Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS FOR DIAGNOSTIC RADIOLOGY SERVICES IN EMERGENCY DEPARTMENTS

Daniel R. Levinson
Inspector General

April 2011
OEI-07-09-00450

OBJECTIVES

To determine the extent to which, in 2008, Medicare allowed claims for interpretation and reports of diagnostic radiology services—specifically computed tomography (CT), magnetic resonance imaging (MRI), and x-ray services—performed in hospital outpatient emergency departments that:

1. met Medicare documentation requirements,
2. were performed before beneficiaries left the hospital outpatient emergency departments, and
3. followed suggested documentation practice guidelines promoted by the American College of Radiology.

BACKGROUND

The Social Security Act and Centers for Medicare & Medicaid Services (CMS) regulations govern Medicare payments for all radiology services and require that services be medically necessary, have documentation to support the claims, and be ordered by physicians.

We used the 2008 National Claims History File to identify 9.6 million Medicare claims ($215 million) for interpretation and reports of diagnostic radiology services for beneficiaries in hospital outpatient emergency departments. Our review consisted of two simple random samples of claims: a sample of 220 CT and MRI claims and a sample of 220 x-ray claims. We used a document review instrument to review all medical record documentation requested from facilities for each sampled claim. We considered sampled claims erroneous if (1) documentation did not support that services were performed or (2) physicians' orders were not present. We also reviewed all interpretation and reports to determine whether they were performed during beneficiaries' diagnoses and treatments in hospital outpatient emergency departments. Finally, we reviewed interpretation and reports for all sampled claims for consistency with the American College of Radiology's suggested documentation practice guidelines.

FINDINGS

In 2008, Medicare claims for interpretation and reports of 19 percent of CTs and MRIs and 14 percent of x-rays in hospital outpatient emergency departments were erroneous because of insufficient

documentation. Of the nearly 3 million claims allowed for interpretation and reports of CT and MRI services in hospital outpatient emergency departments in 2008, Medicare erroneously allowed 19 percent, amounting to nearly $29 million. Of the nearly 6.6 million claims allowed for interpretation and reports of x-ray services in hospital outpatient emergency departments in 2008, Medicare erroneously allowed 14 percent, amounting to nearly $9 million. Physicians' orders were not present in medical record documentation for 12 percent of CT and MRI interpretation and report claims, amounting to nearly $18 million. Physicians' orders were not present in medical record documentation for 9 percent of x-ray interpretation and report claims, amounting to $5 million. Documentation was not provided to support that interpretation and reports had been performed for 12 percent of CT and MRI claims, amounting to nearly $19 million, and 8 percent of x-ray claims, amounting to $5 million.

In 2008, Medicare paid for interpretation and reports performed for 16 percent of x-rays and 12 percent of CTs and MRIs after beneficiaries left hospital outpatient emergency departments; CMS offers inconsistent payment guidance on the timing for interpretation. CMS's guidance to contractors states that contractors are to pay only for the interpretation performed "at the same time" as the diagnosis and treatment of the beneficiary in the emergency room if contractors receive multiple claims from, for example, the emergency room physician and the radiologist. However, contractors are not required to confirm that the interpretation was performed while the beneficiary was in the emergency department if only one claim is received. Medicare allowed more than $10 million (16 percent of claims) for interpretation and reports of x-rays that were performed after beneficiaries left hospital outpatient emergency departments and, based on OIG's prior work in this area, may not have contributed to beneficiaries' diagnoses and treatments. Of the $10 million, $7.5 million was for claims that had physicians' orders and documentation to show that interpretation and reports had been performed. In addition, Medicare allowed $19 million for interpretation and reports of CTs and MRIs that were performed after beneficiaries left hospital outpatient emergency departments. Of the $19 million, $5.4 million was for claims that had physicians' orders and documentation to show that interpretation and reports were performed.

Interpretation and reports for 71 percent of x-rays and 69 percent of CTs and MRIs in hospital outpatient emergency departments did not follow one or more suggested documentation practice guidelines promoted by the American College of Radiology. Seventy-one percent of interpretation and reports for x-rays did not follow one or more suggested practice guidelines. Sixty-nine percent of interpretation and reports for CTs and MRIs did not follow one or more suggested practice guidelines. Documentation standards for interpretation and reports are essential for determining whether diagnostic radiology services contribute to beneficiaries' diagnoses and treatments.

RECOMMENDATIONS

We recommend that CMS:

Educate providers on the requirement to maintain documentation on submitted claims.

Adopt a uniform policy for single and multiple claims for interpretation and reports of diagnostic radiology services to require that claimed services be contemporaneous or identify circumstances in which noncontemporaneous interpretations may contribute to the diagnosis and treatment of beneficiaries in hospital outpatient emergency departments.

Take appropriate action on the erroneously allowed claims identified in our sample.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS concurred with the first and third recommendations. CMS did not concur with the second recommendation.

In response to the first recommendation, CMS indicated that it will issue an educational article to the provider community to emphasize that documentation requirements will be enforced. In response to the third recommendation, CMS indicated that upon receipt of the files from the Office of Inspector General, it will take appropriate action. CMS will instruct the Medicare Administrative Contractors to consider this issue when prioritizing their medical review strategies or other interventions.

In response to the second recommendation, CMS indicated that it does not believe that a single billed interpretation must, in all cases, be contemporaneous with the beneficiary's diagnosis and treatment to contribute to that diagnosis and treatment. A uniform policy requiring that interpretation and reports be contemporaneous with, or, if not contemporaneous, demonstrably contribute to the beneficiary's diagnosis and treatment could reduce unexplained complexity in what is already a complicated billing system for medical diagnostics. We have revised the language of the second recommendation to clarify what we are recommending.

