Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE PART B BILLING FOR ULTRASOUND


Daniel R. Levinson
Inspector General

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# EXECUTIVE SUMMARY

## OBJECTIVES

To analyze Medicare Part B claims for ultrasound services to:

1. Describe utilization of ultrasound services in counties with high use of ultrasound and compare it to utilization in other counties.
2. Identify claims with questionable characteristics.

## BACKGROUND

In 2007, Medicare Part B covered about 17 million ultrasound services in ambulatory settings at a cost of over $2 billion. Previous Office of Inspector General work has raised concerns about the growth in other types of imaging covered under Part B and found that high geographic concentrations of providers or services may indicate weaknesses in Medicare's program safeguards.

We used 2007 Medicare Part B claims data to identify 20 counties that were in the top 1 percent of counties for both average allowed charges for ultrasound per Medicare beneficiary and percentage of beneficiaries who received ultrasound services. Nine of these counties were in Florida; five in New York; three in New Jersey; and one each in Alabama, Michigan, and Texas. We analyzed the claims data to compare use of ultrasound in the high-use counties to that in all other counties. We also examined claims for the presence of a limited set of questionable characteristics, such as suspect combinations of procedures or lack of a service claim from the doctor who ordered the service. We did not assess the medical necessity of services.

## FINDINGS

**In 2007, 20 high-use counties accounted for 16 percent of Part B spending on ultrasound despite having only 6 percent of Medicare beneficiaries.** The 20 high-use counties accounted for $336 million of the $2.1 billion in Part B spending on ultrasound services. Average per-beneficiary spending on ultrasound in high-use counties was over three times that for beneficiaries in the rest of the country. Twice as many beneficiaries received ultrasound services in high-use counties as in the rest of the country. When these beneficiaries received ultrasound services, they received more services than other beneficiaries receiving ultrasound services in the rest of the country. Finally, the ratio of

ultrasound providers to beneficiaries in high-use counties was over three times that for the rest of the country.

**Nearly one in five ultrasound claims nationwide had characteristics that raise concerns about whether the claims were appropriate.** These 3.2 million claims represent $403 million in Part B charges. The overall rate of ultrasound claims exhibiting one or more questionable characteristics was the same in high-use counties as it was in all other counties. Lack of a service claim by the ordering doctor for treating the beneficiary was the most common of the questionable characteristics. The other characteristics were far less common but more prevalent in high-use counties than other counties.

**Certain providers billed for a large number of ultrasound claims with questionable characteristics.** A group of 672 providers each billed 500 or more claims with questionable characteristics. These providers collectively billed over half a million such claims representing over $81 million in Part B charges in 2007.

## RECOMMENDATIONS

Given our findings, we recommend that the Centers for Medicare & Medicaid Services (CMS):

**Monitor ultrasound claims data to detect questionable claims.** This would reduce Medicare's vulnerability to questionable claims for ultrasound services by enabling CMS to develop claims-processing edits that flag them for review prior to payment.

**Take action when providers bill for high numbers of questionable claims for ultrasound services.** When its monitoring identifies providers that bill for large numbers of questionable claims, CMS should review their claims to ensure that they are legitimate prior to payment. If CMS determines that such providers submit fraudulent claims, it should take steps to revoke their Medicare billing numbers.

## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments to this report, CMS concurred with both of our recommendations and described actions it would take to address them. We did not make any changes to the report based on CMS's comments.

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# INTRODUCTION

## OBJECTIVES

To analyze Medicare Part B claims for ultrasound services to:

1. Describe utilization of ultrasound services in counties with high use of ultrasound and compare it to utilization in other counties.
2. Identify claims with questionable characteristics.

