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Emergency Department Procedure Codes Used on Medicare Claims for Services Billed With Nonemergency Department Sites of Service Resulted in Over $15 Million in Improper and Potentially Improper Payments

REPORT HIGHLIGHTS

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Emergency Department Procedure Codes Used on Medicare Claims for Services Billed With Nonemergency Department Sites of Service Resulted in Over $15 Million in Improper and Potentially Improper Payments

Why OIG Did This Audit

- Medicare billing for emergency department services is not appropriate if the site of service is other than an emergency department. Physicians and hospitals (providers) should use emergency department procedure codes only when an enrollee has received care in an emergency department.
- We reviewed emergency department procedure codes that providers billed for dates of service in 2021 and 2022 to determine whether CMS ensured compliance with Medicare requirements for claims that were billed using emergency department procedure codes, but the place of service or revenue center code was billed as being provided in a nonemergency department place of service.

What OIG Found

CMS did not ensure compliance with Medicare requirements for claims that were billed using emergency department procedure codes, but the place of service code (for physician claims) or revenue center code (for hospital claims) was billed as a nonemergency. Medicare improperly paid physicians for 9,749 procedures totaling $922,524 that physicians improperly billed for emergency department procedures with nonemergency place of service codes. Medicare also made $14.2 million in potentially improper payments to hospitals for claims billed with emergency department procedure codes and nonemergency revenue center codes. In addition, enrollees may have been held responsible for Part B deductibles that the hospitals potentially should not have charged.

CMS did not ensure that Medicare contractors had adequate claims processing controls in place—specifically system edits—to identify and prevent the improper payments. Additionally, CMS did not provide adequate guidance to ensure that hospitals complied with Medicare requirements when billing for these services.

What OIG Recommends

We made five recommendations, including that CMS direct the Medicare contractors to: recover the $922,524 in improper payments made to physicians, assess $14.2 million in potentially improper payments made to hospitals to determine their allowability and recoup any improper payments, and instruct hospitals to reimburse enrollees for deductibles that the hospitals should not have charged. We made procedural recommendations regarding the implementation or refinement of claims processing controls, the billing guidance to hospitals, and the review of claims after our audit period. The full recommendations are in the report.

CMS concurred with our first recommendation and detailed steps it plans to take in response to that recommendation. CMS did not concur with our other four recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Previous Office of Inspector General audits identified instances in which Medicare paid higher rates for physician services for which the associated claims incorrectly reflected the settings in which services had been rendered. These instances resulted in overpayments totaling millions of dollars.[1] Medicare billing for emergency department services is not appropriate if the site of service is other than an emergency department. Physicians and hospitals should use emergency department procedure codes only when an enrollee has received care in an emergency department. It is important to ensure that Medicare payments for emergency department services comply with requirements. Our analysis of claims indicated that physicians and hospitals (collectively referred to as "providers" for this report) may not always be following Federal requirements and guidance when billing for emergency department services.

OBJECTIVE

Our objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) ensured compliance with Medicare requirements for claims that were billed using emergency department procedure codes, but the place of service or revenue center code was billed as being provided in a nonemergency department place of service.

BACKGROUND

The Medicare Program

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

CMS administers the Medicare program. CMS contracts with Medicare administrative contractors (Medicare contractors) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A inpatient claims submitted for hospital services, process and pay Medicare Part B claims submitted for physician services, safeguard against fraud and abuse, and educate providers and practitioners about Medicare billing requirements. (For more detailed information on the seven Medicare contractors and their associated jurisdictions, see Appendix B.)

[1] *Medicare Paid Millions More for Physician Services at Higher Nonfacility Rates Rather Than at Lower Facility Rates While Enrollees Were Inpatients of Facilities* (A-04-21-04084), May 30, 2023; and *Incorrect Place-of-Service Coding Resulted in Potential Medicare Overpayments Costing Millions* (A-01-13-00506), May 6, 2015.

The Medicare program includes provisions for cost sharing, which is the portion of health care costs for which enrollees are responsible, such as deductibles, coinsurance, and copayments. The amount of cost sharing for an enrollee varies depending on the type of service and the provisions of the enrollee's Medicare plan.

Emergency Department Services and Medicare Billing Requirements

An emergency department is defined as an organized, hospital-based facility that renders unscheduled or episodic services to patients who present for immediate medical attention. Medicare Part B usually covers emergency department services when there is an injury, a sudden illness, or an illness that quickly becomes much more serious.

To be paid for these services, the provider must furnish the information necessary for Medicare to determine the amount due to that provider.[2] In addition, under the provisions of the *Medicare Claims Processing Manual* (the Manual), CMS requires physicians (chapter 12) and hospitals (chapter 4) to bill Medicare for emergency department services using emergency department procedure codes. Providers bill for services rendered in emergency departments using Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes.[3, 4, 5]

[2] The Social Security Act (the Act) § 1833(e); 42 CFR § 424.5(a)(6).

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[5] The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

Table 1 depicts emergency department CPT and HCPCS codes that can be billed for services rendered to an enrollee in a Type A or Type B emergency department and the level of service and resource intensity associated with each code.[6, 7]

Table 1: Emergency Department Procedure Codes

"Type A" Emergency Department (Open 24/7)	"Type B" Emergency Department (Not Open 24/7)	
CPT® Codes[9]	HCPCS Codes	Level of Service/ Resource Intensity[8]
99281	G0380	1—least resource intensive
99282	G0381	2
99283	G0382	3
99284	G0383	4
99285	G0384	5—most resource intensive

CMS guidance in the Manual also states (chapter 12) that with respect to billing for physician services, emergency department coding is not appropriate if the site of service is an office or outpatient setting or any setting other than an emergency department (collectively referred to as "nonemergency" for this report). As discussed below, Medicare claims use place of service codes to reflect settings in which services are rendered by physicians, and revenue center codes to reflect settings in which services are rendered by hospitals. This report sometimes uses the term "sites of service" to refer collectively to the locations where services were rendered.