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 9

In 2008, Medicare claims for interpretation and reports of 19 percent of CTs and MRIs and 14 percent of x-rays in hospital outpatient emergency departments were erroneous because of insufficient documentation 9

In 2008, Medicare paid for interpretation and reports performed for 16 percent of x-rays and 12 percent of CTs and MRIs after beneficiaries left hospital outpatient emergency departments ... 11

Interpretation and reports for 71 percent of x-rays and 69 percent of CTs and MRIs in hospital outpatient emergency departments did not follow one or more suggested documentation practice guidelines promoted by the American College of Radiology 12

RECOMMENDATIONS 15

Agency Comments and Office of Inspector General Response. ... 16

APPENDIXES 18

A: Document Review Instrument 18

B: Point Estimates and Confidence Intervals 19

C: Agency Comments 22

ACKNOWLEDGMENTS 24

INTRODUCTION

OBJECTIVES

To determine the extent to which, in 2008, Medicare allowed claims for interpretation and reports of diagnostic radiology services—specifically computed tomography (CT), magnetic resonance imaging (MRI), and x-ray services—performed in hospital outpatient emergency departments that:

1. met Medicare documentation requirements,
2. were performed before beneficiaries left the hospital outpatient emergency departments, and
3. followed suggested documentation practice guidelines promoted by the American College of Radiology.

BACKGROUND

In 2005, the Medicare Payment Advisory Commission testified before Congress about the increasing cost of diagnostic radiology services and the potential overuse of these services. In 2009, the Senate Finance Committee released *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*, which indicated that the number of imaging services increased more than other Medicare physician services for the period under review.

The Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations govern Medicare payments for all services, including diagnostic radiology services,[1] and require that these services be ordered by physicians, have documentation to support the claims, and be medically necessary. The Act states that Medicare payments can be made when providers furnish appropriate information about the service (i.e., services are ordered by practitioners with clinical privileges or, consistent with State law, by other practitioners authorized by the medical staff and the governing body to order the services. We refer to these practitioners as physicians in this report).[2] Further, Medicare pays only for services considered to be reasonable and necessary.[3]

[1] For the purposes of this report, diagnostic radiology services include x-rays, CTs, and MRIs.

[2] Section 1833(e) of the Act; 42 CFR § 482.26(b)(4).

[3] Section 1862(a)(1)(A) of the Act; 42 U.S.C. § 1395y(a)(1).

Generally, reasonable and necessary services are those used to diagnose or treat illness or injury or to improve the functioning of a malformed body part.[4]

Payment for Interpretation of Diagnostic Tests Furnished to Emergency Room Patients

As a condition of fee schedule payment, services are required to contribute directly to the diagnosis or treatment of an individual beneficiary.[5] When Medicare Administrative Contractors (MAC) receive a single claim for interpretation and report, "they must presume that the one service billed was a service to the individual beneficiary rather than a quality control measure …"[6] The *Medicare Claims Processing Manual* does not require contractors to confirm that interpretations were performed at the same time that the patient was in the emergency department or that the interpretation contributed to the diagnosis and treatment of the individual beneficiary when a single claim is submitted.

However, when a MAC receive[s] multiple claims for the same interpretation "[MACs must] pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient."[7] The *Medicare Claims Processing Manual* goes on to state that MACs must "pay for the interpretation billed by the . . . radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary." Any other reinterpretation of the original interpretation (e.g., one that was performed after the beneficiary has left the emergency department) should be treated and reimbursed through the diagnosis-related group as part of the hospital's quality assurance program.[8]

---

[4] Section 1862(a)(1)(A) of the Act; 42 U.S.C. § 1395y(a)(1).

[5] 42 CFR § 415.102(a)(2).

[6] CMS, *Medicare Claims Processing Manual* (Internet-only manual), Pub. 100-04, ch. 13, § 100.1. Accessed at http://www.cms.gov/Manuals/IOM/list.asp on October 1, 2010.

[7] Ibid.

[8] A diagnosis-related group is a system developed as part of the prospective payment system to reimburse providers for treatment of similar diagnoses.

Medicare payments for diagnostic radiology services in hospital outpatient emergency departments have two components: a technical component,[9] paid by Part A; and a professional component, paid by Part B. This report addresses only the professional component, which includes payments for physicians' interpretations of images and reports on the clinical findings for inclusion in beneficiaries' hospital-maintained medical records.[10] Payments for the professional component are sent to interpreting physicians (i.e., emergency room physicians or radiologists).[11]

After diagnostic radiology services are ordered by emergency department physicians, they can:

- review diagnostic radiology images as part of evaluation and management (E/M) services for beneficiaries,[12]
- perform interpretation and reports of diagnostic radiology services, and/or
- consult with radiologists for their interpretation and reports on the findings for diagnostic radiology services.[13]

Claims submitted for interpretations without complete written reports do not meet the conditions for payment.

---

[9] The technical component of diagnostic radiology services includes the administration and supervision of diagnostic equipment, supplies, and use of facilities. CMS *Medicare Claims Processing Manual* (Internet-only manual), Pub. 100-04, ch. 13, § 20. Accessed at http://www.cms.gov/Manuals/IOM/list.asp on October 1, 2010.

[10] 42 CFR § 415.120(a).

[11] The physician should use modifier 26 to bill the professional component. American Medical Association, *Current Procedural Terminology*, 2008.

[12] E/M services refer to visits and consultations furnished by physicians. CMS, *Medicare Claims Processing Manual* (Internet-only manual), Pub. 100-04, ch. 13, § 100.1. Accessed at http://www.cms.gov/Manuals/IOM/list.asp on August 29, 2010. Billing Medicare for a patient visit requires the selection of a Current Procedural Terminology (CPT) code that best represents the level of E/M service performed. For example, there are five CPT codes (99281–99285) that may be selected to bill for office or other outpatient visits for a new patient. American Medical Association, *Current Procedural Terminology*, 2008.

[13] CMS, *Medicare Claims Processing Manual* (Internet-only manual), Pub. 100-04, ch. 13, § 100.1. Accessed at http://www.cms.gov/Manuals/IOM/list.asp on October 1, 2010.