## BACKGROUND

In 2007, Medicare spent over $2 billion for about 17 million ultrasound services in doctors' offices, independent diagnostic testing facilities (IDTF), and other settings covered under Medicare Part B. Previous Office of Inspector General (OIG) work has documented the growth in other types of imaging covered under Part B and raised concerns about the appropriateness of services.[1] Previous OIG work has also found that high geographic concentrations of providers or services may indicate weaknesses in Medicare's program safeguards.[2]

### Overview of Ultrasound Services

Ultrasound imaging uses high-frequency sound waves to enable medical practitioners to view structures inside the body. Ultrasound has numerous clinical applications, including diagnosing conditions in organs and monitoring blood flow in veins and arteries. One example is echocardiography, which enables doctors to view and assess the pumping action of the heart.

Ultrasound machines vary in size, imaging capabilities, and the parts of the body that they can examine. Compared to other types of diagnostic imaging machines, which can cost millions of dollars to acquire and install, ultrasound machines are relatively inexpensive. Providers can buy used machines for under $5,000 and roll them into examining rooms on carts.

[1] OIG, "Growth in Advanced Imaging Covered Under the Medicare Physician Fee Schedule," OEI-01-06-00260, October 2007.

[2] OIG, "South Florida Suppliers' Compliance With Medicare Standards," OEI-03-07-00150, March 2007. OIG, "Aberrant Billing in South Florida for Beneficiaries With HIV/AIDS," OEI-09-07-00030, September 2007.

### Payment for Ultrasound Services Under Medicare Part B

Medicare covers ultrasound as a diagnostic service under § 1861(s)(3) of the Social Security Act. Medicare generally covers specified ultrasound procedures and will cover additional procedures if they are clinically effective and medically justified.[3]

Medicare divides imaging services into two components: the technical component, which is the taking of the image, and the professional component, which is the doctor interpreting the image. The technical component of ultrasound services provided in ambulatory settings, such as doctors' offices and IDTFs, is covered under Part B. The technical component of services provided in institutional settings, such as hospitals and hospital outpatient departments, is covered under Part A. The professional component of ultrasound is always covered under Part B regardless of setting.

## METHODOLOGY

### Scope and Data Sources

This study is national in scope and focuses on the technical component of fee-for-service ultrasound services billed under Part B in 2007. We focus on the technical component because it is the more costly component of ultrasound services and represents the best way to identify services that were provided entirely in settings covered under Part B. Our data sources are Medicare's 100-percent physician/supplier National Claims History (NCH) File and the Denominator File from the Medicare Enrollment Data Base. We also consulted with a Medicare Program Safeguard Contractor (PSC).[4]

### Identification of High-Use Counties

We first built a national file of all claims for the technical component of ultrasound services billed under Part B in 2007. To do so, we used Berenson-Eggers type of service groups in the range of I3A through I3F as the criteria for selecting claim records from the NCH.[5] This resulted in a file of 41,513,455 ultrasound claims representing $2,750,575,063 in

[3] Centers for Medicare & Medicaid Services (CMS), "Medicare National Coverage Determinations Manual," Pub. No. 100-03, ch. 1, § 220.5.

[4] PSCs are contractors tasked with detecting and deterring fraud and abuse in the Medicare program.

[5] Berenson-Eggers type of service groups organize Part B procedure codes into clinical categories that aid in analysis of Medicare services and expenditures.

Medicare-allowed charges. From this file, we used the procedure modifier codes on the claims to identify those for the technical component of ultrasound services. This resulted in a file of 18,836,768 claims representing $2,172,037,957 in allowed charges. From this file, we dropped 1,385,229 claims that had zero allowed charges and 423,675 claims with invalid county codes and invalid or missing billing provider identifiers. Together these represented 10 percent of ultrasound claims for the technical component of services and $52,617,857, or 2 percent, of allowed charges. Thus our final analysis included 17,027,864 ultrasound claims representing $2,119,420,100 of allowed charges.