Place of Service Codes Billed Under Physician Fee Schedule

Since 1992, Medicare payment has been made under the Physician Fee Schedule (PFS) for the services of physicians and other billing professionals. Physicians' services paid under the PFS are furnished in various settings, such as an emergency department, and each payment is based on the relative resources typically needed to render that service.

[6] A "Type A" emergency department refers to a full-service emergency room that is open 24 hours a day, 7 days a week. A "Type B" emergency department is one that does not operate around the clock, meaning that it may have limited hours of operation, but still provides emergency care.

[7] 72 Fed. Reg. 66580, 66789 (Nov. 27, 2007).

[8] Resource intensity refers to the relative volume and types of diagnostic, therapeutic, and bed services used in the management of a particular illness. The more resources needed, the higher the intensity level.

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Guidance in the Manual (chapter 26, sections 10.5 and 10.6) specifies that physicians must include place of service codes on claims for emergency department services that the physicians submit to Medicare. Physicians can render services in a variety of settings but can render emergency department settings only in an emergency department.

CMS guidance to physicians in the Manual states that emergency department procedure codes should be used only if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. Emergency department coding is not appropriate if the site of service is coded as a nonemergency (the Manual, chapter 12, section 30.6.11(B)). For physicians, the place of service code for an emergency department is 23.[10]

Revenue Center Codes Billed Under Outpatient Prospective Payment System

Under the outpatient prospective payment system (OPPS), Medicare pays for hospital outpatient services, such as emergency department procedures, on a rate-per-service basis that varies according to the assigned ambulatory payment classification.[11, 12] For hospitals, revenue center codes that identify emergency department services are codes 0450 through 0459 and 0981.[13, 14] See Table 2 for emergency department revenue center codes and descriptions.

Table 2: Emergency Department Revenue Center Codes and Descriptions

Emergency Department Revenue Centers	
Codes	**Descriptions**
0450	General
0451	Emergency Medical Screening Services
0452	Emergency Room Beyond Emergency Medical Screening Services
0456	Urgent Care
0459	Other
0981	Emergency Room (Professional Services)

[10] Physicians can bill for emergency department telehealth services. The place of service codes for emergency department telehealth services are 02 and 10.

[11] Ambulatory payment classifications group together items and services that are similar clinically and in terms of resource use.

[12] The Act § 1833(t); 42 CFR § 419.31; the Manual, chapter 4, sections 10.2 and 10.3.

[13] The term "revenue center" generally refers to cost centers in a hospital that are assigned specific billing codes used to identify services and locations.

[14] The CMS Research Data Assistance Center publishes guidance for researchers using Medicare administrative contractors' claims data. The most recent definition, published in July 2015, defines an emergency department visit as one that reflects hospital outpatient or inpatient claims with the revenue center codes shown in Table 2.

Some Medicare-participating hospitals can become certified Critical Access Hospitals (CAHs) by meeting certain regulatory requirements and can bill for emergency department procedures.[15] CAHs use the emergency department procedure codes and revenue center codes to bill services; however, these services are reimbursed slightly differently than the same services are reimbursed on the OPPS's rate-per-service basis. Medicare reimburses CAHs at 101 percent of their reasonable costs for providing services to enrollees rather than using rates set by Medicare's prospective payment system or Medicare's fee schedules, which are used to reimburse facilities that are not classified as CAHs (non-CAHs).[16]

CMS officials stated that during our audit period, CMS generally did not instruct hospitals on the assignment of HCPCS codes to revenue center codes for services provided under the OPPS, because hospitals' assignment of cost varies. These officials also stated that CMS's guidance (the Manual) did not standardize the emergency department CPT codes for emergency services provided by hospitals to enrollees. These officials added that CMS did instruct hospitals to report emergency department visits using emergency department CPT codes and to develop and apply internal hospital guidelines to determine what level of intensity to report for each patient visit.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $15,132,429 in Medicare payments to providers for 121,454 claims for emergency department procedures that were billed with either nonemergency place of service (for all 9,749 procedures on physician claims that we reviewed, totaling $922,524) or revenue center codes (for all 111,705 procedures on hospital claims that we reviewed, totaling $14,209,905).[17, 18] The dates of service for these procedures occurred between January 1, 2021, and December 31, 2022 (audit period).[19] We evaluated compliance with selected billing requirements pertaining to emergency department procedures to determine whether CMS's and the Medicare contractors' controls identified and prevented overpayments by denying unallowable claims.

[15] The complete list of requirements is at 42 CFR § part 485, subpart F.

[16] "Reasonable costs" are the direct and indirect costs associated with providing services to Medicare enrollees (42 CFR § 413.9(b)(1)).

[17] We extracted claims that contained CPT codes 99281 through 99285 or HCPCS codes G0380 through G0384. For physician claims, we selected procedure codes not coded with an emergency department place of service code of 23, or telehealth codes 02 or 10. For hospital claims, the billed procedure did not have emergency department revenue center codes of 0450 through 0459 and 0981. We excluded claims submitted by the Indian Health Service (IHS). *CPT copyright 2023 American Medical Association*. All rights reserved.

