit covered evaluation and management services that dermatologists provided on the same day as a minor procedure during calendar years 2019 and 2020, and found that the vast majority of dermatology providers met Medicare requirements. This is consistent with CMS's own improper payment data collected through the Comprehensive Error Rate Testing (CERT) program, which calculates an improper payment rate of 1.8% for dermatology office visits.[3]

Additionally, as stated in OIG's report, after CMS was notified of OIG's audit the Supplemental Medical Review Contractor (SMRC) completed a review of claims for Medicare Part B evaluation and management dermatology services that also included a minor surgical procedure.

CMS continues to request that OIG remove this recommendation, or close as implemented.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with the MACs to educate dermatologists on Medicare requirements for billing E/M services, including maintaining sufficient information to support that the E/M services were performed and billed at the appropriate service level and using modifier 25 appropriately when billing E/M services performed on the same day as a minor surgical procedure.

CMS Response

CMS does not concur with this recommendation. CMS and the MACs are continuously educating physicians on Medicare requirements. As stated above, CMS maintains Medicare Learning Network (MLN) booklets, along with other educational materials, that include information about the principles of documentation for evaluation and management services, choosing the code that characterizes the service (including the level of service), and proper use of modifier 25 when billing evaluation and management services performed on the same day as a minor surgical procedure. Further, as stated above, the Supplemental Medical Review (SMRC) also conducted education as part of their review.

[3] The CERT program measures the improper payment rate in the Medicare Fee-for -Service (FFS) program. The CERT program reviews a statistically valid stratified random sample of all Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules. The fiscal year 2024 Medicare FFS improper payment rate included claims submitted during the 12-month period from July 1, 2022 through June 30, 2023. Additional information is available at: https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

The OIG found that the vast majority of dermatology providers generally met Medicare requirements for evaluation and management services. During this audit, OIG identified 10 errors, half of which were because the dermatologists did not submit medical records in response to OIG's request. The OIG's findings, along with the current Comprehensive Error Rate Testing (CERT) rate, do not suggest a widespread misunderstanding of the requirements and therefore do not support the need for additional education at this time. CMS continues to request that OIG remove this recommendation, or close as implemented.

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