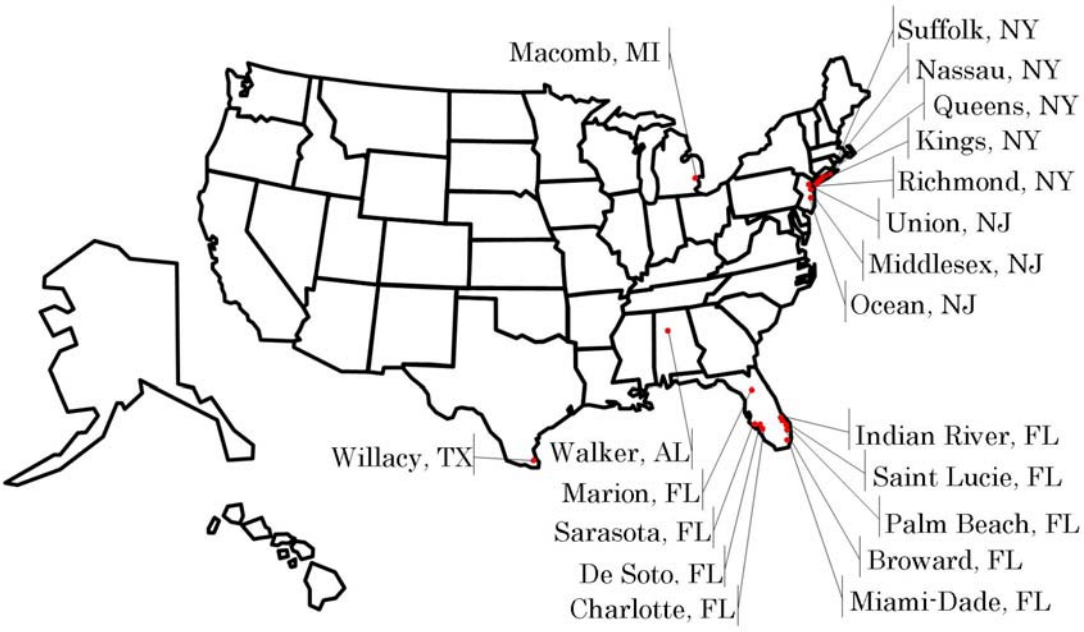
Next, we summarized the claims by county to generate totals of ultrasound services, allowed charges, and beneficiaries who received ultrasound in each of the 3,239 counties that had ultrasound claims. We used the 2007 Denominator File to obtain a count of fee-for-service beneficiaries in each county as of July 1, 2007. We then merged these files to calculate utilization measures for each county. They included average allowed charges and services per beneficiary and percentage of beneficiaries receiving services.

After analyzing this file, we defined high-use counties as those that ranked in the top 1 percent for both of the following measures:

- average allowed charges for ultrasound per fee-for-service beneficiary, and
- the percentage of fee-for-service beneficiaries who received ultrasound services.

Of the 3,239 counties in our analysis, 20 were in the top 1 percent for both of the measures above. Nine of these counties were in Florida; five in New York; three in New Jersey; and one each in Alabama, Michigan, and Texas. See Figure 1 for a map showing the locations of these counties.

**Figure 1: Counties with highest use of ultrasound covered under Part B, 2007.**




### Analysis of Billing Patterns

We analyzed our county-level file and our national claims file to describe utilization in the high-use counties and to compare utilization in the high-use counties to that of all other counties. In consultation with a certified fraud examiner and a registered sonographer at a PSC, we identified five characteristics that may indicate questionable ultrasound claims. These characteristics were:

- The absence of a prior service claim from the doctor who ordered the ultrasound service. We identified the ordering doctor reported on each ultrasound claim and determined whether the doctor had a service claim for treating the beneficiary any time from 2006 up to and including the date of the ultrasound service. Such an absence raises questions as to whether the doctor who reportedly ordered the service ever saw the beneficiary.
- Questionable use of ultrasound billing codes, such as suspect combinations of ultrasound services billed for the same beneficiary on the same day by the same provider, or specific procedures that are not effective in adults. An example would be duplicative services, such as billing for both a complete abdominal scan and a

scan of an individual organ within the abdominal cavity. This raises concerns of unnecessary or inappropriate use of services.

