



DEPARTMENT OF JUSTICE | OFFICE OF THE INSPECTOR GENERAL

MANAGEMENT ADVISORY MEMORANDUM

22-035

FEBRUARY 2022

Notification of Concerns Regarding Potential
Overpayment by the Federal Bureau of
Prisons for Inmate Health Care Services

INVESTIGATIONS DIVISION



January 31, 2022

Management Advisory Memorandum

To: Michael Carvajal
Director
Federal Bureau of Prisons

A handwritten signature in blue ink that reads "Michael E. Horowitz".

From: Michael E. Horowitz
Inspector General

Subject: Notification of Concerns Regarding Potential Overpayment by the Federal Bureau of Prisons for Inmate Health Care Services

The purpose of this memorandum is to advise you of concerns the Department of Justice (DOJ) Office of the Inspector General (OIG), has identified in connection with potential overpayment by the Federal Bureau of Prisons (BOP) to contractors for health care services provided to inmates at BOP institutions nationwide. Through data analytics and recent OIG investigative activity, we learned that at least one prime Comprehensive Medical Services Contractor sometimes selected and submitted to the BOP Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes on behalf of its subcontracted providers of medical services, instead of having the providers select such codes themselves. We found that this resulted in the BOP potentially overpaying for medical services provided to inmates. In this memorandum, the OIG makes one recommendation to address the concerns we identified.

Background

From 2010 to 2019, the DOJ paid approximately \$1.2 billion to nine different Comprehensive Medical Services Contractors for health care services. Comprehensive Medical Services Contractors enter into subcontractor agreements with providers of varying medical specialties that are responsible for providing medical care both on and off-site to BOP inmates. Utilizing supporting documentation provided to Comprehensive Medical Services Contractors by the subcontracted healthcare providers, Comprehensive Medical Services Contractors prepare and submit invoices to the BOP for reimbursement using Current Procedure Terminology (CPT) codes, which are also sometimes referred to as Healthcare Common Procedure Coding System (HCPCS) codes.¹ CPT/HCPCS codes are five-digit numeric codes published by the American Medical Association (AMA) that correspond to a variety of medical procedures and services under public and private health insurance programs. Based on the OIG's data analytics, we determined that the most commonly used CPT/HCPCS codes for services provided to inmates are for evaluation and management (E&M) services, such as physician office visits and hospital care visits.

¹ We refer to these codes collectively as CPT/HCPCS codes.

According to the AMA's 2019 CPT Professional Edition Codebook (AMA Codebook), within each category of E&M services, there are three to five levels of CPT/HCPCS codes available for reporting and billing purposes. Table 1 outlines the top ten CPT/HCPCS codes Comprehensive Medical Service Contractors submitted to the BOP for reimbursement between 2010 and 2019, by number of claims.

Table 1²

Top 10 CPT/HCPCS Codes Billed to the BOP

	CPT/HCPCS	CPT/HCPCS Description	Total Number of Claims	Total Paid Amount
1	99232	Subsequent Hospital Care	74,624	\$ 15,827,999.96
2	99233	Subsequent Hospital Care	39,229	\$ 11,370,754.24
3	99285	Emergency Department Visit	38,114	\$ 20,668,524.55
4	93010	Electrocardiogram Report	34,967	\$ 1,400,413.60
5	99204	Office/Outpatient Visit New	33,387	\$ 10,354,253.06
6	99203	Office/Outpatient Visit New	33,316	\$ 7,176,398.47
7	71010	Chest X-Ray	32,620	\$ 1,682,039.45
8	99214	Office/Outpatient Visit EST	32,421	\$ 6,535,052.80
9	99213	Office/Outpatient Visit EST	31,663	\$ 4,273,841.42
10	99223	Inpatient Hospital Care	24,822	\$ 10,875,126.41
	Total		375,163	\$ 90,164,403.96

Relevant Authorities

The BOP relies on outside medical services to provide care for inmates that cannot be provided by institution staff. There are no statutes or regulations that set BOP reimbursement rates for medical care provided to inmates. Instead, the BOP solicits and awards Comprehensive Medical Services Contracts for each BOP institution to obtain outside medical services. Within each Comprehensive Medical Services Contract, there is a section outlining rates for various inpatient and outpatient services. The

² The data in tables 1, 2, and 3 of this memorandum was provided from each contractor and consolidated by the OIG. The OIG did not audit or validate the claims data provided for accuracy. Table 1 includes claims data from all 9 Comprehensive Medical Services contractors.

Comprehensive Medical Services Contracts generally state that medical services provided to BOP inmates will be reimbursed using the Medicare benchmark rate for the applicable CPT/HCPCS code, plus an additional premium that varies with locality and service type.

