

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**QUESTIONABLE
BILLING PATTERNS OF
PORTABLE X-RAY SUPPLIERS**



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EXECUTIVE SUMMARY

OBJECTIVES

1. To identify portable x-ray suppliers with questionable billing patterns that may be associated with inappropriate Medicare payments.
2. To identify claims for portable x-ray services that may warrant further review.

BACKGROUND

Medicare paid portable x-ray suppliers approximately \$225 million under the Part B benefit in 2009 for x-rays of the extremities, pelvis, spine, skull, chest, and abdomen. Portable x-ray suppliers provide diagnostic imaging services at patients' locations—most often residences, including private homes and group living facilities, such as nursing homes—rather than in a traditional clinical setting, such as a doctor's office or hospital. Medicare pays portable suppliers separately for up to four components of the service: transporting the equipment to the beneficiary's location, setting it up for use, administering the test, and interpreting the results. Eighty percent of the amount Medicare paid to portable suppliers in 2009 reimbursed them for transporting and setting up the x-ray equipment.

Federal regulations stipulate that portable x-rays must be ordered by a licensed medical doctor or doctor of osteopathy who is treating the beneficiary for a specific medical problem and who uses the results of the x-ray in managing it. The order must also state the need for portable services.

Medicare pays for the full transportation component once for each trip to a particular location. For example, if a supplier furnishes chest x-rays to three patients at one nursing home during a single trip, Medicare pays one-third the full transportation component rate for each patient. While it pays the full rate only once per trip, Medicare pays that full rate again for each return trip to a facility on a particular day.

We used Medicare claims data to assess portable x-ray suppliers on eight characteristics we developed that describe questionable billing patterns: (1) portable services ordered by nonphysicians, (2) no recent contact between beneficiary and ordering provider, (3) same-day services in multiple settings, (4) billing for return trips, (5) portable x-rays per beneficiary, (6) beneficiary contact with multiple portable

suppliers, (7) beneficiary use of stationary x-ray services, and (8) beneficiary DME utilization. We also merged these characteristics into a combined score for each supplier describing its overall billing pattern. We then identified thresholds for each characteristic and the combined score, which, if exceeded by a supplier, signified questionable billing. In addition, we analyzed claims data to determine the total amount Medicare paid for portable services ordered by nonphysicians and for apparent return trips to facilities.

FINDINGS

Twenty portable x-ray suppliers exhibited questionable billing patterns. We identified 20 suppliers that exceeded thresholds on at least 2 of the characteristics of questionable billing we developed and exceeded the threshold for the combined score. Thirteen of these suppliers were located in the Miami, Florida, area.

Medicare paid portable x-ray suppliers approximately \$12.8 million for return trips to nursing facilities. As a typical example, one supplier submitted a claim for the full transportation component for each of two beneficiaries on a particular day (rather than one-half of the full transportation component for two beneficiaries on a particular day) and each claim was paid at the full rate. However, data show that these two beneficiaries were located in the same nursing home on that date. Claims data do not provide sufficient information to determine whether the supplier billed correctly for two separate trips to the facility or whether the supplier administered tests to the two beneficiaries during a single trip and incorrectly claimed full reimbursement of the transportation component for each beneficiary.

Medicare paid at least \$6.6 million for portable x-ray services that were ordered by nonphysicians and therefore not covered. Nurse practitioners ordered \$4.3 million of these services, while physician assistants and podiatrists ordered \$1 million and \$900,000, respectively. Registered nurses, chiropractors, and other medical professionals accounted for the remainder. Medicare paid an additional \$5.9 million for services for which we could not determine the credentials of the ordering providers.

RECOMMENDATIONS

Portable x-rays constitute a small portion of overall Medicare payments for diagnostic imaging services, but the questionable claims patterns we found raise concerns about the integrity of payments to certain suppliers. Furthermore, payments for portable services ordered by nonphysicians clearly violate Federal regulations and should be recovered. Lastly, payments for return trips to facilities, while not necessarily inappropriate, may represent an additional opportunity for program savings. Therefore, we recommend that CMS:

Take appropriate action on portable x-ray suppliers referred by the Office of Inspector General.

Establish a process to periodically identify portable x-ray suppliers that merit greater scrutiny and follow up as appropriate.

Determine what portion of the \$12.8 million it paid for return trips in 2009 actually reimbursed suppliers for incorrectly billed transportation component claims and collect overpayments where appropriate.

Collect the \$6.6 million in overpayments for portable x-ray services rendered in 2009 that were ordered by nonphysicians.

Implement procedures to ensure that it pays for portable x-ray services only when ordered by a physician and establish appropriate controls.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations. CMS stated that since the draft report was issued, it has embarked on a new fraud prevention initiative to help identify suspect fee-for-service claims, including the kinds of questionable billing described in this report. CMS also stated that it is leveraging internal data and publicly available information to strengthen its provider-screening process. CMS further indicated that it is revising the *Medicare Benefit Policy Manual* to be consistent with the regulations that would preclude Medicare from paying for portable x-ray services that are not ordered by a licensed medical doctor or doctor of osteopathy.

For the full text of CMS's comments, see Appendix D.



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OBJECTIVES

1. To identify portable x-ray suppliers with questionable billing patterns that may be associated with inappropriate Medicare payments.¹
2. To identify claims for portable x-ray services that may warrant further review.

BACKGROUND

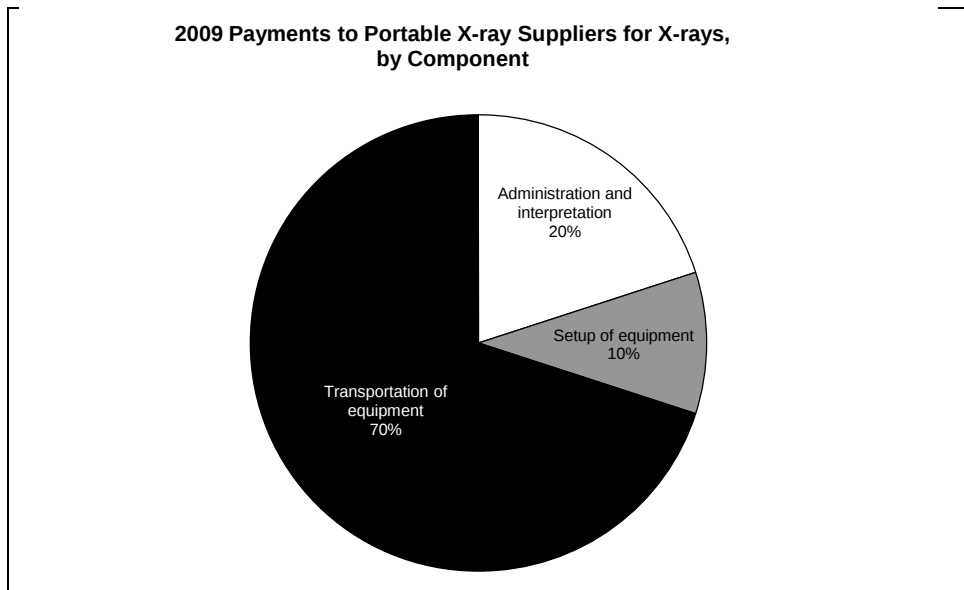
Medicare paid portable x-ray suppliers approximately \$225 million under the Part B benefit for x-rays rendered in 2009. Portable x-ray suppliers provide diagnostic imaging services at patients' locations—most often residences, including private homes and group living facilities, such as nursing homes—rather than in a traditional clinical setting, such as a doctor's office or hospital. The supplier transports mobile diagnostic imaging equipment to the patient's location, sets up the equipment, and administers the test onsite. The supplier may interpret the results itself or it may provide the results to an outside physician for interpretation.