- Instances of more than five ultrasound services provided to the same beneficiary on the same day by the same provider. This raises concerns of excessive utilization of services.
- Beneficiaries who had ultrasound services billed for them by more than five providers in 2007. This raises concerns of misuse of beneficiaries' Medicare numbers.
- Missing or invalid data in the claim fields that identify the doctor who ordered the service. This raises questions about whether the service was ordered by a physician treating the beneficiary.

We created variables to show the presence or absence of each of these characteristics on each claim. We analyzed them to determine the extent to which ultrasound claims exhibited these characteristics and the extent to which high-use counties and all other counties varied in their prevalence.

### Limitations

This study relies on claims and enrollment data from CMS. We did not independently verify these data.

The five characteristics we used to identify questionable claims for ultrasound are not intended to be a comprehensive set of markers for identifying questionable claims. Also, although the presence of such characteristics raises questions about the appropriateness of claims, it does not necessarily mean that such claims are inappropriate or fraudulent. We did not assess compliance of ultrasound claims with Medicare billing requirements or the medical necessity of their underlying services.

The Health Insurance Portability and Accountability Act of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other health care providers. CMS began issuing NPIs on May 23, 2005; however, it was not until May 23, 2008, that CMS required all claims to have an NPI.[6] In the interim, CMS allowed submitted claims to have the NPI only, the Medicare legacy identifier only (i.e., Unique Physician Identification Number), or a combination of an NPI and a Medicare legacy identifier on the claims.

[6] 45 CFR §§ 162.404 and 162.410.

For calculations in this report, we excluded claims that had only an NPI for the billing provider and relied on the legacy numbers to identify the billing provider and ordering doctor. We did so to simplify counting and matching claims by provider identifier. In 2007, less than 2 percent of ultrasound claims had only an NPI for the billing provider and less than 1 percent had only an NPI for the ordering doctor.

### Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency (now Council of the Inspectors General on Integrity and Efficiency).

**In 2007, 20 high-use counties accounted for 16 percent of Part B spending on ultrasound despite having only 6 percent of Medicare beneficiaries**

The 20 high-use counties accounted for $336 million, or 16 percent, of the $2.1 billion of Part B spending on ultrasound services. Similarly, high-use counties accounted for 2.3 million, or 13 percent, of the 17 million ultrasound services that Part B covered in 2007.

#### Average per-beneficiary spending on ultrasound in high-use counties was over three times that for beneficiaries in the rest of the country

Part B spent an average of $171 on ultrasound for every beneficiary in the high-use counties compared to $55 in the rest of the country. The average expenditure per individual in high-use counties ranged from $123 in Walker County, Alabama, and Sarasota County, Florida, to $235 in Kings County, New York. See Table A1 in Appendix A for details on usage of ultrasound in the high-use counties.

#### Twice as many beneficiaries received ultrasound services in high-use counties as in the rest of the country

In the high-use counties, 36 percent of beneficiaries received ultrasound services in 2007 compared to only 18 percent in the rest of the country. The percentage of beneficiaries who received ultrasound services in high-use counties ranged from 31 percent in Union County, New Jersey, to 42 percent in Miami-Dade County and Charlotte County, Florida.

#### Beneficiaries in high-use counties who received ultrasound services received more services than those in the rest of the country

Beneficiaries who received ultrasound services in the high-use counties received an average of 3.2 services compared to 2.5 services for beneficiaries in the rest of the country. The average Part B charge per beneficiary receiving ultrasound services in high-use counties was $474 versus $302 in the rest of the country.

#### The ratio of ultrasound providers to beneficiaries in high-use counties was over three times that for the rest of the country

In the high-use counties, the ratio of ultrasound providers to beneficiaries was 1 for every 90 beneficiaries. In the rest of the country, this ratio was 1 provider for every 329 beneficiaries. In both the high-use counties and the rest of the country, over 90 percent of services were billed by doctors and under 10 percent were billed by group providers, such as multispecialty groups or IDTFs.