Both emergency department physicians and radiologists may be paid for their interpretation and reports for CTs, MRIs, or x-rays.[14] Medicare generally pays for only one interpretation and report for each diagnostic radiology service furnished to an emergency department patient.[15]

Comprehensive Error Rate Testing

CMS monitors the rates of inappropriate payments for Medicare fee-for-service claims through the Comprehensive Error Rate Testing (CERT) program. CMS established the CERT program to randomly sample and review different types of service claims submitted to Medicare. To calculate error rates, CERT staff randomly select claims for services each month from each contractor that processes Medicare claims. CERT staff then request the medical record associated with each sampled claim from the provider that submitted the claim. For 2007, the CERT-listed paid claims error rates for diagnostic radiology services ranged from 0 to 7 percent, and provider compliance error rates ranged from 0 to 29 percent depending on the contractor. Error rates for this report are based on a methodology different from the methodology used by CERT.

Previous OIG Work

The Office of Inspector General (OIG) issued a report in July 1993 entitled *Medicare's Payment for Interpretations of Hospital Emergency Room X-rays* (OEI-02-89-01490). The report found that in 44 percent of the cases, radiologists reinterpreted sampled x-rays at least 1 day after the emergency departments discharged the patients. These reinterpretations had no effect on the treatments provided to beneficiaries, and OIG recommended that these be treated and reimbursed as part of the hospitals' quality assurance programs.

METHODOLOGY

Scope

We evaluated whether claims allowed in 2008 for interpretation and reports of diagnostic radiology services performed in hospital outpatient

[14] The physician specialty (i.e., emergency department physician or radiologist) has no bearing upon which claim is paid. CMS, *Medicare Claims Processing Manual* (Internet-only manual), Pub. 100-04, ch. 13, § 100.1 Accessed at http://www.cms.gov/Manuals/IOM/list.asp on August 29, 2010. Radiologists provided interpretation and reports for 97 percent of x-rays and 99 percent of CTs and MRIs for beneficiaries in hospital outpatient emergency departments.

[15] 60 Fed. Reg. 63130–63133 (Dec. 8, 1995).

emergency departments met two Medicare payment requirements—namely, that: (1) physicians' orders for the services be present and (2) interpretation and reports be documented in the medical record. Although contemporaneity is not a requirement, we determined the percentage of interpretations that were performed after beneficiaries left the hospital outpatient emergency department. Based on prior OIG work in this area, we determined that interpretations performed after the patient was discharged from the emergency room may not have contributed to beneficiaries' diagnosis and treatment. We did not evaluate the proper coding or medical appropriateness of diagnostic radiology services associated with claimed interpretation and reports. Finally, we determined whether the interpretation and reports followed suggested documentation practice guidelines promoted by the American College of Radiology, although we did not question the appropriateness of claims for services that did not follow these practice guidelines.

Data Sources

Medicare outpatient claims identification. We used the 2008 National Claims History Standard Analytical File to identify 46 million Medicare outpatient claims allowed from 10.8 million hospital emergency department visits not resulting in inpatient stays.[16, 17] From these 46 million claims, we identified claims that (1) were for diagnostic radiology services;[18] (2) included modifier 26, indicating the professional component; (3) included codes 22 or 23 for place of service, indicating outpatient or emergency department settings; and (4) included Healthcare Common Procedure Coding System (HCPCS) codes in the range of 70010–76140, indicating interpretation and reports of CTs, MRIs, and x-rays.[19] This yielded a total of 9.6 million Medicare-allowed claims (for a total of $215 million) for interpretation and reports in hospital outpatient emergency departments. Of these, Medicare allowed 3 million claims (for a total of $151 million) for interpretation

[16] We included claims with the following Ambulatory Payment Classifications: 00609, 00613, 00614, 00615, or 00616.

[17] Allowed claims were for services performed up to 2 days after the beneficiary's discharge from the hospital outpatient emergency department because nearly all claims for interpretation and reports were created within 2 days of discharge.

[18] We included claims with the following Revenue Centers: 320, 321, 322, 323, 324, 329, 350, 351, 359, 610, 611, 612, or 619.

[19] We consulted with a practicing board-certified radiologist to identify which HCPCS codes to include.

and reports of CTs and MRIs and 6.6 million claims (for a total of $64 million) for interpretation and reports for x-rays.

Sample selection. From the 9.6 million claims that we identified for interpretation and reports, we selected two simple random samples of claims for our review. The first sample included 220 CT and MRI claims, and the second sample included 220 x-ray claims. See Table 1 for population and sample statistics.

Table 1: Population and Sample Claims

Stratum	Claims in Population	Sample Size
CT and MRI claims	2,979,761*	220
X-ray claims	6,618,103	220
Total	**9,597,864**	**440**

* Of the 2,979,761 claims, 2,906,441 were for CTs and 73,320 were for MRIs.
Source: OIG analysis of claims data, 2010.

Documentation request. We requested medical record documentation from facilities that provided care to Medicare beneficiaries on the sampled dates of service. This request included all documentation (including physicians' orders) relevant to diagnostic radiology services, and interpretation and reports for those services provided in hospital outpatient emergency departments.

To request medical documentation necessary to conduct this study, we contacted—up to three times, if needed—the facilities where claimed services were provided. Although we established contact with all facilities, we had five sampled claims for which none of the corresponding five facilities provided the documentation we requested.[20] We will forward these claims to CMS for appropriate action. Because we made contact with these five facilities, we determined the five claims from these facilities to be undocumented for the purposes of our study. Therefore, we consider our response rate to be 100 percent.

Analysis

We created a document review instrument (see Appendix A) to guide our review of the medical records to ensure that all information was

[20] The OEI Medical Review Policy, June 2006, recommends treating sampled claims as undocumented/unsubstantiated services when contact was made with providers but OEI never received the corresponding medical records.

captured and that all reviews were consistent. During development of the document review instrument, we conducted structured interviews with officials from the CMS central office and staff for all 10 MACs to ensure that we included relevant questions. To pretest the document review instrument, we conducted documentation reviews of 24 medical records with staff from two hospitals, including radiologists, emergency department physicians, and compliance officers.[21]

We reviewed documentation from medical records for all sampled claims to determine whether interpretation and reports (1) were ordered by physicians, (2) were present in the medical record, (3) were performed contemporaneously with (i.e., at the same time as) diagnoses and treatments of beneficiaries in the hospital outpatient emergency departments, and (4) followed suggested documentation practice guidelines promoted by the American College of Radiology. To determine whether interpretation and reports were performed contemporaneously with beneficiaries' diagnoses and treatments, we used the dictated dates and times on the interpretation and reports and evaluated physicians' notes for clinical findings and/or consultations with the radiologists.

