Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF ANESTHESIA, PHARMACY AND SUPPLY SERVICES INCIDENT TO OTHER OUTPATIENT DIAGNOSTIC SERVICES PROCESSED BY ASSOCIATED HOSPITAL SERVICE

JANET REHNQUIST
Inspector General

June 2002
A-01-01-00542

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
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JUN 06 2002

CIN: A-01-01-00542

David Crowley
Executive Director
Associated Hospital Service
2 Gannett Drive
South Portland, Maine 04106

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services (OAS) final report entitled "Review of Anesthesia, Pharmacy and Supply Services Used Incident to Other Outpatient Diagnostic Services Processed by Associated Hospital Service." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS Action Official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Act) (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to HHS grantees and contractors are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which HHS chooses to exercise. (See 45 CFR Part 5).

To facilitate identification, please refer to Common Identification Number A-01-01-00542 in all correspondence relating to this report.

Sincerely,

Michael J. Armstrong
Regional Inspector General for Audit Services

Direct reply to HHS Action Official:

Roger Perez, Acting Regional Administrator, Region I
Centers for Medicare and Medicaid Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

EXECUTIVE SUMMARY

Background

Medicare regulations require that the payment limit for other outpatient diagnostic services include pharmacy, anesthesia and medical supplies used in connection with other outpatient diagnostic services. Hospitals may bill for such services as part of the amount charged for the other diagnostic services or under the incident to other diagnostic services revenue codes if this facilitates hospital accounting. Hospitals may not use general revenue codes for billing those services that are incident to other diagnostic procedures and subject to the payment limit.

Objective

The objective of our review was to determine whether outpatient anesthesia, pharmacy and medical supplies used incident to other outpatient diagnostic services during the providers' Fiscal Year (FY) 1999 were billed for and reimbursed in accordance with Medicare requirements.

Summary of Findings

Many hospitals serviced by Associated Hospital Service (AHS) did not establish adequate internal controls to ensure that claims for anesthesia, pharmacy and medical supply services used incident to other outpatient diagnostic services were coded in accordance with Medicare requirements. We found this was particularly true of providers of cardiac catheterization services. In this regard, hospitals, that rendered cardiac catheterizations, incorrectly coded pharmacy, anesthesia and medical supplies used incident to other outpatient diagnostic services during their FY 1999. We found that the hospitals coded these services using general revenue codes instead of the specific revenue codes required when billing for services incident to other outpatient diagnostic services. As a result, the hospitals overcharged an estimated $518,000 on claims submitted to AHS.

Recommendations

We recommend that AHS require hospitals that provide cardiac catheterization services to perform compliance reviews of FY 1999 claims to determine if any pharmacy, anesthesia or supplies claimed incident to other outpatient diagnostic services were coded incorrectly. If so, AHS should either:

- Require the hospital to re-bill the miscoded claims with the correct procedure codes and re-open their FY1999 cost report for adjustment and collection of overpayment, if any or;
- Require the hospital adjust or re-file the current open cost report to reflect the amount of miscoded claims from FY 1999 or
- Require the hospital to report the amount of miscoded claims from FY 1999 and use that amount in conjunction with the FY 1999 cost report data to calculate the amount of any overpayment. The hospital would then be required to make separate payment for the overpayment.

In response to our draft report (see APPENDIX B), the AHS concurred with our recommendations.

INTRODUCTION

BACKGROUND

The Medicare Intermediary Manual (MIM) section 3631(C)(1)(b) and Medicare Hospital Manual (MHM) section 443(C)(1)(b) state that the payment limit for other diagnostic services includes pharmacy, anesthesia, and medical supplies used in connection with other diagnostic services. Hospitals may bill such services as part of the amount for the other diagnostic procedure under revenue codes 46x, 471, 480, 481, 482, 73x, 730, 731, 732, 74x, 75x, 920, 921, 922, or 924, or separately, under the incident-to-other diagnostic services revenue codes for pharmacy (254), anesthesia (372), or supplies (622) if this facilitates hospital accounting. Hospitals may not use general revenue codes for pharmacy (250), anesthesia (370), or supplies (270) for billing those services incident to other diagnostic procedures that are subject to the payment limit. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year-end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final reimbursement.

Associated Hospital Service (AHS) is the Medicare Fiscal Intermediary (FI) responsible for processing claims submitted by hospitals in Massachusetts and Maine. In this regard, AHS is also responsible for establishing a payment system that will provide reasonable assurances that payments are correct. Throughout Massachusetts and Maine, there are 95 acute care hospitals in the population that submitted 55,570 outpatient claims containing at least one outpatient other diagnostic service during each providers' respective FY 1999.

OBJECTIVES, SCOPE AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine whether outpatient pharmacy, anesthesia and medical supplies used incident to other outpatient diagnostic services were billed for and reimbursed in accordance with Medicare requirements. Our review included services rendered during each providers' respective FY 1999.

We limited consideration of the internal control structure to those controls concerning claims submission because the objective of our review did not require an understanding or assessment of the complete internal control structure at AHS or the hospitals included in our review. In this regard, we concluded that our review of the internal control structure at AHS and the hospitals could be conducted more efficiently by expanding substantive testing, thereby placing limited reliance on AHS' and the hospitals' internal control structure.