## Nearly one in five ultrasound claims nationwide had characteristics that raise concern about whether the claims were appropriate

In 2007, 3.2 million, or 19 percent, of Part B ultrasound claims had one or more of the five characteristics we reviewed. These claims accounted for $403 million, or 19 percent, of the $2.1 billion that Part B spent on ultrasound services in 2007. The overall rate of ultrasound claims exhibiting one or more of these characteristics was the same in high-use counties as in all other counties. See Tables 1 and 2 for descriptions of the characteristics and the number of claims and allowed charges that each characteristic represents.

### Lack of a service claim by the ordering doctor was the most common of the questionable characteristics overall

About 2.8 million, or nearly 17 percent, of Part B ultrasound claims billed in 2007 lacked prior service claims by the ordering doctor. These claims account for nearly 15 percent of claims from high-use counties and 17 percent of claims from all other counties. For these claims, the ordering doctor did not bill Part B for treating the beneficiary, such as for an office visit, any time in 2006 or 2007 up to and including the day of the ultrasound service. These claims account for $356 million in Part B charges. Ultrasound claims without prior service claims raise questions because they suggest that the doctor who ordered the service may never have seen the beneficiary. When an ultrasound claim was accompanied by a service claim, the service claim fell on the same day or within 30 days prior to the ultrasound claim 72 percent of the time.

Further, 4 percent of billing providers, or 4,525, lacked preceding or same-day service claims from the ordering doctors for all ultrasound claims they billed. Although most of these providers billed fewer than 10 ultrasound claims during the year, 92 providers billed more than 100 claims each and 1 billed 5,066 claims. In 2007, these 92 providers collectively billed Part B for 34,673 ultrasound claims, accounting for $4.8 million of allowed charges.

### The other questionable characteristics were far less common but more prevalent in high-use counties than other counties

About half a million, or 3 percent, of Part B ultrasound claims had at least one of the other four characteristics we reviewed, such as questionable use of procedure codes. These claims account for 5 percent of claims from high-use counties compared to 2.7 percent of claims from all other counties. They represent about $63 million in allowed charges.

Tables 1 and 2 show the number of Part B ultrasound claims and the allowed charges that each questionable characteristic represents.

***Table 1: Part B Ultrasound Claims With Questionable Characteristics, 2007***

| Questionable Characteristic | High-Use Counties | | All Other Counties | |
|---|---|---|---|---|
| | Number of Claims* | Percentage of Claims* | Number of Claims* | Percentage of Claims* |
| Claim lacked a prior service claim from the doctor who ordered the service | 331,993 | 14.5% | 2,496,149 | 16.9% |
| Claim involved questionable use of ultrasound procedure codes** | 55,808 | 2.4% | 231,928 | 1.6% |
| Claim was for one of more than five services provided to the same beneficiary on the same day by the same provider | 33,458 | 1.5% | 101,777 | 0.7% |
| Claim was for a beneficiary who had ultrasound services billed for him or her by more than five providers in 2007 | 31,024 | 1.4% | 12,966 | 0.1% |
| Claim had missing or invalid data in the field that identifies the doctor who ordered the service | 7,097 | 0.3% | 66,287 | 0.5% |
| **Unduplicated total** | 423,862 | 18.5% | 2,765,452 | 18.8% |

*Claims may have had more than one questionable characteristic.
**See Tables A2 and A3 in Appendix A for details on questionable uses of procedure codes.
Source: OIG analysis of the Medicare National Claims History File, 2007.