[18] IHS hospital Medicare claims are paid under a separate "All-Inclusive Rate" methodology for outpatient services, as IHS hospitals are not included in the OPPS system. By CMS regulations, IHS hospitals bill a single, predetermined rate per patient encounter. This rate covers all costs associated with providing outpatient care and is approved by the Office of Management and Budget.

[19] The data on procedures during our audit period were the most recent data available at the start of the audit.

We reviewed all of the Medicare claims payment data associated with the 121,454 emergency department procedures and determined whether each emergency department procedure was billed to Medicare using nonemergency place of service or revenue center codes. Specifically, we used data analytics to identify claim payments for which the providers used emergency department procedure codes and a nonemergency place of service code or revenue center code. Our analysis of the data identified unallowable coding combinations in the billing of emergency department services to Medicare; however, we did not determine whether the site of service codes were the specific causes of the billing errors. This audit focused on data analysis of the claims; therefore, we did not use medical review to determine the medical necessity of the 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.

See Appendix A for the details of our audit scope and methodology.

FINDINGS

CMS did not ensure compliance with Medicare requirements for claims that were billed using emergency department procedure codes, but the place of service code (for physician claims) or revenue center code (for hospital claims) was billed as a nonemergency. Specifically, we determined that:

- physicians improperly billed for emergency department procedures with nonemergency place of service codes (9,749 procedures totaling $922,524), and

- hospitals received potentially improper payments for claims billed with emergency department procedure codes and nonemergency revenue center codes (111,705 procedures totaling $14,209,905, which consisted of 62,846 procedures totaling $9,553,078 at non-CAHs and 48,859 procedures totaling $4,656,827 at CAHs).

In addition, the enrollees may have been held responsible for Medicare Part B deductibles that the hospitals potentially should not have charged.[20]

The errors involving improper payments to physicians and the potentially improper payments to hospitals occurred because CMS did not ensure that the Medicare contractors had adequate claims processing controls in place. Specifically, Medicare contractors did not have system

[20] We could not identify the actual amount of the deductibles collected by the hospitals; however, we determined that it could have totaled up to $394,591, based on the summation of the deductible amounts calculated in the Medicare payment data supplied by CMS.

edits to identify and prevent emergency department procedure codes being billed with a nonemergency place of service code. Additionally, CMS did not provide adequate guidance to ensure that hospitals complied with Medicare requirements for claims that were billed using emergency department procedure codes.

OVERALL FEDERAL REQUIREMENTS

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due to the provider (the Social Security Act § 1833(e)). In addition, providers must furnish sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6). Furthermore, providers must submit claims to their Medicare contactor using the required form prescribed by CMS in accordance with CMS guidance (42 CFR § 424.32(a)(1)).

PHYSICIANS IMPROPERLY BILLED CLAIMS WITH EMERGENCY DEPARTMENT PROCEDURE CODES AND NONEMERGENCY PLACE OF SERVICE CODES

CMS Guidance

CMS guidance to physicians in the Manual (chapter 12, section 30.6.11, "Emergency Department Visits (Codes 99281 – 99288)," subsection (B)), states:

> Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any [site] of service other than an emergency department. The emergency department [procedure] codes should only be used if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

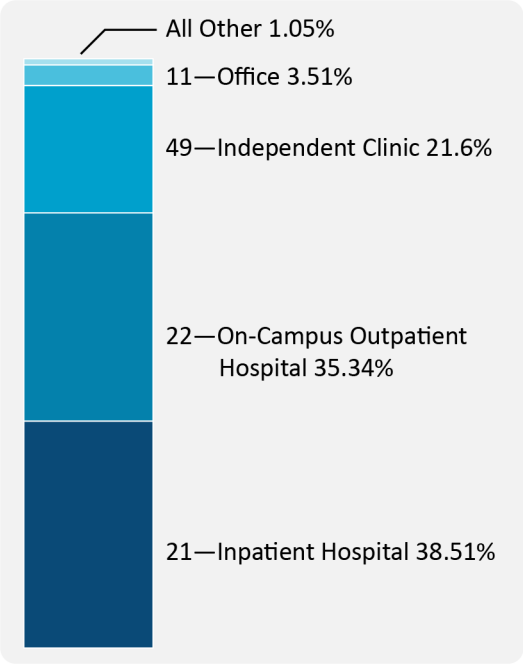
Medicare Claims Incorrectly Billed by Physicians

Physicians improperly billed for emergency department procedures with nonemergency place of service codes. The correct place of service code for emergency department services is 23. Specifically, all 9,749 physician-billed emergency department procedures that we reviewed, totaling $922,524, had incorrect nonemergency place of service codes. The three most frequent incorrectly billed place of service codes were inpatient hospital (place of service code: 21), on-campus-outpatient hospital (place of service code: 22), and independent clinic (place of service code: 49). According to the Federal requirements, emergency department procedure codes should be used only if the patient is seen in the emergency department.[21]

[21] The Manual, chapter 12, section 30.6.11 (B).