It should also be noted that while our results are stated as dollars charged for miscoded services, the final effect of the miscoding cannot be determined without adjusting the providers' FY 1999 cost reports.

To accomplish our objective, we:

- reviewed the criteria related to other outpatient diagnostic services,
- randomly selected eight hospitals for review using a multistage sample based on probability-proportionate-to-size weighted by the total dollars charged for claims containing other outpatient diagnostic services;

- randomly selected 100 claims for review at each of the eight hospitals;
- obtained and reviewed the billing records for each of the 800 claims;
- interviewed appropriate hospital staff concerning the internal controls over the submission of claims for other outpatient diagnostic services; and
- used a variable appraisal program to estimate the total dollar impact of improper charges (see APPENDIX A).

Our field work was performed from November, 2001 through March, 2002 at selected hospitals in Massachusetts and Maine.

The AHS's response to the draft report is appended to this report (see APPENDIX B) and is addressed on page 4.

FINDINGS AND RECOMMENDATIONS

Many hospitals serviced by AHS did not establish adequate internal controls to ensure that claims for anesthesia, pharmacy and medical supply services used incident to other outpatient diagnostic services were coded in accordance with Medicare requirements. We found this was particularly true of providers of cardiac catheterization services. In this regard, hospitals that rendered cardiac catheterizations, incorrectly coded pharmacy, anesthesia and medical supplies used incident to other outpatient diagnostic services. We found that the hospitals coded these services using general revenue codes instead of the specific revenue codes required when billing for services incident to other outpatient diagnostic services. As a result, the hospitals overcharged an estimated $518,000 on claims submitted to AHS.

PAYMENT LIMITATION REQUIREMENTS

The Omnibus Budget Reconciliation Act (OBRA) of 1987 established payment limitations for other diagnostic procedures furnished by a hospital on an outpatient basis after September 30, 1989. The payment limit for other diagnostic services is determined using prevailing charges developed by the Medicare carrier for the hospital's locality. Aggregate payments are the lesser of the amount that would be paid under the law prior to enactment of applicable OBRA of 1987 sections or a blended amount based in part on prevailing charges or fee schedule amounts for the same services performed in physicians' offices in the same locality. Final payment is based upon the hospital's cost report.

The MIM section 3631(C)(1)(b) and MHM section 443(C)(1)(b) further state that the payment limit for other diagnostic services includes pharmacy, anesthesia, and supplies used in connection with other diagnostic services. Hospitals may bill such services as part of the amount for the other diagnostic procedure under revenue codes 46x, 471, 480, 481, 482, 73x, 730, 731, 732, 74x, 75x, 920, 921, 922, or 924, or separately, under the incident-to-other diagnostic services revenue codes for pharmacy (254), anesthesia (372), or supplies (622) if this facilitates hospital accounting. Hospitals may not use general revenue codes for pharmacy (250), anesthesia (370), or supplies (270) for billing those services incident to other diagnostic procedures subject to the payment limit.

CLAIM CODING FOR ANESTHESIA, PHARMACY AND MEDICAL SUPPLIES

To facilitate our review of anesthesia, pharmacy and medical supply services used incident to other outpatient diagnostic services, we employed computer programs to extract all claims containing such services from providers in Massachusetts and Maine whose claims are processed by AHS. As a result, we determined that the 95 hospitals submitted 55,570 claims containing at least one other outpatient diagnostic service plus a medical supply service during their respective FY 99. However, further refinement of the population of claims to include only those medical supplies used in connection with outpatient diagnostic services could not be accomplished without manual review. Accordingly, we used statistical sampling to focus on those services that we intended to be within the scope of our review.

To identify anesthesia, pharmacy and medical supplies used incident to other outpatient diagnostic services and to determine the appropriateness of their reimbursement coding, we employed a multistage sample methodology by selecting 8 hospitals based on a probability proportional to the size of their submitted claims in our population. We then randomly selected 100 claims for each of these 8 hospitals for a total sample of 800 claims.

Of the 800 claims reviewed, we found 117 claims contained errors totaling $11,529. Specifically, we determined that $300 of anesthesia supplies, $41 of pharmacy supplies and $11,188 of medical supplies were incorrectly coded. The hospitals coded these services using general revenue codes instead of the specific revenue codes required when billing for services incident to other outpatient diagnostic services. Officials from a majority of the hospitals informed us that they were unaware of the billing requirements for outpatient other diagnostic services. Accordingly, they didn't establish procedures to ensure the correct coding of claims containing services incident to outpatient other diagnostic services. As a result, the providers may have been overpaid for these services during cost report settlement.

Our population of claims reviewed was not limited to just those claims for other outpatient diagnostic services with a high probability of error, but all claims for other outpatient diagnostic services containing at least one supply service. Further, without extensive manual review, we could not refine our population of claims to include only those supplies used in connection with outpatient diagnostic services. As a result, the rate of claims containing miscoded anesthesia, pharmacy and medical supplies used incident to other outpatient diagnostic services appears to be insignificant.