***Table 2: Allowed Charges for Ultrasound Part B Claims With Questionable Characteristics, 2007***

| Questionable Characteristic | High-Use Counties | | All Other Counties | |
|---|---|---|---|---|
| | Allowed Charges* | Percentage of Allowed Charges* | Allowed Charges* | Percentage of Allowed Charges* |
| Claim lacked a prior service claim from the doctor who ordered the service | $49,124,035 | 14.6% | $306,924,252 | 17.2% |
| Claim involved questionable use of ultrasound procedure codes** | $7,622,384 | 2.3% | $27,336,668 | 1.5% |
| Claim was for one of more than five services provided to the same beneficiary on the same day by the same provider | $5,226,099 | 1.6% | $14,494,316 | 0.8% |
| Claim was for a beneficiary who had ultrasound services billed for him or her by more than five providers in 2007 | $4,321,776 | 1.3% | $1,331,304 | 0.1% |
| Claim had missing or invalid data in the field that identifies the doctor who ordered the service | $846,112 | 0.3% | $6,495,270 | 0.4% |
| **Unduplicated total** | $62,403,039 | 18.6% | $340,235,572 | 19.1% |

*Claims may have had more than one questionable characteristic.
**See Tables A2 and A3 in Appendix A for details on questionable uses of procedure codes.
Source: OIG analysis of the Medicare National Claims History File, 2007.

## Certain providers billed for a large number of ultrasound claims with questionable characteristics

Although most of the 104,598 providers who billed for ultrasound billed 20 or fewer claims with questionable characteristics, 672 each billed Part B for 500 or more such claims in 2007. On average, about half of the ultrasound claims billed in 2007 by these providers had questionable characteristics associated with them. Collectively, these claims accounted for 588,534 of the 1,412,459 ultrasound claims they billed to Part B, accounting for $81 million of their $192 million in allowed charges for ultrasound.

This report found that Medicare beneficiaries in a small group of counties with the highest use of ultrasound received a disproportionate number of services compared to beneficiaries in other counties. In these counties, more beneficiaries received ultrasound services, and when they received them, they received more services from more providers. These factors drive per-beneficiary Part B spending on ultrasound services that is three times that in other counties.

In addition, nearly one in five claims billed for ultrasound services under Medicare Part B in 2007 had characteristics that raise concern about their appropriateness. This rate is consistent when comparing high-use counties to all other counties. Such claims account for 3.2 million services and represent $403 million in Part B charges.

Given our findings, we recommend that CMS:

**Monitor Ultrasound Claims Data To Detect Questionable Claims**

This would reduce Medicare's vulnerability to questionable claims for ultrasound services by enabling CMS to develop claims-processing edits that flag them for review prior to payment. As part of its analysis, CMS should examine claims for characteristics that are readily identifiable, such as suspect combinations of services for the same beneficiary on the same day, and those that become evident across beneficiaries' and providers' claims over time.

**Take Action When Providers Bill for High Numbers of Questionable Claims for Ultrasound Services**

When its monitoring identifies providers that bill for large numbers of questionable claims, CMS should review the claims to ensure that they are legitimate prior to payment. If CMS determines that such providers submit fraudulent claims, it should take steps to revoke their Medicare billing numbers. Toward that end, we will provide CMS with information on the providers that we identified as having submitted high numbers of questionable ultrasound claims.

## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on this report, CMS concurred with both of our recommendations. In response to our recommendations, CMS will share our findings with the Medicare Administrative Contractors for potential additional prepay edits and prepay medical review. CMS also

stated that it will forward questionable claims identified by this report to its Recovery Audit Contractors for them to consider in prioritizing areas for postpayment review. Finally, CMS stated that it will share with its program integrity contractors for appropriate followup information on providers that OIG provides.

We did not make any changes to the report based on CMS's comments. For the full text of CMS's comments, see Appendix B. We have provided CMS with information on the providers that we identified as having submitted high numbers of questionable claims.