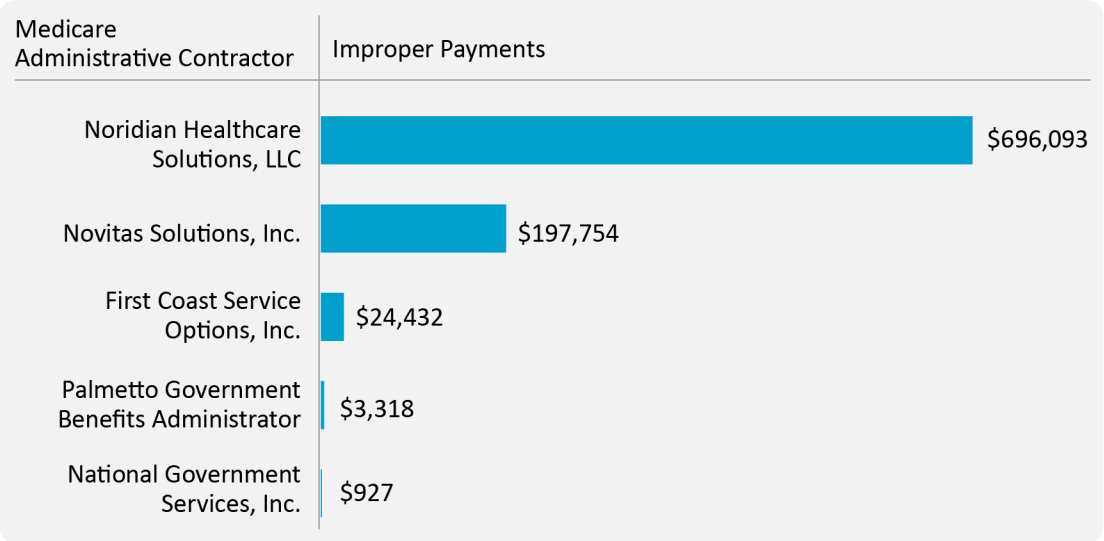
Figure 1 depicts the most frequently billed nonemergency place of service codes that physicians used in the 9,749 physician-billed emergency department procedures that we reviewed.

Figure 1: Most Frequently Billed Nonemergency Place of Service Codes



Based on our analysis of the data, we determined that five of the seven Medicare contractors made improper payments to physicians for claims that physicians billed to Medicare using emergency department procedure codes but the place of service code was for a nonemergency. These improper payments were primarily made by Noridian Healthcare Solutions, LLC (Noridian), and Novitas Solutions, Inc. (Novitas), totaling $893,847 of the $922,524 that we identified. See Figure 2 on the following page for the improper payments made to physicians that were billed using emergency department procedure codes, arranged by Medicare contractor.

Figure 2: Medicare Contractors With Improper Payments Made to Physicians That Were Billed Using Emergency Department Procedure Codes



Medicare Contractors Did Not Have Adequate Claims Processing Controls

The errors involving improper payments to physicians occurred because, during our audit period, CMS did not ensure that the Medicare contractors had adequate claims processing controls in place. Specifically, Medicare contractors did not have system edits to deny claims billed for emergency department procedures coded with nonemergency place of service codes, or system edits were bypassed by some Medicare contractors.

Noridian and Novitas stated that they had updated their system edits after the end of our audit period.[22]

HOSPITALS RECEIVED POTENTIALLY IMPROPER PAYMENTS FOR CLAIMS BILLED WITH EMERGENCY DEPARTMENT PROCEDURE CODES AND NONEMERGENCY REVENUE CENTER CODES

CMS Guidance

CMS guidance to providers in the Manual (chapter 4, section 160) states:

> Providers should continue to apply their current internal guidelines to the existing CPT codes. Each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of

[22] We did not test these edits because they occurred after our audit period had ended.

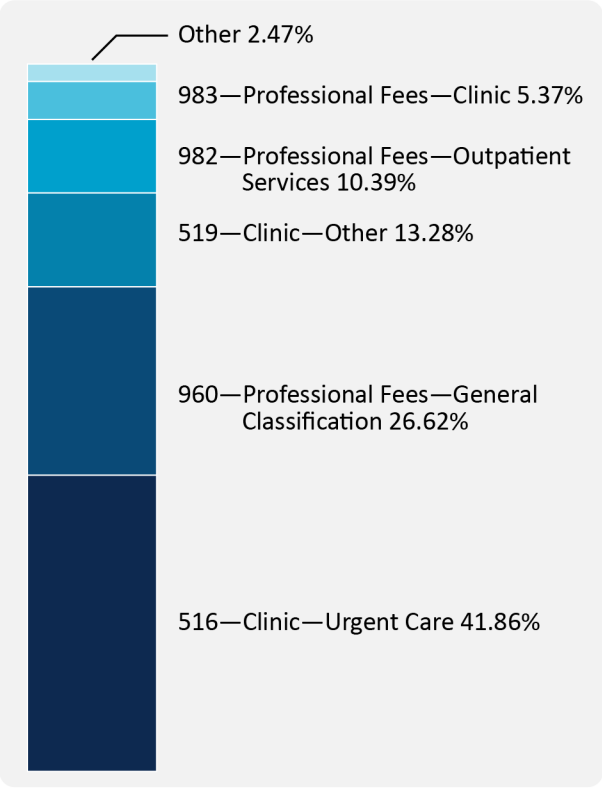
effort represented by the codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes.

Potentially Improper Payments Received by Hospitals

Hospitals received potentially improper payments for 111,705 procedures, totaling $14,209,905, that they billed with emergency department procedure codes and nonemergency revenue center codes. Specifically, Medicare made potentially improper payments to non-CAHs for 62,846 emergency department procedures, totaling $9,553,078, for which the associated claims contained at least 1 nonemergency revenue center code. In addition, Medicare made potentially improper payments to CAHs for 48,859 emergency department procedures, totaling $4,656,827, for which the associated claims contained at least 1 nonemergency revenue center code.