Only 20 percent of 2009 Medicare payments to portable x-ray suppliers, \$44 million, was for administering the test and interpreting the results, services for which portable suppliers are paid the same rates as stationary x-ray providers. The remaining 80 percent, \$181 million, reimbursed suppliers for transporting the equipment to the beneficiary's location and setting it up for use (see Figure 1). On average, Medicare paid approximately \$17 for administration and interpretation and \$80 for transportation and setup of each portable x-ray in 2009, a substantial premium over the cost of the stationary service. Nevertheless, to the extent beneficiaries would otherwise require medical transportation to a stationary x-ray provider, portable x-rays may represent a cost savings to Medicare. If a portable x-ray patient had qualified for and received nonemergency ambulance transportation to a stationary provider instead of receiving the portable service,

¹ Payments (also known as reimbursed amounts) refer to the amount paid for a covered service after the deductible and coinsurance amounts have been deducted. Centers for Medicare & Medicaid (CMS), *Glossary*. Accessed at <http://www.cms.gov/apps/glossary/search.asp?Term=payment&Language=English> on May 16, 2011.

Medicare would have paid the same \$17 to the stationary provider for administration and interpretation, but \$119 (on average) to the ambulance company for transportation.²

FIGURE 1
Most payments to portable x-ray suppliers are for transporting the equipment.



Source: Office of Inspector General (OIG) analysis of 2009 Medicare National Claims History weekly carrier data, 2011.

Medicare coverage of portable x-ray services is governed by Federal laws and regulations and CMS policy. The Code of Federal Regulations (CFR) provides licensing, registration, staffing, and safety requirements for portable x-ray suppliers.³ In particular, 42 CFR § 486.106 requires that portable x-rays be ordered by a physician, defined by that regulation as a licensed medical doctor (MD) or doctor of osteopathy (DO). The order must specify, in writing, both the reason for the x-ray service and the need for portable services. Portable x-rays, like all diagnostic tests, also “must be ordered by the physician who is treating the beneficiary ... and who uses the results in the management of the beneficiary’s specific medical problem.”⁴ The *Medicare Benefit Policy Manual* limits reimbursable portable x-rays to those of the extremities, pelvis, spine, skull, chest, and abdomen (collectively referred to hereafter as “covered x-rays”).⁵ Portable x-ray suppliers may also

² OIG analysis of 2009 Medicare National Claims History weekly carrier data, 2010.

³ Applicable regulations are found at 42 CFR § 486.100 through 42 CFR § 486.110.

⁴ 42 CFR § 410.32(a).

⁵ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, § 80.4.3.

furnish electrocardiograms and mammograms,⁶ though these services accounted for less than 1 percent of portable suppliers' Medicare payments for services rendered in 2009.⁷

Billing Procedures for Portable X-Ray Services

The *Medicare Claims Processing Manual* separates portable x-rays into as many as four components for billing and payment purposes.⁸ As with all diagnostic imaging tests, Medicare pays separately for administering the portable x-ray (the technical component) and interpreting the results (the professional component). For portable x-rays, Medicare also pays separately for bringing the equipment to the beneficiary's location (the transportation component) and preparing it for use (the setup component).

Portable x-ray suppliers bill the technical and professional components in the same manner as other diagnostic imaging providers. To bill for the professional or technical component, the supplier submits a billing code to Medicare that identifies the test along with a modifier that specifies which component was furnished (modifier TC for the technical component or modifier 26 for the professional component).⁹ If the supplier furnishes both the technical and professional components (referred to as a global service), it submits a code with neither modifier.¹⁰

The setup and transportation components pertain solely to portable services. To bill for the setup component, the supplier submits one unit of billing code Q0092 for each imaging procedure furnished to the beneficiary (e.g., if the supplier furnishes a chest x-ray and a wrist x-ray, the supplier bills two units of Q0092).¹¹ To bill for the transportation component, the supplier submits a billing code and modifier that, taken together, specify the number of patients to whom the supplier furnished a portable x-ray during a single trip to a particular location. If the supplier used the equipment for one patient during the trip, the supplier bills code R0070 for the transportation component. If the supplier used the equipment for more than one

⁶ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, §§ 80.4.3 and 80.4.5.

⁷ OIG analysis of 2009 Medicare National Claims History weekly carrier data, 2010.

⁸ CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 13, § 90.

⁹ CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, Addendum – MPFSDB Record Layouts, 2008 File Layout and 2009 File Layout, Field #5.

¹⁰ Ibid.

¹¹ CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.13, § 90.4.

patient during the trip, it bills code R0075 for each patient. The supplier also attaches a modifier that further specifies the total number of patients seen at the location during the trip (modifier UN, UP, UQ, UR, or US for two, three, four, five, or six or more patients, respectively).¹²

No modifier or code exists to indicate when a supplier makes a return trip to a particular location on a given day, which creates ambiguity in the claims data. For example, a supplier might bill R0070 for each of two beneficiaries known to be at the same location on a given day. This could represent the correct billing of the transportation component for two separate trips to that location or the miscoding of a single trip during which the supplier saw both beneficiaries.

Payment for Portable X-Ray Services

The Medicare Physician Fee Schedule establishes payment rates for the technical and professional components of diagnostic imaging services. Medicare pays portable x-ray suppliers the same rates for these components as it does other diagnostic imaging providers. The fee schedule also establishes the payment rate for the setup component. Each Medicare claims payment contractor determines the transportation component rate for its jurisdiction based on instructions in the *Medicare Claims Processing Manual*.