## APPENDIX ~ A

Table A-1: Ultrasound Covered Under Part B in High-Use Counties, 2007

| County and State | Beneficiary Population | Percentage of Beneficiaries Receiving Ultrasound | Allowed Charges for Ultrasound | Average Charges per Beneficiary |
|---|---|---|---|---|
| Kings, NY | 213,049 | 35% | $50,067,967 | $235 |
| Miami-Dade, FL | 182,733 | 42% | $42,374,761 | $232 |
| Nassau, NY | 182,738 | 39% | $36,985,652 | $202 |
| Willacy, TX | 2,692 | 41% | $524,329 | $195 |
| Suffolk, NY | 189,873 | 35% | $34,399,935 | $181 |
| Queens, NY | 194,434 | 33% | $34,250,651 | $176 |
| Richmond, NY | 41,697 | 32% | $6,850,116 | $164 |
| Palm Beach, FL | 182,177 | 40% | $27,980,686 | $154 |
| Charlotte, FL | 34,351 | 42% | $4,961,687 | $144 |
| Union, NJ | 67,657 | 31% | $9,747,483 | $144 |
| Middlesex, NJ | 94,291 | 33% | $13,306,923 | $141 |
| Saint Lucie, FL | 40,111 | 37% | $5,519,626 | $138 |
| Macomb, MI | 113,766 | 33% | $15,543,312 | $137 |
| Broward, FL | 136,416 | 33% | $18,461,816 | $135 |
| De Soto, FL | 4,779 | 37% | $641,599 | $134 |
| Ocean, NJ | 114,346 | 35% | $15,338,042 | $134 |
| Marion, FL | 73,343 | 39% | $9,748,060 | $133 |
| Indian River, FL | 30,932 | 38% | $3,993,748 | $129 |
| Sarasota, FL | 97,804 | 36% | $12,066,955 | $123 |
| Walker, AL | 12,636 | 35% | $1,558,896 | $123 |

Source: Office of Inspector General (OIG) analysis of the Medicare National Claims History File, 2007.

Table A-2: Part B Claims Involving Questionable Use of Ultrasound Procedure Codes, 2007

| Questionable Use | High-Use Counties | | All Other Counties | |
|---|---|---|---|---|
| | Number of Claims* | Percentage of Claims* | Number of Claims* | Percentage of Claims* |
| **Claim involved a combination of procedures billed for the same beneficiary, on the same day, by the same provider:** | | | | |
| 76700 Ultrasound, abdominal, real time with image documentation, complete<br>76705 Ultrasound, abdominal, limited (e.g., single organ, quadrant, followup) | 911 | 0.04% | 4,554 | 0.03% |
| 76830 Ultrasound, transvaginal documentation, complete<br>76856 Ultrasound, pelvic (nonobstetric), real time with image documentation, complete | 29,242 | 1.27% | 152,688 | 1.04% |
| 93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study<br>93978 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study | 18,826 | 0.82% | 71,926 | 0.49% |
| **Claim involved a procedure that is not indicated for use in adults:** | | | | |
| 76800 Ultrasound, spinal canal and contents | 6,861 | 0.30% | 2,848 | 0.02% |
| **Unduplicated total** | 55,808 | 2.43% | 231,928 | 1.57% |

*Claims may have involved multiple questionable uses of ultrasound procedure codes.

Source: OIG analysis of the Medicare National Claims History File, 2007.

## Table A-3: Allowed Charges for Part B Claims Involving Questionable Use of Ultrasound Procedure Codes, 2007

| Questionable Use | High-Use Counties | | All Other Counties | |
|---|---|---|---|---|
| | Allowed Charges | Percentage of Allowed Charges | Allowed Charges | Percentage of Allowed Charges |
| **Claim involved a combination of procedures billed for the same beneficiary, on the same day, by the same provider:** | | | | |
| 76700 Ultrasound, abdominal, real time with image documentation, complete<br>76705 Ultrasound, abdominal, limited (e.g., single organ, quadrant, followup) | $107,139 | 0.03% | $616,248 | 0.03% |
| 76830 Ultrasound, transvaginal documentation, complete<br>76856 Ultrasound, pelvic (nonobstetric), real time with image documentation, complete | $3,554,520 | 1.06% | $15,638,645 | 0.88% |
| 93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study<br>93978 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study | $3,190,638 | 0.95% | $10,745,783 | 0.60% |
| **Claim involved a procedure that is not indicated for use in adults:** | | | | |
| 76800 Ultrasound, spinal canal and contents | $774,107 | 0.23% | $347,109 | 0.02% |
| **Unduplicated total** | $7,622,384 | 2.27% | $27,336,668 | 1.53% |

*Claims may have involved multiple questionable uses of ultrasound procedure codes.
Source: OIG analysis of the Medicare National Claims History File, 2007.