Figure 3 depicts the most frequently billed nonemergency revenue center codes that hospitals used in the 111,705 emergency department procedures discussed above.

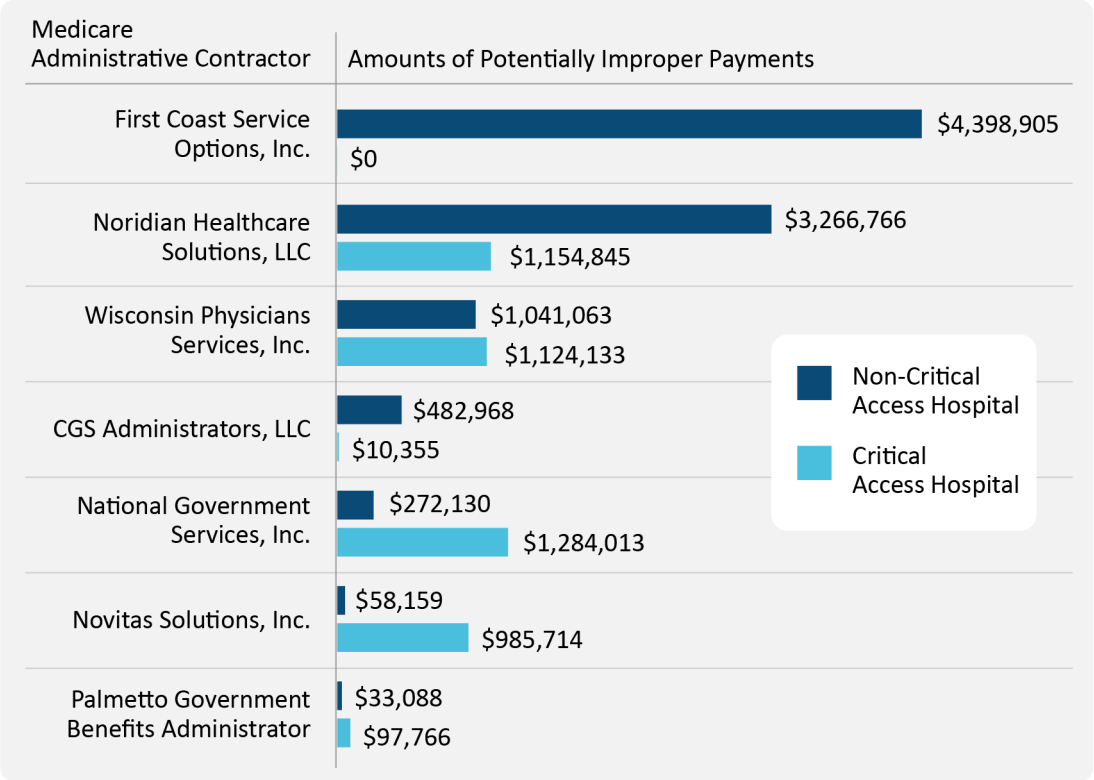
Figure 3: Most Frequently Billed Nonemergency Revenue Center Codes



Our analysis also determined that seven Medicare contractors made these potentially improper payments to hospitals. These payments were primarily made by First Coast Service Options, Inc. (FCSO), and Noridian, totaling $8,820,516 of the $14,209,905 that we identified. See Figure 4 on the following page for the potentially improper payments made to hospitals for

procedures that were billed using emergency department revenue center codes, arranged by Medicare contractor.

Figure 4: Medicare Contractors With Potentially Improper Payments Made to Hospitals That Were Billed Using Emergency Department Revenue Center Codes



In addition to the potentially improper payments to hospitals, the enrollees on whose behalf hospitals submitted these claims may have been held responsible for Medicare Part B deductibles that hospitals should not have charged.[23]

CMS Did Not Provide Adequate Guidance, and Medicare Contractors Did Not Have Adequate Claims Processing Controls

The errors involving potentially improper payments to hospitals occurred for two reasons. First, CMS officials told us that CMS's guidance (the Manual) did not standardize the emergency department CPT codes to be used for emergency services provided by hospitals to enrollees. In this regard, CMS officials also stated that generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue center codes, but rather, it has instructed hospitals to

[23] We could not identify the actual amount of the deductibles collected by the hospitals; however, we determined that it could have totaled up to $394,591, based on the summation of the deductible amounts calculated in the Medicare payment data supplied by CMS.

apply their current internal guidelines to determine what level of intensity to report for each patient visit.