We considered claims erroneous if (1) physicians' orders were not part of the medical record documentation or (2) documentation did not support that interpretation and reports were performed. Although lack of contemporaneity does not solely determine whether a claim is erroneous in instances in which a single claim is submitted, we sought to determine whether interpretation and reports were performed contemporaneously with beneficiaries' diagnoses and treatments in hospital outpatient emergency departments. To establish contemporaneity, we determined primarily whether interpretation and reports were dictated after beneficiaries left hospital outpatient emergency departments. In the absence of documented dictation times on interpretation and reports, we looked for other documentation in the medical records that clearly indicated that information from the interpretation and reports was communicated after beneficiaries left hospital outpatient emergency departments.

As an additional component of our medical record documentation review, we determined the extent to which interpretation and reports contained information consistent with suggested practice guidelines and

[21] These medical records were not included in our final sample.

technical standards for documentation for interpretation and reports from the American College of Radiology. We used these suggested practice guidelines because CMS has not established minimum documentation standards for interpretation and reports.[22] We were able to determine whether practice guidelines were followed for the 194 CT and MRI claims and for the 202 x-ray claims that included documentation of the interpretation and reports.

We projected our findings to the population of Medicare claims listed in Table 1. See Appendix B for point estimates and confidence intervals.

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

[22] The American College of Radiology Practice Guidelines and Technical Standards are educational tools designed to provide consensus-based, scientifically valid, and medically credible information to assist health care providers in delivering effective, efficient, consistent, and safe medical care. Accessed at http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines.aspx on October 1, 2010. Although OIG used industry-suggested documentation practice guidelines and technical standards in this study, it does not constitute endorsement or official Federal guidance.

In 2008, Medicare claims for interpretation and reports of 19 percent of CTs and MRIs and 14 percent of x-rays in hospital outpatient emergency departments were erroneous because of insufficient documentation

Of the 3 million claims allowed for interpretation and reports of CT and MRI services in 2008, Medicare erroneously allowed 19 percent. Medicare allowed $29 million for interpretation and reports that did not have physicians' orders as part of the medical record documentation and/or did not have documentation to support that interpretation and reports were performed (see Table 2).

Table 2: Erroneous Claims and Amounts for CT and MRI Interpretation and Reports

Type of Error	Claims (percentage)	Allowed Amount
Did not have physicians' orders as part of the medical record documentation	11.8	$17,619,327
Did not have documentation to support that interpretation and reports were performed	11.8	$18,591,135
Total errors (gross)	**23.6**	**$36,210,462**
(Overlapping errors)	4.5	$7,257,343*
Total errors (net)	**19.1**	**$28,953,119**

* Relative precision exceeds 50 percent; the 95-percent confidence interval for this estimate is $2,602,939–$11,911,747.
Source: OIG medical review of 2008 claims.

Of the nearly 6.6 million claims allowed for interpretation and reports of x-ray services in 2008, Medicare erroneously allowed 14 percent. Medicare allowed almost $9 million for interpretation and reports that did not have physicians' orders as part of the medical record documentation or did not have documentation to support that interpretation and reports were performed (see Table 3).

Table 3: Erroneous Claims and Amounts for X-Ray Interpretation and Reports

Type of Error	Claims (percentage)	Allowed Amount
Did not have physicians' orders as part of the medical record documentation	8.6	$5,448,504
Did not have documentation to support that interpretation and reports were performed	8.2	$5,418,121
Total errors (gross)	**16.8**	**$10,866,624**
(Overlapping errors)	2.7	$1,889,468*
Total errors (net)	**14.1**	**$8,977,156**

*Relative precision exceeds 50 percent; the 95-percent confidence interval for this estimate is $361,541–$3,417,396.
Source: OIG medical review of 2008 claims.

Physicians' orders were not present in medical record documentation for 12 percent of CT and MRI claims and 9 percent of x-ray claims

Medicare allowed almost $18 million for interpretation and report claims of CTs and MRIs not supported by documented physicians' orders. Medicare allowed $5 million for interpretation and report claims of x-rays that did not have documented physicians' orders. As a condition for Medicare payment for these services, medical records must include documented physicians' orders.

Documentation was not provided to support that interpretation and reports were performed for 12 percent of CT and MRI claims and 8 percent of x-ray claims

Medicare allowed almost $19 million for undocumented interpretation and reports of CTs and MRIs. Medicare allowed $5 million for undocumented interpretation and reports of x-rays. The Act states that as a condition for Medicare payment, providers must furnish appropriate information about the service (i.e., documentation to support that the service was performed).

In 2008, Medicare paid for interpretation and reports performed for 16 percent of x-rays and 12 percent of CTs and MRIs after beneficiaries left emergency departments

CMS's guidance on payment for interpretation of diagnostic tests furnished to emergency room patients offers inconsistent direction regarding whether interpretations are payable only if they were performed while patients were in the emergency room.

According to CMS guidance, if claims processing contractors receive multiple billing claims from, for example, the emergency room physician and the radiologist, contractors are to pay only for the interpretation performed "at the same time" as the diagnosis and treatment of the beneficiary in the emergency room. However, if only one claim is received, contractors are not required to confirm that the interpretation was performed while the beneficiary was in the emergency department.[23]

Interpretation and reports for 16 percent of x-rays were performed after beneficiaries left hospital outpatient emergency departments

Medicare allowed more than $10 million for interpretation and reports of x-rays that were performed after beneficiaries left hospital outpatient emergency departments. These interpretations may not have contributed to the diagnosis and treatment of beneficiaries, given prior OIG work questioning the value of interpretations performed after patients were discharged from the emergency room. We identified more than $7.5 million of these claims that did not overlap with the erroneous payments previously described in Table 3. In one example, a beneficiary was discharged with the emergency department physician indicating a "possible fibular head fracture." However, documentation indicated that the radiologist's interpretation and report was not performed until the following day. In another example, the beneficiary was discharged from the hospital at 9:53 p.m., but the x-ray was not interpreted until 9:45 a.m. the following day.