As noted above, the AMA publishes CPT/HCPCS codes, which correspond to a variety of medical procedures and services, including E&M services. According to the AMA Code Book, billing for an E&M service requires the selection of a CPT/HCPCS code that best represents the type of patient (new versus established), the place of service (office, nursing facility, emergency department, etc.), and the level of E&M service performed. There are three key considerations when selecting the appropriate level of E&M service performed: the history of the patient, examination of the patient, and level of medical decision making. In general, the more complex the visit, the higher the level of CPT/HCPCS code that may be billed. Higher code levels, in turn, correspond to higher reimbursement rates.

In order to bill a particular CPT/HCPCS code, medical providers must meet the definition of the code. According to the AMA Codebook, self-limited or minor medical issues typically warrant a “level one” physician office visit CPT code (99201 or 99211), which corresponds to the lowest reimbursement rates for an E&M service, whereas the most complicated medical issues warrant a “level five” code (99205 or 99215), which corresponds to the highest reimbursement rates for an E&M service. The 2021 Medicare physician fee schedule, typically utilized as a baseline to reimburse Comprehensive Medical Services Contractors for services, reports the national payment amount for CPT level one (99211) as \$23.03, which represents the lowest level in the E&M established, office/outpatient series. CPT levels two (99212), three (99213) and four (99214) reimburse \$56.88, \$92.47, and \$131.20, respectively. CPT level five (99215), the highest level in the E&M established, office/outpatient series, reimburses the provider \$183.19, almost eight times more than its level one counterpart.³

The Federal Acquisition Regulation (FAR) § 42.202 (e)(2) states the prime contractor is responsible for managing its subcontracts.

The Issue

In 2016, as part of our oversight of BOP healthcare expenditures, the OIG began collecting and analyzing healthcare claims from Comprehensive Medical Service Contractors responsible for coordinating both on and off-site medical care for inmates at BOP institutions nationwide. During recent OIG investigative activity, the OIG found that one of the BOP’s Comprehensive Medical Services Contractors selected CPT/HCPCS codes on behalf of some of its subcontracted medical service providers for onsite services, while for other of its subcontracted providers it had the provider submit the CPT/HCPCS codes to the Comprehensive Medical Services Contractor. Having the Comprehensive Medical Services Contractor select the CPT/HCPCS code is contrary to the approach typically used in traditional medical practices, wherein the CPT/ HCPCS code submitted for reimbursement is selected by the provider rendering the medical services, or individuals from their staff. A review of contracts between this Comprehensive Medical Services Contractor and those subcontractors for whom it selected CPT/HCPCS codes revealed that the subcontracted healthcare providers were compensated at an hourly rate for on-site services. Paying subcontracted medical service providers at an hourly rate eliminates the provider’s need to include CPT/HCPCS codes in their supporting medical documentation, because they are being compensated per hour, not per service. However, when a subcontracted medical service provider fails to include a CPT/HCPCS code in its supporting documentation, the prime Comprehensive Medical Services Contractor

³ The payment amounts identified utilize a Medicare Administrative Contractor (MAC) locality code of 0000000, which indicates the national payment amount. Actual payment amounts vary by locality.

must select what it believes is a suitable CPT/HCPCS code for the BOP to process payment to the Comprehensive Medical Services Contractor.

The OIG’s investigation into this issue revealed that when this Comprehensive Medical Services Contractor selected CPT/HCPCS codes for its subcontracted healthcare providers, in almost every instance the selected code represented the highest level, or costliest, in the applicable series. By contrast, when the subcontractor healthcare provider selected the CPT/HCPCS code, in the overwhelming number of cases, the subcontractor did not select the highest level in the applicable series.

Table 2 outlines the E&M coding levels for onsite services when this prime Comprehensive Medical Services Contractor, instead of its contracted service providers which rendered the services, selected CPT/HCPCS codes to submit to the BOP.

Table 2⁴

Coding Levels for Onsite Evaluation and Management Visits When Selected by Prime Contractor

Coding Level Submitted to BOP	Number of Claims	Percentage of Claims Population
Level 5 E&M	322	97%
Level 4 E&M or Lower	10	3%
Total	332	100%

In comparison, Table 3 outlines coding levels for onsite services when the same Comprehensive Medical Services Contractor used CPT/HCPCS codes selected by the subcontractors for services they provided.

Table 3

Coding Levels for Onsite Evaluation and Management Visits Selected by Sub-Contractor

Coding Level Submitted to BOP	Number of Claims	Percentage of Claims Population
Level 5 E&M	1,343	13%
Level 4 E&M or Lower	8,984	87%
Total	10,327	100%

⁴ The data provided in tables 3 and 4 is limited to the Comprehensive Medical Services Contractor who admitted to at times, selecting codes on behalf of their subcontractors. Multiple claim lines in the data provided by the Comprehensive Medical Services Contractor included multiple CPT codes. All of the CPT codes identified in the claim line data were counted and included with the final totals in tables 3 and 4.