Medicare pays each jurisdiction's full transportation rate for R0070 and a prorated portion of the full rate for R0075 based on the modifier submitted. For example, Medicare pays one-fourth the full rate for each instance of R0075 with modifier UQ (four patients). As shown in Table 1, Medicare pays more for the transportation and setup components than it does for the professional and technical components of any of the three diagnostic imaging tests for which portable x-ray suppliers most commonly bill.¹³ This difference is most substantial when a portable x-ray supplier sees only one patient during a trip to a location. In that case, Medicare pays at least four times as much for the transportation and setup of the equipment as it does for the technical and professional components combined.

¹² If a supplier sees more than six patients in a single trip to a location, it bills R0075 with the US modifier for each patient, regardless of the actual number of patients seen. CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.13, § 90.3.

¹³ The three x-ray billing codes displayed accounted for approximately 53 percent of the total amount that portable x-ray suppliers billed for covered x-rays in 2009.

TABLE 1
Payment Rates for Common Portable X-Ray Services

Service Description	Billing Code	Modifier	2009 Payment Rate*
Chest x-ray; single view, frontal	71010	Technical Component (TC)	\$14.79
		Professional Component (26)	\$ 9.02
Chest x-ray; two views, frontal and lateral	71020	TC	\$20.56
		26	\$11.18
Hip x-ray; complete, minimum two views	73510	TC	\$25.25
		26	\$10.82
Setup component	Q0092	-	\$16.23
Transportation component; one patient	R0070	-	\$145.41
Transportation component; multiple patients	R0075	UN (2 patients)	\$72.71
		UP (3 patients)	\$48.47
		UQ (4 patients)	\$36.35
		UR (5 patients)	\$29.08
		US (6 or more patients)	\$24.24

Source: Medicare Physician Fee Schedule, 2009, and OIG analysis of 2009 Medicare National Claims History Carrier Claims File, 2010.

*The payment rates displayed for the x-rays and setup components are the physician fee schedule national payment amounts for 2009. The payment rates displayed for the transportation component are the median 2009 allowed amounts.

Additional Background

This study was conducted as part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which focuses on reducing health care fraud through the use of innovative data analysis and enhanced cooperation between the Department of Justice (DOJ), Department of Health and Human Services (HHS) OIG, and CMS.¹⁴

METHODOLOGY

To meet our objectives, we used the Medicare National Claims History weekly carrier data (hereafter, Part B data); nursing home stay information in the Minimum Data Set (MDS); and Medicare Skilled Nursing Facility (SNF), Inpatient, Outpatient, Hospice, and Durable Medical Equipment (DME) National Claims History Standard Analytic

¹⁴ DOJ and HHS, *HEAT Task Force Success*. Accessed at <http://www.stopmedicarefraud.gov/heatsuccess/index.html> on January 19, 2011.

I N T R O D U C T I O N

File data for services rendered in 2008 and 2009.¹⁵ We also used National Plan and Provider Enumeration System (NPPES) data, which link Medicare providers' names, addresses, and other information to their National Provider Identifiers (NPI), to identify the suppliers and ordering entities reported on claims.

To focus on suppliers that regularly billed Medicare for portable x-ray services, we used the following process to define our study population. First, we identified all 2009 Part B claims billed with specialty code 63, which identifies the service provider as a portable x-ray supplier. There were 521 such suppliers in this set of claims. Next, we identified all claims from these suppliers for covered x-rays by examining the billing codes on the claims. We then identified all claims for the transportation or setup components billed by the same supplier for the same beneficiary on the same day as a covered x-ray. Lastly, we summarized these transportation and setup component claims by supplier to determine the amount that each supplier billed for these components for a covered x-ray. We selected the 352 suppliers that billed at least \$1,000 for the transportation and setup components to be our population.

We used the claims data to calculate eight characteristics that represent questionable claims patterns for each supplier. Based on conversations with CMS staff and OIG investigators, prior experience in other payment areas, and our own professional judgment, we determined that these characteristics may be associated with inappropriate Medicare payments for portable x-rays. The characteristics generally reflected situations that occurred rarely in the population, but, with one exception (portable services ordered by nonphysicians), were not necessarily inappropriate. Analysis of these characteristics are meant to identify suppliers that merit greater scrutiny, not to provide conclusive evidence of improper payments. The eight characteristics are briefly described below; Appendix A provides a full description of all characteristics and the process for selecting them.

- o Portable services ordered by nonphysicians. This characteristic represents the percentage of each supplier's charges for portable

¹⁵ At the time we conducted our analysis, claims received through March 24, 2010, were the most recent available. These claims represent approximately 98 percent of the total payments made through December 2010 to portable x-ray suppliers for services rendered in 2009.

services that was ordered by entities that lack MD or DO credentials. Federal regulations require that Medicare portable x-ray services be ordered by a licensed MD or a licensed DO.

- o *No recent contact between beneficiary and ordering provider.* This characteristic represents the percentage of each supplier's charges that was for a service when the beneficiary had not seen the ordering provider within 6 weeks prior to the service. By regulation, all diagnostic tests must be ordered by the physician treating the beneficiary and the results must be used by the ordering physician to treat a specific medical problem.¹⁶ We expect that a claim for service from the ordering provider would generally precede the portable x-ray by a reasonably short period—we used 6 weeks to be conservative. Additionally, prior OIG work has shown that apparent lack of contact between an ordering provider and the beneficiary may predict improper activity in other benefit areas.
- o *Same-day services in multiple settings.* This characteristic represents the percentage of each supplier's portable services that occurred on a day on which the beneficiary also had services in a clinical setting (e.g., office or hospital). Pursuant to Federal regulations, a beneficiary must have a specific need for portable services documented by the ordering physician.¹⁷ Logically, if the beneficiary received services in a clinical setting on a particular day, the need for portable services is less clear than if all services on that day were rendered at the beneficiary's location. We excluded claims for services and items for which the beneficiary is not normally physically present at the place of service (e.g., laboratory services) from this analysis.
- o *Billing for return trips.* This characteristic represents the percentage of each supplier's Medicare payments related to transportation component claims that appear to be billed for a trip to a facility already visited that day. While a supplier may legitimately make multiple trips to a facility, it is also financially advantageous for the supplier to see all beneficiaries at a location in a single trip, but bill as if it made a separate trip for each. Additionally, a supplier that

¹⁶ 42 CFR § 410.32.

¹⁷ 42 CFR § 486.106.

submitted fictitious claims using fraudulently acquired beneficiary numbers might be unaware that the beneficiaries were collocated.