For 25 percent of x-ray claims, contemporaneity was difficult to establish because documentation in the medical record on dictation times was incomplete. In one medical record, the emergency department notes included an interpretation of a chest x-ray; however,

[23] CMS, *Medicare Claims Processing Manual* (Internet-only manual), Pub. 100-04, ch. 13, § 100.1. Accessed at http://www.cms.gov/Manuals/IOM/list.asp on October 1, 2010.

the record said: "[T]he radiologist will read this later. If there is any significance to that, we will notify the patient." This documentation suggests that the treating physician was preparing to discharge the beneficiary prior to receiving the report from radiology. Although the final interpretation and report was included in the medical record and was dictated on the same day as the beneficiary's emergency room visit, it was difficult to determine whether the radiologist verbally communicated the interpretation and report to the treating physician prior to discharge.

Interpretation and reports for 12 percent of CTs and MRIs were performed after beneficiaries left hospital outpatient emergency departments

Medicare allowed more than $19 million for interpretation and reports of CTs and MRIs that were performed after beneficiaries left hospital outpatient emergency departments. Presumably, these interpretation and reports did not contribute to beneficiaries' diagnoses and treatments. We identified $5.4 million of these claims that did not overlap with the erroneous payments previously described in Table 2. For 27 percent of CT and MRI claims, contemporaneity was difficult to establish because documentation in the medical record on dictation times was incomplete.

Interpretation and reports for 71 percent of x-rays and 69 percent of CTs and MRIs in hospital outpatient emergency departments did not follow one or more suggested documentation practice guidelines promoted by the American College of Radiology

Of the 9.6 million x-ray, CT, and MRI claims allowed, interpretation and reports did not follow suggested documentation practice guidelines for 71 percent of x-ray claims and 69 percent of CT and MRI claims. At the time of our review, CMS had not established minimum documentation standards for interpretation and reports of diagnostic radiology services. However, the American College of Radiology provides suggested practice guidelines for documentation of interpretation and reports as an educational tool to help practitioners deliver effective, efficient, consistent, and safe medical care. While the American College of Radiology indicates that these guidelines are not inflexible rules or practice requirements and are not intended to establish a legal standard of care, we used some of these practice guidelines, specifically dictation date and time, when available, to establish whether interpretation and reports contributed to diagnoses and treatments through contemporaneity.

Seventy-one percent of interpretation and reports for x-rays did not follow one or more suggested practice guidelines for documentation

Seventy-one percent of interpretation and reports for x-rays did not follow one or more suggested practice guidelines (see Table 4). Although following these practice guidelines is not required, the dictation date and time are essential to establish contemporaneity and to establish that these interpretation and reports were performed while beneficiaries were in hospital outpatient emergency departments. The time of dictation was missing from 25 percent of interpretation and reports, and the date of dictation was missing from 18 percent of interpretation and reports. In certain instances, we had to rely on other documentation to establish contemporaneity. For example, notes in medical records may have indicated that interpretation and reports were communicated by the radiologists to the treating emergency department physicians while beneficiaries were in hospital outpatient emergency departments.

Table 4: American College of Radiology Practice Guidelines for X-Rays

Practice Guidelines	Percentage of Interpretation and Reports for X-Rays That Did Not Follow Suggested Practice Guidelines (n=202)
Time examination performed	48.5
Time report dictated	24.8
Date report dictated	18.3
Referring physician	14.9
Date/time report transcribed	9.9
Date examination performed	1.0
Type of examination performed	0.5
Name of interpreting physician	0.5
Procedures and materials	0.5
Beneficiary identifier	0.0
Findings, limitations, and clinical issues	0.0
Diagnosis, if relevant	0.0
Missing at least one practice guideline	71.3

Source: OIG analysis of claims data, 2010.

Sixty-nine percent of interpretation and reports for CTs and MRIs did not follow one or more suggested practice guidelines for documentation

Sixty-nine percent of interpretation and reports for CTs and MRIs did not follow one or more suggested practice guidelines (see Table 5). Although following these practice guidelines is not required, dictation date and time are critical to establishing that the results of the interpretation and report are communicated in a timely manner to the treating physician in the emergency department. The time of dictation was missing from 27 percent of interpretation and reports, and the date of dictation was missing from 18 percent of interpretation and reports. However, as with interpretation and reports for x-rays, we relied on other documentation to establish contemporaneity.

Table 5: American College of Radiology Practice Guidelines for CTs and MRIs

Practice Guidelines	Percentage of Interpretation and Reports for CTs and MRIs That Did Not Follow Suggested Practice Guidelines (n=194)
Time examination performed	45.4
Time report dictated	26.8
Date report dictated	18.0
Date/time report transcribed	12.9
Referring physician	9.8
Beneficiary identifier	1.0
Date examination performed	1.0
Name of interpreting physician	1.0
Procedures and materials	1.0
Type of examination performed	0.5
Findings, limitations, and clinical issues	0.5
Diagnosis, if relevant	0.5
Missing at least one practice guideline	68.6

Source: OIG analysis of claims data, 2010.

RECOMMENDATIONS

In 2008, Medicare erroneously allowed 19 percent of claims for CT and MRI interpretation and reports in hospital outpatient emergency departments, amounting to nearly $29 million for interpretation and reports that were not documented and/or not ordered by physicians. Medicare erroneously allowed 14 percent of claims for x-ray interpretation and reports in hospital outpatient emergency departments, amounting to nearly $9 million. These claims were erroneous because they were not documented and/or were not ordered by physicians. CMS guidance is inconsistent regarding whether diagnostic radiology interpretations are payable only if they were performed while patients were in the emergency room. We found that 16 percent of interpretation and reports for x-rays and 12 percent of interpretation and reports for CTs and MRIs were provided after beneficiaries left hospital outpatient emergency departments. Prior OIG work has questioned whether radiologists' interpretations of x-rays after patients are discharged from the emergency room contributed to patient care.