Second, CMS did not ensure that the Medicare contractors had adequate claims processing controls in place, specifically system edits, to identify and prevent the potentially improper payments for emergency department services that hospitals billed using nonemergency revenue center codes. In the absence of explicit billing instructions and the necessary system edits, the Medicare contractors may not have been able to determine the correct amounts that were due to the hospitals.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the Medicare contractors to recover the $922,524 in improper payments made to physicians for claims in which emergency department procedure codes were billed with nonemergency place of service codes;

- direct the Medicare contractors to assess the potentially improper payments made to hospitals identified in this report for:

    - non-CAHs totaling $9,553,078, to determine the allowability of those payments and recoup any improper payments,

    - CAHs totaling $4,656,827, to determine the allowability of those payments and adjust any Medicare reimbursement, and

    - deductibles that the Medicare contractors determine to have been improperly collected from enrollees, and direct the relevant hospitals to reimburse enrollees for the deductibles that the hospitals should not have charged;

- direct the Medicare contractors to implement or refine claims processing controls, such as system edits, to identify and prevent improper payments of claims for emergency department services billed with nonemergency place of service codes;

- specify in the Manual that hospitals are required to use emergency revenue center codes when billing Medicare claims containing emergency department procedure codes; and

- direct the Medicare contractors to review claims submitted by providers after our audit period to identify instances when Medicare paid providers for claims in which emergency department procedure codes were billed with nonemergency place of service or revenue center codes, and recover any improper payments identified.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first recommendation and described corrective actions that it planned to take with the Medicare contractors. CMS did not concur with our other four recommendations. After reviewing CMS's written comments, we maintain that all of our recommendations are valid.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, are included in their entirety as Appendix C.

The following sections summarize CMS's comments and our response.

RECOMMENDATION TO DIRECT THE MEDICARE CONTRACTORS TO ASSESS THE POTENTIALLY IMPROPER PAYMENTS MADE TO HOSPITALS

CMS Comments

CMS did not concur with our second recommendation. CMS pointed out that our audit period overlapped with the timeframe of the COVID-19 Public Health Emergency (PHE). CMS stated: "During this time there were flexibilities, such as the CMS Hospitals Without Walls initiative, in place that allowed providers to relocate where they were furnishing hospital services." The PHE, CMS added, "likely impacted how services were provided and/or how they were billed" during our audit period. CMS also referred to concerns it had expressed to us (during our audit) regarding our inclusion of CAHs in this report, and said that based on its understanding of our analysis, CMS believed that the potentially improper CAH payments were made appropriately.[24]

Furthermore, CMS referred to its use of contractors to help identify improper payments and promote provider compliance in the Medicare fee-for-service program. Generally, according to CMS, "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." CMS added that it does not believe that it is in its best interest to direct the Medicare contractors to assess the potentially improper payments we identified, "as it does not represent a rational investment of CMS's limited resources."

Office of Inspector General Response

We agree that our audit covered procedures with dates of service that overlapped CMS's Hospitals Without Walls Initiative and the COVID-19 PHE. The Hospitals Without Walls Initiative did, as CMS said, create flexibilities that allowed providers to furnish hospital services in alternative locations. However, these flexibilities included allowances for hospitals to provide care to patients in their homes and for ambulatory surgical centers to provide inpatient care. We excluded from our audit any claim coded with a site of service as home, because enrollees'

[24] Office of Inspector General Note—See footnote 15 and our associated discussion earlier in this report.

homes were allowable sites of service during the COVID-19 PHE. Furthermore, we excluded from our audit any inpatient claims because emergency department services are outpatient services. Also, we agree with CMS that CAHs can use an optional method for payment for outpatient services. However, our audit objective focused, not on payment methods for facility services, but rather on the sites of service for which emergency department services were billed as nonemergency revenue center codes.

We also acknowledge CMS's concerns about resource limitations. Assessments of potentially improper payments to hospitals and deductibles that were improperly collected from enrollees unquestionably require allocations of some of those limited resources. We believe, though, that if resources were not allocated to help implement this recommendation, the Medicare program could be at an increased risk of allowing improper payments to hospitals and of allowing enrollees to be held responsible for deductibles that hospitals should not have charged.

Therefore, we continue to recommend that CMS direct the Medicare contractors to assess the potentially improper payments made to hospitals (both non-CAHs and CAHs) to determine the allowability of those payments, recoup any improper payments or adjust any Medicare reimbursement, determine whether these hospitals improperly collected deductibles from enrollees, and if so, direct the relevant hospitals to reimburse enrollees for the deductibles that the hospitals should not have charged. Implementing our fourth recommendation (discussed below) and assessing these potentially improper payments to hospitals and improperly collected deductibles can help ensure compliance with Medicare billing requirements.

RECOMMENDATION TO DIRECT THE MEDICARE CONTRACTORS TO IMPLEMENT CLAIMS PROCESSING CONTROLS

CMS Comments

CMS did not concur with our third recommendation and said that the two Medicare contractors we named earlier in this report (Figure 2) accounted for 97 percent of the improper payments we identified. CMS also referred to our statements earlier in this report that both of these Medicare contractors had updated their system edits after the end of our audit period "to address the identified concern." CMS stated that therefore, it did not believe that further action is needed, and it requested that the recommendation be removed or closed as implemented.

Office of Inspector General Response

As we state earlier in this report, we agree with CMS that two Medicare contractors with the majority of the improper payments reported that they had updated their system edits to prevent improper payments of claims for emergency department services billed with nonemergency place of service codes. However, our audit identified other Medicare contractors that had made a smaller amount of improper payments. To address those

contractors, we revised our draft report's third recommendation to say that CMS should direct all Medicare contractors to implement *or refine* claims processing controls, such as system edits, to help identify improper claims and help reduce future improper payments.

RECOMMENDATION TO REQUIRE HOSPITALS TO USE EMERGENCY REVENUE CENTER CODES WHEN BILLING MEDICARE CLAIMS CONTAINING EMERGENCY DEPARTMENT PROCEDURE CODES

CMS Comments

CMS did not concur with our fourth recommendation to add language to the Manual regarding the use of emergency revenue center codes. CMS stated: "There are currently no evaluation and management CPT codes for emergency services provided to hospital outpatients. CMS has previously attempted to establish a standardized methodology, but ultimately did not proceed based on comments received during the rulemaking process." CMS added that therefore, "providers have been instructed to apply their current internal guidelines to the existing CPT codes when determining what level of visit to report for each patient," as outlined in the Manual.