- o Portable x-rays per beneficiary. This characteristic represents the average number of covered x-rays each supplier billed for its beneficiaries in 2009. Suppliers that submit an unusually large number of x-rays compared to the number submitted by their peers could be billing for medically unnecessary tests or services not rendered.
- o Beneficiary contact with multiple portable suppliers. This characteristic represents the percentage of each supplier's beneficiaries who also appeared on claims from another portable x-ray supplier in 2009. Preliminary data analysis showed that few beneficiaries received portable services from more than one supplier. Therefore, a large percentage with this characteristic may signify inappropriate patient sharing.
- o Beneficiary use of stationary x-ray services. This characteristic represents the percentage of beneficiaries who received frequent x-rays from both portable x-ray suppliers and stationary providers in 2009. First, we identified the 10 covered x-ray codes most frequently billed by portable x-ray suppliers as a whole. These 10 services accounted for 75 percent of the total allowed charges for x-rays from suppliers in our population in 2009. We then determined the percentage of each portable x-ray supplier's beneficiaries for whom both the supplier and a stationary x-ray provider submitted a claim for any of these services. If a large percentage of a portable supplier's beneficiaries also get stationary services, it may indicate that the supplier is billing for medically unnecessary services or services not rendered.
- o Beneficiary DME utilization. This characteristic represents the average amount billed in 2009 for any DME item by any entity for each beneficiary of a portable x-ray supplier. DME is a frequently abused benefit, and if a supplier's beneficiaries receive unusually large amounts of DME compared to those of other suppliers, it could indicate that the supplier is billing using compromised beneficiary numbers.

We used these eight characteristics to evaluate suppliers' billing patterns. First, we analyzed the distribution of each characteristic to establish thresholds that signify questionable billing. Next, we determined the number of characteristics on which each supplier

surpassed the related threshold. Then we combined the eight characteristics to create a score for each supplier that we used to compare suppliers' overall patterns of questionable billing (referred to hereinafter as the combined score). We analyzed the distribution of the combined score to establish a "questionable" threshold in the same manner as for the individual characteristics. Finally, to focus on the suppliers most likely to be associated with inappropriate payments, we set criteria to identify suppliers that exhibited questionable billing patterns. To be selected, a supplier had to exceed thresholds for at least two individual characteristics and the threshold on the combined score.

In addition to evaluating the supplier-level characteristics, we conducted two related analyses of claims for portable x-ray services as a whole to identify individual claims that may warrant further review. First, we matched the Part B data to the NPPES data to determine the credentials of the ordering provider on each claim and then calculated the amount Medicare paid for services ordered by nonphysicians. The methodology for this analysis was identical to that for the characteristic "Portable services ordered by nonphysicians," except that we applied it to the entire set of claims billed by suppliers in our population.

Second, we applied the methodology we used for the characteristic "Billing for return trips" to claims from our entire population to determine the total amount Medicare paid portable x-ray suppliers for return trips. That is, we matched the Part B and MDS data to identify the nursing facility, if any, where each beneficiary was located on the day of the service.¹⁸ We then determined the number of trips the supplier appeared to have made to each facility each day based on the codes and modifiers used to bill for the transportation component for beneficiaries located at that facility. For example, if a supplier billed R0070 for two patients located in the same facility, we determined the supplier made two trips to that facility. Then we calculated the total amount Medicare paid for return trips to a facility.

¹⁸ If the portable x-ray service fell on the first or last day of a nursing facility stay, we considered the beneficiary to not be in a nursing facility that day.

Limitations

We did not independently verify the accuracy of the data we used for this study; therefore, the accuracy of our findings is limited by the accuracy of the data. With the exception of portable services ordered by nonphysicians, none of the characteristics we analyzed necessarily implies that a particular claim is inappropriate or that a particular supplier submitted inappropriate claims. We designed this study to identify suppliers that merit greater scrutiny, not to provide conclusive evidence of improper payments.

A portion of our analysis focuses on the ordering NPIs reported on claims submitted by portable x-ray suppliers. In an October 15, 2008, program transmittal, CMS instructed suppliers to use their own NPIs as the ordering NPIs on Medicare claims if they cannot determine the NPIs of the ordering providers.¹⁹ Therefore, we cannot determine whether claims that report the suppliers' own NPIs in the ordering NPI field represent services ordered by nonphysicians. Instead, we specifically report on the incidence of suppliers' using their own NPIs in the ordering field in the findings. According to a CMS Transmittal, Medicare contractors were to stop paying claims that lack a valid NPI for the ordering provider on July 5, 2011.²⁰ The transmittal also indicated that the date was subject to change. CMS recently stated that it anticipates implementing edits in early 2012 to stop payment for claims that lack a valid NPI.

Standards

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

¹⁹ CMS, *Transmittal 270, Change Request 6093*, October 15, 2008.

²⁰ CMS, *Transmittal 825, Change Request 6417*, December 16, 2010.

Twenty portable x-ray suppliers exhibited questionable billing patterns

Most suppliers rarely billed for the unusual situations described by the characteristics in our methodology, but 20 of the 352 in our population (5.7 percent) met our criteria for identifying questionable billing patterns. That is, 20 suppliers exceeded thresholds for questionable billing on at least 2 individual characteristics and the threshold on the combined score, which describes suppliers' overall billing patterns. As shown in Table 2, 12 of the 20 suppliers exceeded thresholds on 4 or more characteristics. The characteristics on which the 20 suppliers most often exceeded thresholds were those that measured beneficiary use of stationary x-ray services (16 suppliers exceeded this threshold), same-day services in multiple settings (16 suppliers), beneficiary contact with multiple portable suppliers (15 suppliers), and beneficiary DME utilization (13 suppliers). Collectively, Medicare paid the selected suppliers approximately \$5.2 million for portable services rendered in 2009. Appendix B provides for more information on how the supplier population performed on each characteristic. Appendix C displays detailed information about each of the 20 suppliers that met our criteria for questionable billing.

**Table 2 :
Count of Suppliers That
Exceeded Exact Number
of Thresholds for
Individual Characteristics**

Number of Thresholds	Supplier Count
2	5
3	3
4	4
5	7
6	1

Source: OIG analysis of 2008 and 2009 Medicare and NPPES data, 2011.

The supplier with the most questionable billing pattern had the highest combined score and exceeded thresholds on six individual characteristics. Furthermore, the supplier ranked in the top 10 on the following 4 characteristics:

- Services ordered by nonphysicians accounted for 30 percent of the charges for portable services this supplier submitted, compared to the median value of 1.1 percent for suppliers in the population.
- The supplier billed 53 percent of its portable services on a day when the beneficiary had a service in a clinical setting (median value 6 percent).
- In addition, 55 percent of the supplier's patients got services from at least one other portable x-ray supplier (median value 9.9 percent).