Therefore, we recommend that CMS:

Educate providers on the requirement to maintain documentation on submitted claims

CMS should remind providers of the requirement for documentation to support claims for payment. This could include reminding providers about the need for the medical record documentation to include (1) physicians' orders to support diagnostic radiology services performed and (2) complete interpretation and reports.

Adopt a uniform policy for single and multiple claims for interpretation and reports of diagnostic radiology services to require that claimed services be contemporaneous or identify circumstances in which noncontemporaneous interpretations may contribute to the diagnosis and treatment of beneficiaries in hospital outpatient emergency departments

CMS should adopt a clear and uniform policy that requires paid claims to be contemporaneous and to contribute to the diagnosis and treatment of beneficiaries in hospital outpatient emergency departments regardless of whether a single claim or multiple claims are submitted. A uniform policy requiring that interpretation and reports be contemporaneous with, or, if not contemporaneous, demonstrably contribute to the beneficiary's diagnosis and treatment could reduce unexplained complexity in what is already a complicated billing system for medical diagnostics.

We understand, however, that diagnosis and treatment may be informed by interpretation of the radiology services after emergency department encounters. As such, CMS should clearly define exceptions for which noncontemporaneous interpretations may contribute to the diagnosis and treatment of patients after they leave the emergency department. As one possibility, CMS may wish to consider requiring modifiers to track instances in which emergency department diagnostic interpretations were performed after patients were discharged from emergency department care.

Take appropriate action on the erroneously allowed claims identified in our sample

We will forward information on the erroneously allowed claims identified in our sample to CMS in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS concurred with the first and third recommendations. CMS did not concur with the second recommendation.

CMS stated that it would continue to monitor and refine its oversight of diagnostic radiology services. In addition, CMS will request a meeting with the American College of Radiology to review its suggested practice guidelines for the documentation of interpretation and reports of CTs, MRIs, and x-rays administered to patients in outpatient emergency departments.

In response to the first recommendation, CMS indicated that it will issue an educational article to the provider community to emphasize that documentation requirements will be enforced.

In response to the third recommendation, CMS indicated that upon receipt of the files from OIG, it will take appropriate action, including forwarding the list of questionable claims to the Recovery Audit Contractor and MACs. CMS will instruct the MACs to consider this issue when prioritizing their medical review strategies or other interventions.

In response to the second recommendation, CMS did not concur. CMS indicated that it does not believe that a single billed interpretation must, in all cases, be contemporaneous with the beneficiary's diagnosis and treatment to contribute to that diagnosis and treatment. CMS

further indicated that continued diagnosis and treatment can extend beyond the emergency encounter to other followup settings.

We agree that diagnosis and treatment may extend to other settings subsequent to the emergency department encounter. We maintain, however, that payment rules should uniformly require that an interpretation and report on an emergency department x-ray be contemporaneous with the beneficiary's diagnosis and treatment. Or, if interpretations are not contemporaneous, they should satisfy some other criteria demonstrating the interpretations' contribution to patient care. CMS's current payment policy applies requirements inconsistently in different situations. When a MAC receives multiple claims for the interpretation and report of an emergency department x-ray, it pays only for the interpretation and report that was contemporaneous with, and directly contributed to, the diagnosis and treatment of the beneficiary. Any other interpretation and report is treated as part of the hospital's quality assurance program. In contrast, when a MAC receives only a single interpretation and report claim in connection with an emergency department x-ray, current policy drops the requirement for contemporaneity and contribution altogether. The MAC must presume that the one service billed was a medical service to the individual and not quality assurance and pays the claim if it otherwise meets any applicable reasonable and necessary test. This inconsistency is not explained, nor do we believe the underlying rationale is obvious. We have revised the language of the second recommendation to clarify what we are recommending.

The full text of CMS's comments can be found in Appendix C.

APPENDIX ~ A

Document A: Document Review Instrument

Diagnostic Radiology Services 07-09-00450
Document Review Instrument

Sample number: Beneficiary last name:

Claims Information

Claim Date: Date of hospital visit (Date RCA):

Diagnosis Code Procedure Code Place of Service

Documentation Information

Time of hospital visit: ◯ Not Documented Date of hospital visit: ☐ Procedure code in record matches claim

Was there evidence that the claimed service was ordered by the treating physician?

Were treating physician's notes located in the medical record?

Is there evidence in the medical record that the interpreting physician communicated the I&R to the treating physician contemporaneous with the diagnosis and treatment of the beneficiary?

Please describe:

Interpretation & Report (I&R) Information

Was the Final I&R located in the medical record? If yes, was the I&R a separate and distinct document?

Was the (preliminary) I&R performed by a third party?

Was the beneficiary's diagnosis and treatment based on a preliminary or final I&R?

Was the I&R performed the during the beneficiary's hospital visit? (Date RCA)

If no, how much time elapsed between the date of the I&R and the beneficiary's discharge?

[The final report is considered to be the definitive means of communicating to the referring physician the results of an imaging procedure. The final report should be transmitted to the referring physician or health care provider who provides the clinical follow-up. Routine reporting of imaging findings is communicated through the usual channels established by the hospital or diagnostic imaging facility. However, in emergent clinical situations, all non-routine communications should be documented and include the time and method of communication and specifically name the person to whom the communication was made. Documentation preserves a history for the purpose of substantiating certain findings or events.]

Within the Final I&R (check all that apply; provide notes if relevant):

☐ (1) name of the patient and other identification such as birth date and Social Security number,

☐ (2) name of requesting (referring, if no requesting) physician, if any,

☐ (3) name or type of examination performed,

☐ (4) date on which the scan was performed,

☐ (4a) time the scan was performed,

☐ (5) date of dictation,

☐ (5a) time of dictation,

☐ (6) date and/or time of transcription,

☐ (7) name of the interpreting physician,

☐ (8) procedures and materials,
[includes a description of the studies and/or procedures performed and any contrast media (including concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere]

☐ (9) findings, limitations, clinical issues, and
[The report should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings. The report should, when appropriate, identify factors that may compromise the sensitivity and specificity of the examination. The report should address or answer any specific clinical questions. If there are factors that prevent answering of the clinical question, this should be stated explicitly.]