In light of this data, if this prime Comprehensive Medical Services Contractor had always required its subcontracted medical service providers to select the CPT/HCPCS codes, which is the traditional medical practice, we believe it likely that the number of claims coded at level five would have been far lower than the 322 claims referenced in Table 2. As noted above, coding fewer claims at level five would have resulted in a cost savings for the BOP given that the 2021 Medicare physician fee schedule reports the national payment amount for CPT level five was \$183.19, far more than the cost for the lower coding levels.

Conclusion

We concluded the BOP potentially paid higher amounts for similar services when a Comprehensive Medical Services Contractors selected CPT/HCPCS codes on behalf of its subcontracted medical service providers, as compared to when this Comprehensive Medical Services Contractor used codes submitted by its subcontracted providers.

Recommendation

The OIG recommends that the BOP take the following action in order to remedy the issue identified.

1. The BOP should establish and implement a plan that ensures all current and future Comprehensive Medical Services Contractors use CPT/HCPCS codes selected by their contracted service providers when submitting requests for reimbursement to the BOP, rather than choosing such codes themselves.

The OIG provided a draft of this memorandum to the BOP, and the BOP's response is incorporated in Appendix 1. The BOP indicated in its response that it agreed with the OIG's recommendation. Appendix 2 provides the OIG's analysis of the BOP's response and a summary of the actions necessary to close the recommendation in this memorandum. The OIG requests that the BOP provide an update on the status of its response to the recommendation within 90 days of the issuance of this memorandum.

If you have any questions or would like to discuss the information in this memorandum, please contact me at (202) 514-3435 or Sarah E. Lake, Assistant Inspector General for Investigations, at (202) 616-4730.

cc: Bradley Weinsheimer
Associate Deputy Attorney General
Department of Justice

Appendix 1: The BOP's Response



U.S. Department of Justice

Federal Bureau of Prisons

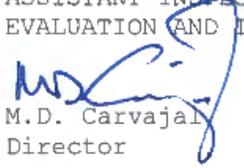
Office of the Director

Washington, D.C. 20534

January 26, 2022

MEMORANDUM FOR RENE ROCQUE LEE
ASSISTANT INSPECTOR GENERAL
EVALUATION AND INSPECTIONS

FROM:


M.D. Carvajal
Director

SUBJECT:

Response to the Office of Inspector General's (OIG)
Formal Draft of a Management Advisory Memorandum:
Notification of Concerns Regarding Potential
Overpayment by the Federal Bureau of Prisons for
Inmate Health Care Services.

The Bureau of Prisons (BOP) appreciates the opportunity to provide a formal response to the Office of the Inspector General's above referenced memorandum. The BOP has completed our review of the memorandum and agrees with the recommendation. We offer the following comments regarding the memorandum and its recommendation.

Recommendation One: The BOP should establish and implement a plan that ensures all current and future Comprehensive Medical Services contractors use CPT/HCPCS codes selected by their contracted service providers when submitting request for reimbursement to the BOP, rather than choosing such codes themselves.

BOP's Response: The BOP agrees to establish and implement a plan to ensure that all current and future Comprehensive Medical Services contractors use CPT/HCPCS codes selected by their contracted service providers when submitting request for reimbursement. The BOP intends to specify this requirement in current solicitations by the end of second quarter 2022, and any subsequent solicitations thereafter. The BOP will clarify this requirement with all current contractors prior to the end of the second quarter 2022.

Appendix 2: Office of Inspector General Analysis and Summary of the Actions Necessary to Close the Report

The OIG provided a draft of this memorandum to the BOP, and the BOP's response is incorporated in Appendix 1. The BOP indicated in its response that it agreed with the OIG's recommendation.

The following provides the OIG's analysis of the BOP's response and a summary of the actions necessary to close the recommendation in this memorandum. The OIG requests that the BOP provide an update on the status of its response to the recommendation within 90 days of the issuance of this memorandum.

Recommendation 1: The BOP should establish and implement a plan that ensures all current and future Comprehensive Medical Services Contractors use CPT/HCPCS codes selected by their contracted service providers when submitting requests for reimbursement to the BOP, rather than choosing such codes themselves.

Status: Resolved.

BOP Response: The BOP reported the following:

The BOP agrees to establish and implement a plan to ensure that all current and future Comprehensive Medical Services contractors use CPT/HCCS codes selected by their contracted service providers when submitting request for reimbursement. The BOP intends to specify this requirement in current solicitations by the end of the second quarter 2022, and any subsequent solicitations thereafter. The BOP will clarify this requirement with all current contractors prior to the end of the second quarter.

OIG Analysis: The BOP's response is responsive to the recommendation. This recommendation can be closed once the BOP (1) establishes and implements a plan that ensures all current and future Comprehensive Medical Services Contractors use CPT/HCPCS codes selected by their contracted service providers when submitting requests for reimbursement to the BOP; and (2) provides the OIG with evidence of this plan, including sample solicitations that incorporate this requirement and evidence that the BOP has clarified this requirement with all current contractors.