FINDINGS

- The supplier's patients had an average of \$7,970 billed on their behalf for DME in 2009 (median value \$3,198).

As a group, the 20 suppliers who met our criteria had several additional features that differentiated them from suppliers with more typical billing patterns. First, only 9 percent of the payments to selected suppliers were associated with services billed for beneficiaries in a nursing facility at the time of service, compared to 73 percent of the payments to other suppliers. Second, 13 of the selected suppliers were located in the Miami, Florida, area, more than half the total 25 suppliers in our population with addresses there. All 13 Miami suppliers surpassed thresholds on at least 3 characteristics, compared to only 2 of the 7 suppliers from outside the Miami area that met our criteria.

Medicare paid portable x-ray suppliers approximately \$12.8 million for return trips to nursing facilities

Medicare paid suppliers approximately \$108 million for transportation component claims for portable x-rays furnished in

2009 while the beneficiary was in a nursing home or SNFs, according to MDS data. Approximately 12 percent of this amount, \$12.8 million, was for trips to a location apparently already visited on the same day. As a typical example, one supplier submitted two separate claims for transportation costs (R0070), one for each of two beneficiaries, on a particular day. Medicare paid each claim at the full transportation component rate. However, MDS data show that these two beneficiaries were located in the same nursing home on that date. Claims data do not provide sufficient information to determine whether the supplier billed correctly for two separate trips to the facility or administered tests to the two beneficiaries during a single trip and failed to use the appropriate prorated billing code.

Medicare paid at least \$6.6 million for portable x-ray services that were ordered by nonphysicians and therefore not covered

Contrary to 42 CFR § 486.106, which requires that portable x-rays be ordered by an MD or DO, Medicare paid \$6.6 million

for portable x-ray services ordered by nonphysicians in 2009. Nurse practitioners ordered services that accounted for \$4.3 million of this amount. Physician assistants and podiatrists ordered approximately \$1 million and \$900,000, respectively. Various other medical

F I N D I N G S

professionals, such as registered nurses and chiropractors, accounted for the remaining \$400,000.

Medicare paid an additional \$5.9 million for services for which we could not determine whether the ordering provider possessed appropriate credentials. The ordering NPIs on claims that generated \$1.2 million of this amount did not match a current record in the NPPES data or identified a group practice, not an individual practitioner. Additionally, about \$4.6 million of the \$5.9 million for services went to suppliers that reported their NPIs as the ordering NPIs on the claims.²¹ This amount included \$3.1 million that went to one supplier that reported its own NPI on nearly 100 percent of its portable x-ray claims and \$842,000 for three suppliers that used their own NPIs on claims that accounted for at least 20 percent of their Medicare payments.

²¹ Because of rounding, the sum of the paid amounts shown for the subcategories does not equal the total paid amount shown for services for which we could not determine whether the ordering providers possessed appropriate credentials.



R E C O M M E N D A T I O N S

Portable x-rays constitute a small portion of overall Medicare payments for diagnostic imaging services, but the questionable claims patterns we found raise concerns about the integrity of payments to certain portable x-ray suppliers. Furthermore, payments for portable services ordered by nonphysicians clearly violate Federal regulations and should be recovered. Lastly, payments for return trips to facilities, while not necessarily inappropriate, may represent an additional opportunity for program savings. Therefore, we recommend that CMS:

Take appropriate action on portable x-ray suppliers referred by the Office of Inspector General

OIG is currently determining what, if any, OIG enforcement action it should take on the 20 suppliers we identified with questionable billing patterns and the 4 suppliers that derived more than 20 percent of their Medicare payments from claims on which the suppliers reported their own NPIs as the ordering NPIs. After we complete our internal process, we will provide CMS (under separate cover) the identities of those suppliers against which we believe it would be appropriate for CMS to take administrative action.

Establish a process to periodically identify portable x-ray suppliers that merit greater scrutiny and follow up as appropriate

Although our methodology cannot positively identify suppliers that have received inappropriate Medicare payments, we identified some suppliers with questionable claims patterns that merit greater scrutiny. CMS should establish a process to identify portable x-ray suppliers that present a likely risk to the program and refer them for appropriate administrative or enforcement action. We leave the details of such a process to CMS's discretion, but as CMS has access to all the data sources we used for our analysis, it could use the methodology in this report as a guide. Given the preponderance of Miami suppliers among those we identified with questionable billing, CMS may initially wish to focus on Miami and later expand to other high-risk jurisdictions.

Determine what portion of the \$12.8 million it paid for return trips in 2009 actually reimbursed suppliers for incorrectly billed transportation component claims and collect overpayments where appropriate

Medicare paid portable x-ray suppliers \$12.8 million for apparent return trips to nursing facilities in 2009, but some portion of this amount may be attributable to incorrectly billed transportation component claims. That is, the supplier may have obtained excess reimbursement by billing as if it made multiple trips to a facility when,

R E C O M M E N D A T I O N S

in fact, it saw all beneficiaries located in that facility in a single trip. CMS should instruct its contractors to conduct a focused medical review on a sample of these claims to identify any overpayments and determine the extent of errors of this type. Depending on the results of this preliminary review, CMS may wish to initiate more extensive reviews of such claims on a regular basis. CMS should also recover any overpayments discovered in the preliminary or more extensive review (if conducted).

Collect the \$6.6 million in overpayments for portable x-ray services rendered in 2009 that were ordered by nonphysicians

Federal regulations at 42 CFR §§ 410.32(a) and 486.106 clearly state that portable x-ray services must be ordered by an MD or a DO to be eligible for Medicare reimbursement. Therefore, CMS should instruct its contractors to collect overpayments on the \$6.6 million paid for portable x-ray services ordered by nonphysicians. Under separate cover, we will provide CMS the information needed to identify these claims.

Implement procedures to ensure that it pays for portable x-ray services only when ordered by a physician and establish appropriate controls

CMS should weigh the costs and benefits of prepayment and postpayment controls to ensure that portable x-ray services meet the requirement established in 42 CFR §§ 410.32(a) and 486.106 concerning the credentials of the ordering provider. Depending on the results of the analysis, CMS could instruct its contractors to verify that the ordering NPI on each claim for portable x-ray services identifies an MD or a DO before paying the claim. Alternatively, CMS could instruct its contractors to periodically review paid portable x-ray claims to verify the credentials of the ordering providers and collect overpayments where appropriate. CMS may explore other options at its discretion.