☐ (10) diagnosis (ICD-9).
[Unless the report is brief, each report should contain an "impression" section. A precise diagnosis should be given when possible. Follow-up or additional diagnostic studies to clarify or confirm the impression.]

Please provide any necessary clarification here:

APPENDIX ~ B

Table B: Point Estimates and Confidence Intervals

Description	Sample Size (n)	Point Estimate	95-Percent Confidence Interval
Percentage of allowed claims lacking documented physicians' orders for interpretation and reports of computed tomography (CT) and magnetic resonance imaging (MRI)	220	11.8	7.5–16.1
Allowed amount of claims lacking documented physicians' orders for interpretation and reports of CTs and MRIs	220	$17,619,327	$10,954,812–$24,283,841
Percentage of allowed claims for interpretation and reports for CTs and MRIs that were not documented	220	11.8	7.5–16.1
Allowed amount of claims for interpretation and reports for CTs and MRIs that were not documented	220	$18,591,135	$11,620,055–$25,562,216
Percentage of allowed claims for CTs and MRIs that were not documented or lacked physicians' orders (gross)	220	23.6	16.7–30.6
Allowed amount of claims for CTs and MRIs that were not documented or lacked physicians' orders (gross)	220	$36,210,462	$24,959,322–$47,461,602
Percentage of allowed claims for CTs and MRIs that were not documented or lacked physicians' orders (overlapping)	220	4.5	1.8–7.3
Allowed amount of claims for CTs and MRIs that were not documented or lacked physicians' orders (overlapping)	220	$7,257,343	$2,602,939–$11,911,747
Percentage of allowed claims for CTs and MRIs that were not documented or lacked physicians' orders (net)	220	19.1	13.9–24.3
Allowed amount of claims for CTs and MRIs with no documented physicians' orders or having undocumented interpretation and reports (net)	220	$28,953,119	$20,756,618–$37,149,619
Percentage of allowed claims with no documented physicians' orders for interpretation and reports of x-rays	220	8.6	4.9–12.4
Allowed amount of claims with no documented physicians' orders for interpretation and reports of x-rays	220	$5,448,504	$3,054,537–$7,842,471
Percentage of allowed claims for interpretation and reports for x-rays that were not documented	220	8.2	4.5–11.8
Allowed amount of claims for interpretation and reports for x-rays that were not documented	220	$5,418,121	$2,952,704–$7,883,537
Percentage of allowed claims for interpretation and reports for x-rays that were not documented or lacked physicians' orders (gross)	220	16.8	10.9–22.7
Allowed amount of claims for interpretation and reports for x-rays that were not documented or lacked physicians' orders (gross)	220	$10,866,624	$6,922,264–$14,810,985
Percentage of allowed claims for interpretation and reports for x-rays that were not documented or lacked physicians' orders (overlapping)	220	2.7	0.6–4.9
Allowed amount of claims for interpretation and reports for x-rays that were not documented or lacked physicians' orders (overlapping)	220	$1,889,468	$361,541–$3,417,396
Percentage of allowed claims for interpretation and reports for x-rays that were not documented or lacked physicians' orders (net)	220	14.1	9.5–18.7

continued on next page

Table B: Point Estimates and Confidence Intervals, Continued

Description	Sample Size (n)	Point Estimate	95-Percent Confidence Interval
Allowed amount of claims for interpretation and reports for x-rays that were not documented or lacked physicians' orders (net)	220	$8,977,156	$5,972,273–$11,982,039
Percentage of allowed claims for interpretation and reports for x-rays that were not contemporaneous with beneficiaries' diagnoses and treatments in hospital outpatient emergency departments	220	15.9	11.0–20.8
Allowed amount of claims for interpretation and reports for x-rays that were not contemporaneous with beneficiaries' diagnoses and treatments in hospital outpatient emergency departments	220	$10,170,821	$6,977,447–$13,364,195
Allowed amount of claims for x-rays that were not contemporaneous and did not overlap with those claims with no documented physicians' orders or having undocumented interpretation and reports	220	$7,575,923	$4,754,169–$10,397,677
Percentage of allowed claims for interpretation and reports for CTs and MRIs that were not contemporaneous with beneficiaries' diagnoses and treatments in hospital outpatient emergency departments	220	11.8	7.5–16.1
Allowed amount of claims for interpretation and reports for CTs and MRIs that were not contemporaneous with beneficiaries' diagnoses and treatments in hospital outpatient emergency departments	220	$19,334,315	$11,892,195–$26,776,434
Allowed amount of claims for CTs and MRIs that were not contemporaneous and did not overlap with those claims with no documented physicians' orders or having undocumented interpretation and reports	220	$5,360,725	$838,027–$9,883,424
Percentage of allowed claims for interpretation and reports for x-rays not following at least one suggested practice guideline promoted by the American College of Radiology	202	71.3	65.0–77.6
X-ray interpretation and reports did not follow practice guideline for listing time examination was performed	202	48.5	41.6–55.5
X-ray interpretation and reports did not follow practice guideline for listing time report was dictated	202	24.8	18.8–30.8
X-ray interpretation and reports did not follow practice guideline for listing date report was dictated	202	18.3	12.9–23.7
X-ray interpretation and reports did not follow practice guideline for listing referring physician	202	14.9	9.9–19.8
X-ray interpretation and reports did not follow practice guideline for listing date/time report was transcribed	202	9.9	5.7–14.1
X-ray interpretation and reports did not follow practice guideline for listing date examination was performed	202	1.0	0.2–3.9*
X-ray interpretation and reports did not follow practice guideline for listing type of examination performed	202	0.5	0.1–3.5**
X-ray interpretation and reports did not follow practice guideline for listing name of interpreting physician	202	0.5	0.1–3.5**
X-ray interpretation and reports did not follow practice guideline for listing procedures and materials	202	0.5	0.1–3.5**