# APPENDIX ~ B

## Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

RECEIVED
2009 MAY 15 PM 3:49
OFFICE OF INSPECTOR GENERAL

**DATE:** MAY 1 1 2009

**TO:** Daniel R. Levinson
Inspector General

**FROM:** Charlene Frizzera
Charlene Frizzera
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Medicare Part B Billing for Ultrasound" OEI-01-08-00100

Thank you for the opportunity to review and comment on the above-referenced OIG draft report.

Medicare Part B covers ultrasound services provided in ambulatory settings, such as doctors' offices and testing centers. In 2007, Medicare spent over $2 billion for about 17 million ultrasound services. The OIG found, among other things, a high concentration of ultrasound providers and/or services in certain counties, which may indicate areas where Medicare's program safeguard efforts should be enhanced.

The OIG reported that in 2007, 20 high-use counties accounted for 16 percent of Part B spending on ultrasound services despite having only 6 percent of Medicare beneficiaries. The OIG also found 3.2 million claims with questionable characteristics that raise concerns about the appropriateness of these claims. These claims represent $403 million in Part B charges. Furthermore, the OIG found that the average per-beneficiary spending on ultrasound services in the 20 high-use counties was more than three times that for beneficiaries in the rest of the country.

The OIG found that lack of a prior service claim by the ordering doctor was the most common questionable characteristic. Other characteristics, such as questionable use of procedure codes, were less common but more prevalent in high-use counties than other counties. In addition, certain providers billed for a large number of ultrasound claims with questionable characteristics, such as suspect combinations of ultrasound services for the same beneficiary.

The OIG made the following recommendations:

**OIG Recommendation**

Monitor ultrasound claims data to detect questionable claims. This would reduce Medicare's vulnerability to questionable claims for ultrasound services by enabling CMS to develop claims-processing edits that flag these questionable claims for review prior to payment.

**CMS Response**

The CMS concurs. CMS will share the OIG findings on questionable ultrasound claims with the Medicare Administrative Contractors (MACs) for potential additional prepay edits and prepay medical review. CMS will inform MACs of this issue so that they may consider it when prioritizing their medical review strategies as part of the CMS effort to protect the Medicare Part B Trust Fund.

**OIG Recommendation**

Take action when providers bill for high numbers of questionable claims for ultrasound services. When its monitoring identifies providers that bill for large numbers of questionable claims, CMS should review their claims to ensure that they are legitimate prior to payment. If CMS determines that such providers submit fraudulent claims, it should take steps to revoke their Medicare billing numbers.

**CMS Response**

The CMS concurs. CMS will take appropriate action to forward the listing of questionable claims to the Recovery Audit Contractors (RACs) and 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 ultrasound issue when prioritizing their medical review strategies.

The OIG has recommended that CMS take action if it determines that ultrasound providers submit fraudulent claims. We request the OIG share with CMS the information on those providers they believe may have been inappropriately paid. When CMS receives this information, we will share it with our integrity contractors for appropriate action. In some cases, the contractors may take administrative action(s) including placing the provider on prepayment review, collecting overpayments, and/or initiating payment suspensions. Additionally, for reviews that result in findings of potential fraud, the contractor may develop a case for referral to the OIG for additional action.

The CMS thanks the OIG for its efforts on this report and for highlighting this potential vulnerability in the Medicare program. CMS is committed to continually reviewing and refining our processes to improve the Medicare program, and we will take the findings of this report under consideration as we continue to strengthen our oversight efforts to further reduce improper payments in the Medicare program. We look forward to continuing to work with the OIG to identify and prevent fraud, waste, and abuse in the Medicare program.

# ACKNOWLEDGMENTS

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