As part of its response to this recommendation, CMS should fully implement the requirement, though not specific to portable x-ray services, that claims for services requiring the supplier to report an ordering provider bear the correct NPI of that ordering provider. This action should eliminate payments for services for which the credentials

of the ordering entity cannot be determined (for which CMS paid \$5.9 million in 2009). OIG made a similar recommendation in a February 2009 report.²²

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations. CMS stated that since the draft report was issued, it has embarked on a new Fraud Prevention System to help identify suspect fee-for-service claims, including the kinds of questionable billing described in this report. CMS also stated that it is leveraging internal data and publicly available information to strengthen its provider-screening process which will help keep portable x-ray providers that have exhibited suspicious or fraudulent behaviors from reenrolling in Medicare. CMS further indicated that it is revising the *Medicare Benefit Policy Manual* to be consistent with the regulations that would preclude Medicare from paying for portable x-ray services that are not ordered by an MD or a DO.

Specifically, in response to our first recommendation, CMS concurred and stated that after it receives and reviews the necessary information about the suppliers and claims discussed in this report, it will take the appropriate administrative action.

In response to our second recommendation, CMS concurred and stated that it implemented a new Fraud Prevention System to detect potential fraud and abuse by suppliers of portable x-ray services. CMS also stated that it will perform periodic analyses on suppliers and will explore opportunities to build reliable models that can detect and generate alerts for suspicious activity.

In response to our third recommendation, CMS concurred but stated that because of limited resources and timing, it cannot initiate a review of a sample of portable x-ray claims at this time. Instead, CMS stated that it would forward the list of questionable claims to the appropriate contractor for further consideration.

In response to our fourth recommendation, CMS concurred and stated that it plans to recover the \$6.6 million in overpayments identified.

²² OIG, *Medicare Payments in 2007 for Medical Equipment and Supply Claims With Invalid or Inactive Referring Physician Identifiers*, OEI-04-08-00470.

In response to our fifth recommendation, CMS concurred and stated it is revising the *Medicare Benefit Policy Manual* to be consistent with the regulations that would preclude Medicare from paying portable x-rays that are not ordered by an MD or a DO.

For the full text of CMS's comments, see Appendix D.

Detailed Methodology for Evaluating Questionable Claims Patterns

Our first step in evaluating the billing patterns of portable x-ray suppliers was to identify potential indicators of inappropriate payments. Based on conversations with Centers for Medicare & Medicaid Services staff and Office of Inspector General investigators, prior experience in other payment areas, and our own professional judgment, we developed an initial set of 16 indicators that could potentially meet this goal. These indicators were based either on characteristics of individual claims (e.g., the percentage of portable services ordered by nonphysicians) or on the claims histories of beneficiaries (e.g., the average number of portable imaging services per beneficiary).

After identifying the initial set of potential indicators, we then calculated each indicator for each supplier and examined the distribution of values across suppliers. If a distribution showed that most suppliers had relatively low values for an indicator, but a small number had distinctly higher values, we determined that, for this indicator, a supplier's deviation from the population was likely to be meaningful. Eight indicators met this criterion; these became the eight characteristics we chose to represent questionable billing patterns of suppliers. The specific methodologies we used to calculate each of the eight characteristics are described below.

- o *Portable services ordered by nonphysicians.* We first matched the ordering National Provider Identifier (NPI) on each claim to National Plan and Provider Enumeration System (NPPES) data to identify the ordering provider. We then used two data elements from the NPPES—the primary taxonomy code (a self-selected code that captures the provider's primary area of expertise) and the credentials—to determine whether the entity was a licensed physician. If the entity's primary taxonomy code corresponded to a physician specialty or the entity listed medical doctor (MD) or doctor of osteopathy (DO) credentials, we considered the ordering provider to be a physician. Failing that, if the primary taxonomy code indicated that the ordering provider was a group practice, the ordering NPI did not match a record in the NPPES or was missing, or the supplier reported its own NPI in the ordering field, we considered the credentials of the entity to be unknowable. Otherwise, we considered the ordering provider to be a nonphysician. We verified that a random sample of 10 nonphysician ordering entities identified through this process did not hold MD or DO credentials by searching State medical licensure Web sites by

the name and State of the entity. We then calculated the percentage of each supplier's submitted charges that were derived from claims ordered by nonphysicians. We limited this analysis to claims for services rendered on the same day and for the same beneficiary as a claim for the transportation or setup component to ensure that we included only services subject to 42 CFR § 486.106, which requires that portable services be ordered by a physician.

- o *No recent contact between beneficiary and ordering provider.* We first excluded claims on which the suppliers reported their own NPIs as the ordering NPI. We then identified each unique combination of beneficiary, ordering provider, and service date among claims submitted by portable x-ray suppliers in our population. We then determined whether the ordering NPI appeared as the performing, attending, operating, or other NPI on a claim for Part B, Skilled Nursing Facility (SNF), Inpatient, Outpatient, or Hospice claim with a service date 6 weeks or less prior to the portable x-ray service. If so, we determined that the beneficiary and ordering provider had recent contact. Otherwise, we determined that the two did not have recent contact. We then calculated the percentage of each supplier's charges submitted for claims with no evidence of recent contact between the beneficiary and ordering provider.
- o *Same-day services in multiple settings.* We first created a dataset with 2009 Part B claims for all beneficiaries in our population. We excluded claims for transportation services, tangible goods (e.g., parenteral nutrition supplies), pathology and laboratory services, the professional component of diagnostic services, and other services and items for which the beneficiary is not normally present at the place of service. We then examined the place of service code on the claim to identify the setting in which the service was rendered. If the place of service code corresponded to a physician's office, hospital, or medical clinic, we considered the setting to be clinical. If the code corresponded to a homeless shelter, private home, nursing facility, hospice, or a residential treatment facility, we considered the setting to be residential. If the beneficiary had a portable x-ray service in a residential setting on the same day as another service in a clinical setting, we determined that the beneficiary had services in multiple settings that day. We then calculated the percentage of each supplier's beneficiary-service day combinations for which the beneficiary had services in multiple settings.