Office of Inspector General Response

The emergency department services CPT codes do not explicitly specify sites of service in the way that the emergency department services HCPCS codes do. However, CMS does explain in the CY 2007 OPPS Final Rule that "CPT defines an emergency department as 'an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.' Under the OPPS, [CMS] ha[s] restricted the billing of emergency department CPT codes to services furnished at facilities that meet this CPT definition."[25] We believe that the preamble in this final rule aligns closely with our statement earlier in this report that the lack of standardization of emergency department CPT codes was one of the two causes of the errors involving potentially improper payments to hospitals.

Because of this lack of standardization, and according to what CMS officials told us during our audit, CMS believes that hospitals may use the emergency department CPT codes according to their own internal guidelines and not according to Federal regulations or guidance. Therefore, we continue to recommend that CMS specify in the Manual that hospitals are required to use emergency revenue center codes when billing Medicare claims containing emergency department procedure codes. CMS should ensure that the language in the Manual is consistent in terms of the requirements for both hospital and physician providers.

[25] 71 Fed. Reg. 67960, 68125 (Nov. 24, 2006).

RECOMMENDATION TO DIRECT THE MEDICARE CONTRACTORS TO REVIEW CLAIMS SUBMITTED BY PROVIDERS AFTER OUR AUDIT PERIOD

CMS Comments

CMS did not concur with our fifth recommendation and again noted that the two Medicare contractors that accounted for the majority of the improper payments had reported that they had "made claim processing edit changes." CMS added that for that reason, "the vast majority of the confirmed improper payments . . . would not be expected to prospectively occur." CMS stated that therefore, it would not direct the Medicare contractors to review claims submitted by providers after our audit period because our findings "do not support that these reviews would [be] the best investment of resources at this time."

Office of Inspector General Response

We acknowledge CMS's concerns about whether implementation of this recommendation would be the best investment of resources. As we say above, assessments of potentially improper payments to hospitals and deductibles that were improperly collected from enrollees unquestionably require allocations of some of those limited resources. We reiterate, though, that if resources were not allocated to help implement this recommendation, the Medicare program could be at an increased risk of allowing improper payments to hospitals and of allowing enrollees to be held responsible for deductibles that hospitals should not have charged.

Furthermore, although CMS stated that the two Medicare contractors associated with our first recommendation reported that they had updated their system edits to prevent the improper payments we identified, we have not tested the edits that those two Medicare contractors implemented after our audit period to confirm that the edits are functioning as described. We note, too, that this fifth recommendation pertains not only to the improper payments made to physicians (upon which CMS's comments on this recommendation focused) but also to the potentially improper payments made to hospitals. Therefore, we continue to recommend that CMS direct the Medicare contractors to review claims submitted by providers after our audit period to identify instances when Medicare paid providers for claims in which emergency department procedure codes were billed with nonemergency place of service or revenue center codes, and recover any improper payments identified. Implementing our fourth recommendation (as discussed above) and assessing these potentially improper payments to hospitals and improperly collected deductibles can help ensure compliance with Medicare billing requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $15,132,429 in Medicare payments to providers for 121,454 emergency department procedures that were billed with either nonemergency place of service or revenue center codes (footnote 17). The dates of service for these procedures occurred between January 1, 2021, and December 31, 2022 (audit period) (footnote 19).

We reviewed all of the Medicare claims payment data associated with the 121,454 emergency department procedures and determined whether each emergency department procedure was billed to Medicare using nonemergency place of service or revenue center codes that were for sites of service other than emergency departments. Our analysis of the data identified unallowable coding combinations in the billing of emergency department services to Medicare; however, we did not determine whether the site of service codes were the specific causes of the billing errors. This audit focused on data analysis of the claims; therefore, we did not use medical review to determine the medical necessity of the services.

We did not perform an overall assessment of the internal control structures of CMS and the Medicare contractors. Rather, we limited our review to those controls that were significant to our objective. Specifically, we performed an overall assessment of all claims for emergency department procedures submitted by the providers for Medicare reimbursement. We also assessed relevant policies, system edits, and provider education.

We performed our audit work from November 2023 to July 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- used computer matching, data mining, and other data analysis techniques to identify paid claims with dates of service in our audit period that physicians and hospitals billed using emergency department procedure codes that were potentially at risk of noncompliance with Medicare billing requirements because they did not have emergency place of service codes or revenue center codes;

- removed any claims that were previously audited, as identified in CMS's Recovery Audit Contractor data warehouse;[26]

- removed Indian Health Service (IHS) hospital claims (footnote 18);

[26] Recovery Audit Contractors are private organizations that contract with CMS to identify and collect improper Medicare payments.