We therefore performed a risk assessment based on the results of our sample and determined that providers of cardiac catheterization services had the greatest risk of miscoding services incident to other outpatient diagnostic services. A review of our population showed that 38 hospitals which rendered cardiac catheterization services during their FY 1999 submitted 35,440 claims valued at $83,704,362 for other outpatient diagnostic services. Further analysis of our sample results showed that of the $11,529 found in error, 78 claims totaling $10,402 was from providers of cardiac catheterization services. Of the 78 claims, 21 claims totaling $7,457 were directly related to cardiac catheterization services while the remainder were for various other outpatient diagnostic services.

Based on our statistical sample, we estimate that the amount charged for improperly coded services made by hospitals that provided cardiac catheterization services and whose claims were processed by AHS is approximately $518,000. The precision of this estimate at the 90 percent confidence level is +/-

92.14 percent. Further details of our statistical estimate are contained in APPENDIX A. The final effect of this miscoding cannot be determined until the providers' cost reports are settled.

CONCLUSION

We found hospitals that provide cardiac catheterization services accounted for most of the miscoded claims for pharmacy, anesthesia and supply services rendered incident to other outpatient diagnostic services. Therefore, we believe that future compliance requirements established by AHS concerning other outpatient diagnostic services should focus on cardiac catheterization services in order to economize resources expended and maximize program returns. We also believe that procedural or system changes are not necessary as hospitals are now reimbursed on a prospective basis. We will work with AHS to identify the 38 hospitals that provided cardiac catheterization services.

RECOMMENDATION

We recommend that AHS require hospitals that provide cardiac catheterization services to perform compliance reviews of FY 1999 claims to determine if any pharmacy, anesthesia or supplies claimed incident to other outpatient diagnostic services were coded incorrectly. If so, AHS should either:

- Require the hospital to re-bill the miscoded claims with the correct procedure codes and re-open their FY 1999 cost report for adjustment and collection of overpayment, if any or;

- Require the hospital adjust or re-file the current open cost report to reflect the amount of miscoded claims from FY 1999; or

- Require the hospital to report the amount of miscoded claims from FY 1999 and use that amount in conjunction with the FY 1999 cost report data to calculate the amount of any overpayment. The hospital would then be required to make separate payment for the overpayment.

AUDITEE RESPONSE

In response to our draft report (see APPENDIX B), the AHS concurred with our recommendations.

APPENDICES

APPENDIX A

REVIEW OF CLAIMS FOR ANESTHESIA, PHARMACY AND SUPPLY SERVICES USED INCIDENT TO OTHER OUTPATIENT DIAGNOSTIC SERVICES PROCESSED BY ASSOCIATED HOSPITAL SERVICE

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	TOTAL ERRORS	CARDIAC CATH ERRORS
Items: 55,570 Dollars: $117,780,573*	Items: 800 Claims Dollars: $364,990*	Items: 117 Dollars: $11,529	Items: 78 Dollars: $10,402

PROJECTION OF SAMPLE RESULTS

Precision at the 90 Percent Confidence Level

Point Estimate: $518,981
Lower Limit: $40,793
Upper Limit: $997,169

* The claims in the population and sample included services other than anesthesia, pharmacy and supplies that were not part of the scope of this review. We were unable to isolate those services relevant to our review due to technical considerations.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare
Part A Intermediary
Maine & Massachusetts
Regional Home Health

May 20, 2002

Mr. Michael J. Armstrong, Regional Inspector General
Office of the Inspector General
Office of Audit Services
JFK Federal Building
Boston MA 02203

RE: A-01-01-00542

Dear Mr. Armstrong:

This letter is in response to your April 29, 2002 correspondence to David Crowley, Executive Director, Associated Hospital Service (AHS), regarding your "Review of Anesthesia, Pharmacy and Supply Services Used Incident to Other Outpatient Diagnostic Services Processed by Asociated Hospital Service." We thank you for the opportunity to respond to your findings and the inclusion of our response in your final report when it is issued.

Based on our review of the Draft Report and our conversations with Curt Roy of your staff, AHS concurs with the OIG findings. We have received the OIG data files containing paid claim information for thirty-three (33) Massachusetts and five (5) Maine hospitals' cardiac catheterization services. Pursuant to your recommendations AHS will require that these hospitals perform compliance audits to report the amount of miscoded claims and overpayments for cardiac catherizations done in FY 1999. AHS will also require that hospitals report miscoded claims and overpayments for cardiac catheterization services rendered in fiscal periods through the July 31, 2000 implementation of the Outpatient Prospective Payment System (OPPPS).

We look forward to working with the OIG on this investigation, and on future projects as they arise. Should you or anyone on your staff have any questions or require assistance with this review, please contact me at (207) 822-7176. Once again we thank you for this opportunity to respond to your review findings, and to safeguard Medicare Program Trust Funds.

Sincerely,

Marc A. Lesperance
Benefit Integrity Manager
Associated Hospital Service (South Portland office)

Cc: Mark Humphreys, AHS
David Crowley, AHS
Margaret Fortin, AHS
Al Harvey, AHS

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