- o Billing for return trips. We matched our portable x-ray claims population to the Minimum Data Set and SNF stay data by beneficiary number and date to identify the facility, if any, where the beneficiary was located on the day of each transportation component service. If the transportation component service fell on the first or last day of a nursing facility stay, we considered the beneficiary to not be in a facility. Otherwise, we considered the beneficiary to be in the facility identified in the stay data. We then grouped the transportation component claims that each supplier submitted for beneficiaries in each facility into trips according to the billing code on the claim. For instance, if a supplier submitted two claims with the two-patient transportation component code and one with the one-patient code for three beneficiaries located in the same facility on a certain day, we would group these claims into two trips. We then assigned an order to the trips according to the amount Medicare paid for each, with the trip for which Medicare paid the most as the “first” trip. Lastly, we determined the percentage of each supplier’s total Medicare payments derived from transportation component claims for any trip beyond the first to a facility.
- o Portable x-rays per beneficiary. We calculated the total number of covered x-rays billed by each portable x-ray supplier in 2009, excluding any tests for which the supplier billed only the professional component. We then divided this total by the number of beneficiaries for whom each supplier submitted a claim to get the average number of portable x-rays per beneficiary for each supplier.
- o Beneficiary contact with multiple portable suppliers. We counted the number of distinct portable x-ray suppliers that submitted a claim for each beneficiary in our population dataset. We then determined the percentage of each supplier’s beneficiaries that had claims from at least two portable suppliers in 2009.
- o Beneficiary use of stationary x-ray services. First, we identified the 10 billing codes for covered x-rays most commonly billed by portable x-ray suppliers in our population, weighted by allowed charges. These 10 codes constituted approximately 75 percent of the total allowed charges for x-rays in our population. We then created a dataset containing all Part B claims for these codes for beneficiaries in our population, regardless of the specialty of the performing provider. Finally, we calculated the percentage of each portable

supplier's beneficiaries who also appeared on a claim for one of the codes from a stationary provider during 2009.

- o *Beneficiary Durable Medical Equipment (DME) utilization.* From the 2009 DME claims data, we calculated the amount billed for any DME item on behalf of each beneficiary in our population. We then calculated the average amount of billed charges for DME per beneficiary who had at least one DME claim for each supplier in our population.

After selecting the characteristics to use for our supplier profiles, we calculated thresholds for each characteristic to define questionable billing. If the distribution of the characteristic was exponential, we set the threshold at the 90th percentile of the characteristic. Otherwise, we set the threshold at a value where, after removing suppliers above the threshold, the remaining values formed an approximately normal distribution.

We then combined the eight characteristics into an overall score, which we called the combined score. We first determined the maximum value for each characteristic among the suppliers in our population. We then divided each supplier's value for each characteristic by the maximum value for that characteristic to create a normalized score on a zero to one scale for each characteristic. We then summed the normalized values for each characteristic to create the combined score. We determined the threshold for the combined score in the same manner as for the individual characteristics. Appendix B shows the median and maximum values for each characteristic and the combined score as well as the corresponding thresholds and the number of suppliers that exceeded each threshold.

For example, the top supplier in our population had a value of 5.125 for the characteristic "Portable x-rays per beneficiary." Therefore, we divided each supplier's value for that characteristic by 5.125 to get each supplier's normalized score. The top supplier had a normalized score of 5.125 divided by 5.125, or 1. Meanwhile, the supplier with the minimum value on that characteristic, 0.4444, had a normalized score of 0.4444 divided by 5.125, which is 0.0867. We performed this operation for each characteristic and then summed the normalized scores into the single combined score for each supplier.

➤ **A P P E N D I X ~ B**

Distributions of Characteristics and Combined Score With Related Thresholds

Characteristic	Detail	Median Supplier Value	Maximum Supplier Value	Threshold	Suppliers Exceeding Threshold
Portable services ordered by nonphysicians	Amount billed for claims with characteristic as percentage of total charges for portable services per supplier	1.09%	95.6%	14.1%	35
No recent contact between beneficiary and ordering provider	Amount billed for claims with characteristic as percentage of total charges per supplier	30.7%	100%	55.0%	27
Same-day services in multiple settings	Service days with characteristic as percentage of total service days per supplier	6.04%	80.7%	11.78%	35
Billing for return trips	Transportation component payments associated with return trips as percentage of total payments per supplier	4.55%	35.4%	11.4%	35
Portable x-rays per beneficiary	Mean number of portable x-rays per beneficiary per supplier	2.11	5.13	3.00	10
Beneficiary contact with multiple portable suppliers	Percentage of each supplier's beneficiaries that received services from at least one additional portable x-ray supplier	9.88%	100%	30.7%	35
Beneficiary use of stationary x-ray services	Percentage of each supplier's beneficiaries that also received similar services from a stationary x-ray provider	11.1%	90.0%	20.8%	40
Beneficiary durable medical equipment (DME) utilization	Mean charges for DME per beneficiary per supplier	\$3,198	\$8,732	\$5,200	32
Combined score	-	1.66	3.73	2.37	22

Source: Office of Inspector General analysis of 2008 and 2009 Medicare and National Plan and Provider Enumeration System data, 2011.

Billing Patterns of the 20 Selected Suppliers

Supplier	Location	Characteristic								Combined score (Threshold =2.37)	Medicare payments for portable x-rays rendered in 2009
		Portable services ordered by nonphysicians	No recent contact between beneficiary and ordering provider	Same-day services in multiple settings	Billing for return trips	Portable x-rays per beneficiary	Beneficiary contact with multiple portable suppliers	Beneficiary use of stationary x-ray services	Beneficiary DME utilization		
A	Miami	X	X	X	-	-	X	X	X	3.73	\$255,749
B	Miami	-	X	X	-	-	X	X	X	3.28	\$482,711
C	Miami	-	X	X	-	-	X	X	X	3.40	\$407,910
D	Miami	-	X	X	-	-	X	X	X	3.16	\$335,339
E	Miami	-	X	X	-	-	X	X	X	3.07	\$136,788
F	Miami	-	X	X	-	X	X	X	-	2.97	\$176,238
G	Miami	X	-	X	-	-	X	X	X	3.62	\$23,201
H	Other	-	X	-	-	X	X	X	X	3.69	\$3,955
I	Miami	-	-	X	-	-	X	X	X	2.66	\$592,970
J	Miami	-	-	X	-	-	X	X	X	2.90	\$407,114
K	Miami	-	-	X	-	-	X	X	X	2.84	\$224,860
L	Other	X	X	X	-	-	-	-	X	3.30	\$42,025
M	Miami	-	-	X	-	-	X	X	-	2.39	\$236,617
N	Miami	-	-	X	-	-	X	X	-	2.62	\$53,462
O	Miami	-	-	-	-	-	X	X	X	2.61	\$833,541
P	Other	-	-	X	X	-	-	-	-	2.44	\$519,355
Q	Other	-	-	X	-	-	-	X	-	2.41	\$226,036
R	Other	-	-	X	-	-	-	-	X	2.37	\$145,410
S	Other	-	-	-	X	X	-	-	-	3.06	\$85,456
T	Other	-	-	-	-	-	X	X	-	2.56	\$2,428
Total		3	8	16	2	3	15	16	13	-	\$5.2 million

Source: Office of Inspector General analysis of 2008 and 2009 Medicare and National Plan and Provider Enumeration System data, 2011.