- interviewed CMS officials to obtain an understanding of CMS's oversight of and controls over these emergency department procedures;

- analyzed the Medicare claims data associated with the 121,454 emergency department procedures to determine whether the procedures were billed with nonemergency place of service codes or revenue center codes;

- provided CMS officials with detailed data supporting the improper and potentially improper payments that we identified and solicited CMS's input on these findings and their causes; and

- discussed our findings 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: MEDICARE ADMINISTRATIVE CONTRACTORS AND ASSOCIATED JURISDICTIONS

Medicare Contractor	Jurisdiction	States and Territories
CGS Administrators, LLC (CGS)	J15	Kentucky, Ohio
First Coast Service Options, Inc. (FCSO)	JN	Florida, Puerto Rico, U.S. Virgin Islands
National Government Services, Inc. (NGS)	J6	Illinois, Minnesota, Wisconsin
NGS	JK	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
Noridian Healthcare Solutions, LLC (Noridian)	JE	California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands
Noridian	JF	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
Novitas Solutions, Inc. (Novitas)	JH	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas
Novitas	JL[27]	Delaware, Maryland, New Jersey, Pennsylvania, District of Columbia
Palmetto Government Benefits Administrators (Palmetto)	JJ	Alabama, Georgia, Tennessee
Palmetto	JM[28]	North Carolina, South Carolina, Virginia, West Virginia
Wisconsin Physicians Service, Inc. (WPS)	J5	Iowa, Kansas, Missouri, Nebraska
WPS	J8	Indiana, Michigan

[27] Includes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia.

[28] Excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 12, 2025

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

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

SUBJECT: Office of Inspector General (OIG) Draft Report: Emergency Department Procedure Codes Used on Medicare Claims for Services Billed With Nonemergency Department Sites of Service Resulted in Over $15 Million in Improper and Potentially Payments (A-07-23-05139)

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 and, at the same time, 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 system, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

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

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to recover the $922,524 in improper payments made to physicians for claims in which emergency department procedure codes were billed with nonemergency place of service codes.

CMS Response

CMS concurs with this recommendation. CMS will direct the Medicare Administrative Contractors to recover identified improper payments associated with OIG's audit consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to assess the potentially improper payments made to hospitals identified in this report for:

- Non-CAHs totaling $9,553,078, to determine the allowability of those payments and recoup any improper payments,
- CAHs totaling $4,656,827, to determine the allowability of those payments and adjust any Medicare reimbursement, and

- Deductibles that the Medicare contractors determine to have been improperly collected from enrollees, and direct the relevant hospitals to reimburse enrollees for the deductibles that the hospitals should not have changed.

CMS Response

CMS does not concur with this recommendation. The OIG's audit covers procedures with dates of service between January 1, 2021, and December 31, 2022 which overlaps with the COVID-19 Public Health Emergency (PHE). During this time there were flexibilities, such as the CMS Hospitals Without Walls initiative, in place that allowed providers to relocate where they were furnishing hospital services. Therefore, the COVID-19 PHE likely impacted how services were provided and/or how they were billed during the audit timeframe. A resource-intensive documentation review would need to be conducted to determine whether these claims were appropriately paid.

Additionally, CMS has expressed concerns regarding OIG's inclusion of Critical Access Hospitals (CAHs) in this report. Based on our understanding of OIG's analysis, we believe that the CAH payments that OIG has designated as potentially improper were made appropriately.

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. Based on the audit timeframe, the inclusion of CAHs, and the limited financial risk identified by OIG, CMS does not believe it is in the Agency's best interest to direct the Medicare contractors to assess the potentially improper payments identified in this audit as it does not represent a rational investment of CMS's limited resources.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to implement claims processing controls, such as system edits, to identify and prevent improper payments of claims for emergency department services billed with nonemergency place of service codes.

CMS Response

CMS does not concur with this recommendation. As stated in the OIG's report, these improper payments were primarily made by two Medicare Administrative Contractors (MACs), which accounted for 97 percent of the improper payments identified. Both MACs reported to the OIG that they updated their system edits after the end of the audit period to address the identified concern. Based on these findings, it does not appear that further action is needed at this time. CMS requests that the recommendation be removed or closed as implemented.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services specify in the Manual that hospitals are required to use emergency revenue center codes when billing Medicare claims containing emergency department procedure codes.

CMS Response

CMS does not concur with this recommendation. There are currently no evaluation and management CPT codes for emergency services provided to hospital outpatients. CMS has previously attempted to establish a standardized methodology, but ultimately did not proceed

based on comments received during the rulemaking process.[1] Because there are no standardized evaluation and management CPT codes for emergency services provided to hospital outpatients, providers have been instructed to apply their current internal guidelines to the existing CPT codes when determining what level of visit to report for each patient. The current process is outlined in the Medicare Claims Processing Manual.[2]

In addition, the agency would need to consider the appropriate methods, such as notice and comment rulemaking, in order to modify this process before such instruction could be provided in the manual.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to review claims submitted by providers after our audit period to identify instances when Medicare paid providers for claims in which emergency department procedure codes were billed with nonemergency place of service or revenue center codes, and recover any improper payments identified.

CMS Response

CMS does not concur with this recommendation. As stated above, 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. We note that the vast majority of the confirmed improper payments found during the OIG's audit would not be expected to prospectively occur because, as stated above, the two MACs responsible for 97 percent of the improper payments identified have made claim processing edit changes. Accordingly, CMS will not direct the Medicare contractors to review claims submitted by providers after the audit period as OIG's findings do not support that these reviews would the best investment of resources at this time.

[1]Medicare Program; Prospective Payment System for Hospital Outpatient Services Final Rule (April 7, 2000) https://www.govinfo.gov/content/pkg/FR-2000-04-07/pdf/00-8215.pdf; Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates (November 24, 2006) https://www.govinfo.gov/content/pkg/FR-2006-11-24/pdf/06-9079.pdf

[2]Medicare Claims Processing Manual Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS) https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf

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