continued on next page

Table B: Point Estimates and Confidence Intervals, Continued

Description	Sample Size (n)	Point Estimate	95-Percent Confidence Interval
X-ray interpretation and reports did not follow practice guideline for listing beneficiary identifier	202	0.0	0.0–1.8*
X-ray interpretation and reports did not follow practice guideline for listing findings, limitations, and clinical issues	202	0.0	0.0–1.8*
X-ray interpretation and reports did not follow practice guideline for listing diagnosis, if relevant	202	0.0	0.0–1.8*
Percentage of allowed claims for interpretation and reports for CTs and MRIs that did not follow at least one suggested practice guideline promoted by the American College of Radiology	194	68.6	62.0–75.1
CT and MRI interpretation and reports did not follow practice guideline for listing time examination was performed	194	45.4	38.3–52.4
CT and MRI interpretation and reports did not follow practice guideline for listing time report was dictated	194	26.8	20.5–33.1
CT and MRI interpretation and reports did not follow practice guideline for listing date report was dictated	194	18.0	12.6–23.5
CT and MRI interpretation and reports did not follow practice guideline for listing date/time report was transcribed	194	12.9	8.1–17.6
CT and MRI interpretation and reports did not follow practice guideline for listing referring physician	194	9.8	5.6–14.0
CT and MRI interpretation and reports did not follow practice guideline for listing beneficiary identifier	194	1.0	0.3–4.1**
CT and MRI interpretation and reports did not follow practice guideline for listing date examination was performed	194	1.0	0.3–4.1**
CT and MRI interpretation and reports did not follow practice guideline for listing name of interpreting physician	194	1.0	0.3–4.1**
CT and MRI interpretation and reports did not follow practice guideline for listing procedures and materials	194	1.0	0.3–4.1**
CT and MRI interpretation and reports did not follow practice guideline for listing type of examination performed	194	0.5	0.1–3.6**
CT and MRI interpretation and reports did not follow practice guideline for listing findings, limitations, and clinical issues	194	0.5	0.1–3.6**
CT and MRI interpretation and reports did not follow practice guideline for listing diagnosis, if relevant	194	0.5	0.1–3.6**

*Confidence intervals were calculated with an exact method based on the binomial distribution because the standard method and logit transformation method cannot be used when no sample units possess the characteristic measured.

**Confidence intervals were calculated using the logit transformation because of poor coverage properties of the standard approximation method when a small number of sample units possess the characteristic of interest.

Source: Office of Inspector General analysis of claims data, 2010.

APPENDIX ~ C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 2 2 2010

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payments for Diagnostic Radiology Services in Emergency Departments" (OEI-07-09-00450)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report, "Medicare Payments for Diagnostic Radiology Services in Emergency Departments." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has invested to determine the extent to which Medicare improperly paid claims for diagnostic radiology services.

According to Medicare policy, emergency department physicians and radiologists may be paid for their interpretation and reports for computed tomography (CT), magnetic resonance imaging (MRI) and x-rays. Based on its review of two samples (220 claims each) of 9.6 million 2008 diagnostic radiology claims, OIG concluded that: 1) Medicare claims for interpretation and reports of an estimated 19 percent of CTs and MRIs and an estimated 14 percent of x-rays in hospital outpatient emergency departments were improperly paid due to insufficient documentation; 2) Medicare paid for interpretation and reports made on an estimated 16 percent of x-rays and an estimated 12 percent of CTs and MRIs after beneficiaries left the hospital outpatient emergency departments; and 3) interpretations and reports for an estimated 71 percent of x-rays and an estimated 69 percent of CTs and MRIs in hospital outpatient emergency departments did not follow one or more suggested documentation practice guidelines promoted by the American College of Radiology.

The CMS will continue to monitor and refine our oversight of diagnostic radiology services. OIG made the following recommendations.

OIG Recommendation 1

Educate providers on the requirement to maintain documentation on the submitted claims.

CMS Response

The CMS concurs. CMS will issue an educational article to the provider community to emphasize that documentation requirements will be enforced.

OIG Recommendation 2

Specify payment policy for single claims for interpretation and reports of diagnostic radiology services to require that claimed services contribute to the diagnoses and treatments of beneficiaries in hospital outpatient emergency departments.

CMS Response

The CMS non-concurs with the recommendation. Section 1862(a)(1)(A) of the Social Security Act authorizes the Secretary to only pay for services that are reasonable and necessary, and the language in Section 100.1 of Chapter 13 of Pub. 100-04 requires that the test must be medically reasonable and necessary for the diagnosis and treatment of a beneficiary in the hospital outpatient emergency department. We do not agree that, in all cases, this single billed interpretation must be contemporaneous with the beneficiary's diagnosis and treatment in order to contribute to that diagnosis and treatment. Continued diagnosis and treatment that may be informed by interpretation of the radiology service can extend beyond the emergency department encounter itself to other follow-up settings where additional services are furnished, such as a physician's office.

OIG Recommendation 3

Take appropriate action on the erroneously allowed claims identified in our sample.

CMS Response

The CMS concurs. Upon receipt of the files from OIG, CMS will take appropriate action on the erroneously allowed claims identified in the sample. CMS will forward the listing of questionable claims to the Recovery Audit Contractors (RACs) and Medicare Administrative Contractors (MACs). The RACs review Medicare claims on a post payment basis and are tasked with identifying inappropriate payments. While CMS does not mandate areas for RAC review, we will share this information with them. We will instruct the MACs to consider this issue when prioritizing their medical review strategies or other interventions.

In addition, CMS will request a meeting with the American College of Radiology to review their suggested practice guidelines for the documentation of interpretation and reports of CTs, MRIs and x-rays administered to patients in outpatient emergency departments.

The CMS appreciates OIG's efforts and insight on this report. CMS looks forward to continually working with OIG on issues related to waste, fraud and abuse in the Medicare program.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Deborah Walden, Deputy Regional Inspector General.

Brian T. Whitley served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Dennis Tharp and Amber Meurs; central office staff who contributed include Kevin Manley, Kevin Farber, Julie Taitsman, and Jeff Weinstein.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating practice guidelines:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.