APPENDIX D

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 04 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. *ISI*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Questionable Billing Patterns of Portable X-Ray Suppliers" (OEI-12-10-00190)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the OIG draft report entitled "Questionable Billing Patterns of Portable X-Ray Suppliers," (OEI-12-10-00190). The purpose of this report is two-fold. First, it seeks to identify portable x-ray suppliers with questionable billing patterns that may be associated with inappropriate Medicare payments. Secondly, it seeks to identify claims for portable x-ray services that may warrant further review.

Portable x-ray suppliers provide diagnostic imaging services at patients' locations such as private homes and group living facilities, rather than in a traditional clinical setting, such as a doctor's office or hospital. As stated in the report portable x-rays constitute eight percent of the amount Medicare paid to portable suppliers in 2009 reimbursed them for transporting and setting up the equipment. According to the OIG's report, Medicare paid approximately \$225 million under the Part B benefit in 2009 for x-rays of the extremities, pelvis, spine, skull, chest, and abdomen. However, we recognize that such questionable billing patterns raise legitimate concerns about potentially inappropriate Medicare payments and appreciate the OIG bringing this issue to our attention. Since the report was issued, CMS has embarked on a new fraud prevention initiative which will help CMS identify suspect fee-for-service claims, including the kinds of questionable billing described in this report.

Launched on June 30, 2011, the CMS's new Fraud Prevention System (FPS) reviews every fee-for-service claim, including those submitted by portable x-ray suppliers, to identify claims and providers that merit greater scrutiny. The new system alerts CMS to unusual billing patterns and other suspicious behavior while simultaneously prioritizing claims so CMS can strategically target resources for additional review, investigation, and administrative action as necessary. CMS is now able to review claims, investigate providers, make referrals to law enforcement, and take administrative actions against providers more efficiently than before. CMS will perform analyses on portable x-ray suppliers and will explore opportunities to build reliable models that can detect and generate alerts for suspicious portable x-ray activity.

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The CMS is also leveraging internal data and publicly available information to strengthen its provider screening process which will help keep portable x-ray providers who have exhibited suspicious or fraudulent behaviors from re-enrolling in Medicare. By linking an automated screening tool to the Medicare enrollment database, CMS can monitor its provider population and applicants for suspicious behavior, outdated enrollment data, and incorrect application information.

The CMS is also revising the Medicare Benefit Policy Manual to be consistent with the regulations that would preclude Medicare from paying for portable x-rays that are not ordered by a doctor of medicine or osteopathy.

We appreciate the OIG's efforts in working with CMS to help ensure that Medicare payment for portable x-ray services is not vulnerable to abuse. Our response to each of the OIG recommendations follows.

OIG Recommendation

Take appropriate action on portable x-ray suppliers referred by the Office of Inspector General.

CMS Response

The CMS concurs with this recommendation. After CMS receives and reviews the necessary information about the specific suppliers and claims discussed in this report, CMS will take the appropriate administrative action. At a minimum, CMS and its contractors review enrollment information upon application and at the time of revalidation. In addition, CMS and its contractors may conduct other reviews off-cycle enrollment revalidations as needed. CMS will take the steps necessary to address the issues brought forth by the OIG.

OIG Recommendation

Establish a process to periodically identify portable x-ray suppliers that merit greater scrutiny and follow up with appropriate action.

CMS Response

The CMS concurs with this recommendation. As mentioned previously, CMS implemented a new Fraud Prevention System that will make it easier to detect potential fraud and abuse by suppliers of portable x-ray services. CMS will perform periodic analyses on portable x-ray suppliers and will explore opportunities to build reliable models that can detect and generate alerts for suspicious portable x-ray activity.

OIG Recommendation

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Determine what portion of the \$12.8 million it paid for return trips in 2009 actually reimbursed suppliers for incorrectly billed transportation component claims, and collect overpayments where appropriate.

CMS Response

The CMS concurs with comments. CMS believes it is important to consider the costs and benefits of taking agency action to protect the Trust Fund and considers the return on investment when conducting medical review due to the high cost and limited resources associated with medical review activities. CMS attempts to focus its medical review resources on the most highly vulnerable areas as identified by sources such as the Comprehensive Error Rate Testing (CERT) program, the individual contractors' data analysis, and other reports including OIG findings. The CERT program annually measures the error rate for the Medicare Fee-For-Service program and provides the agency with improper payment data.

Due to limited resources and timing, CMS cannot initiate a review of a sample of claims all portable x-ray at this time. However, upon receipt of the files from the OIG, CMS will take appropriate action to forward the listing of questionable claims to the Recovery Auditors and/or Medicare Administrative Contractors (MACs). The Recovery Auditors review Medicare claims on a post payment basis and are tasked with identifying inappropriate payments. While CMS does not mandate areas for Recovery Audit review, we will share this information with them. We will also instruct the MACs to consider this issue when prioritizing their medical review strategies or other interventions. However, if OIG-identified claims are beyond the 3-year without fault and 4-year reopening rules, CMS cannot review them and thus cannot collect potential overpayments.

The CMS requests that OIG furnish the necessary data (Provider numbers, claims information including the paid date, HIC#, Contractor Medicare ID number, Contractor Name, Provider Specialty, if applicable, Place of Service Code, if applicable, Provider State, and Number of Beneficiaries, etc.). In addition, CMS also requests all Medicare contract-specific data be written to separate CD-ROMs to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

Collect the \$6.6 million in overpayments it made for portable x-ray services rendered in 2009 that were ordered by nonphysicians.

CMS Response

The CMS concurs. We agree that the \$6.6 million in overpayments should be recovered. CMS plans to recover the overpayments identified consistent with applicable law and regulations. The CMS requests that the OIG provide for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, CMS requests that Medicare contractor specific data be written to separate CD-ROMs or separate

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hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

Implement procedures to ensure that it pays for portable x-ray services only when ordered by a physician and establish appropriate controls.

CMS Response

The CMS concurs with this recommendation. CMS is in the process of revising the Medicare Benefit Policy Manual to be consistent with the regulations that would preclude Medicare from paying from portable x-rays that are not ordered by a doctor of medicine or osteopathy.

Again, CMS appreciates the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Dave Graf, Director, Technical Support Staff, in the Baltimore office.

Scott Hutchison served as the team leader for this study. Other principal Office of Evaluation and Inspections staff who contributed to the report include Berivan Demir Neubert, Rita Wurm, Scott Horning, and Robert Gibbons.

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