# Memorandum

Date SEP 20 1994

From June Gibbs Brown
Inspector General

Subject Review of Claims Processing for Ambulatory Surgical Services Performed in Hospital Outpatient Departments (A-01-93-00502)

To
Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled, "Review of Claims Processing for Ambulatory Surgical Services Performed in Hospital Outpatient Departments." The objective of our review was to determine whether fiscal intermediaries' (FI) controls over processing of claims for ambulatory surgical center (ASC) approved surgical services are adequate to ensure that the correct amount of Medicare reimbursement is computed for payment to hospitals upon cost settlement. Because Medicare reimburses hospitals for ASC services on a cost-settlement basis, accurate and reliable reimbursement data are needed to ensure that overpayments do not occur.

Our review found that FIs' controls are not adequate to preclude ASC reimbursement data from being overstated. For example, for each ASC claim hospitals submit, the FIs accumulate an ASC payment amount to be used later for cost-settlement purposes. We found that hospitals split ASC services among two or more claims causing the FI to accumulate the ASC payment amount two or more times for the same surgery. The Health Care Financing Administration (HCFA) and the FIs need to ensure that controls are in place to identify such billings and preclude multiple accumulation of the same ASC payment amount for the same surgery.

Our finding was based on pilot reviews conducted at seven FIs in Region I. To assess national implications, we performed a computer analysis of nationwide paid claims for hospital outpatient ASC approved surgical services for the period January 1991 through December 1992. Our analysis identified approximately 10,000 claims which result in potential overpayments to hospitals of as much as $2 million.

With the increase of ambulatory surgeries and the volume of claims being processed, tighter controls are needed to prevent potential overpayments. As such, we are recommending that HCFA: (1) implement a computer system edit to ensure that the ASC payment amount is not accumulated subsequent to the original claim, (2) clarify existing

regulations to ensure providers are aware of the proper submission of ASC claims, and (3) instruct FIs to utilize the data from our computer applications to determine if adjustments to providers' cost reports are needed.

In its response to our draft report, HCFA concurred with our recommendations and has taken or is planning to take corrective actions. The HCFA's comments are presented as an Appendix to this report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-01-93-00502 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF CLAIMS PROCESSING FOR AMBULATORY SURGICAL SERVICES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS


JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1994

# Memorandum

Date SEP 20 1994

From June Gibbs Brown
Inspector General

Subject Review of Claims Processing for Ambulatory Surgical Services Performed in Hospital Outpatient Departments (A-01-93-00502)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

The purpose of this final report is to summarize the results of our "Review of Claims Processing for Ambulatory Surgical Services Performed in Hospital Outpatient Departments." The objective of our review was to determine whether fiscal intermediaries' (FI) controls over processing of claims for ambulatory surgical center (ASC) approved surgical services are adequate to ensure that the correct amount of Medicare reimbursement is computed for payment to hospitals upon cost settlement. The period covered by our review included the Health Care Financing Administration's (HCFA) paid claims processing dates of January 1991 through December 1992.

The Medicare Intermediary Manual (MIM), section 3626.4 requires hospital outpatient departments to submit only one claim for services provided on the day the surgical procedure is performed. However, Medicare instructions also provide for the submission of debit only adjustment bills for charges not previously billed. For each claim a provider submits with an ASC covered surgical procedure code, the FI accumulates an ASC payment amount which is utilized in settling the provider's cost report. Splitting services among two or more claims, for an ASC approved surgery, causes the accumulated ASC payment amount to be overstated.

We conducted pilot reviews at seven FIs in Region I (see Appendix I). Our results showed that some providers are splitting services for covered ASC surgeries among two or more claims. These results prompted us to develop a computer application to quantify the effect nationwide. For the period covered by this review, all FIs nationwide processed approximately 8 million claims for ASC approved surgical services, to include original claims, credit adjustments, and debit adjustments. Our computer analysis identified approximately 10,000 claims which potentially overstated the accumulated ASC payment amount by about $5 million because hospitals submitted two or more claims for an ASC approved surgery. In the cost-settlement process, this overstatement could result in potential overpayments of as much as $2 million (see Appendix II).

Based on our analysis, the primary cause for the overstatement is the absence of proper controls for the handling of charges omitted from previously submitted claims for approved ASC surgical procedures. Our analysis also shows that providers are using various ASC bill types which preclude the FIs from determining if more than one claim has been submitted for a single ASC covered surgery.

With the increase of ambulatory surgeries and the volume of claims being processed, tighter controls are needed to prevent potential overpayments. As such, we are recommending that HCFA: (1) implement a computer system edit to ensure that the ASC payment amount is not accumulated subsequent to the original claim, (2) educate providers regarding the proper submission of ASC claims, and (3) instruct FIs to utilize the data from our computer applications to determine if adjustments to providers' cost reports are required.

In its response to our draft report, HCFA concurred with our recommendations and has taken or is planning to take corrective actions. The HCFA's comments are presented as Appendix III to this report.

# INTRODUCTION

## BACKGROUND

Since the inception of the prospective payment system for inpatient hospital services, there has been a shift from inpatient care to outpatient care, especially for surgical services. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) provides for Medicare Part B coverage of facility services furnished in connection with surgical procedures that can be performed safely in a hospital outpatient department. The 42 CFR, section 413.118 established the method for determining Medicare payments for facility services related to covered ASC procedures performed in a hospital on an outpatient basis. Facility services are those items and services that are furnished by a hospital on an outpatient basis in connection with a covered ASC surgical procedure. These services include, but are not limited to nursing services, operating room, drugs, medical supplies, diagnostic services, administrative services, and anesthesia. Examples of services excluded from the facility services are physicians' services, x-rays, and laboratory services. These services are reimbursed separately.

All ASC approved surgical procedures have been classified into nine payment groups. Those procedures within the same group are assigned an ASC payment amount. The amount is equal to a prospectively determined payment rate established by HCFA for a procedure if it had been furnished by an independent ASC in the same geographic area. Currently, the amounts range from $285 to $1,150. The accumulated ASC payment amount for all ASC surgical services rendered in a hospital's fiscal year is utilized in the cost-settlement process. In this respect, section 3626.4 of the MIM states that final

payment for ASC surgical procedures is handled through the cost-settlement process. Therefore, as claims are processed, the Provider Statistical and Reimbursement (PS&R) system accumulates facility charges attributable to ASC procedures (by identifying the charges billed under certain hospital revenue codes) and the ASC payment amount for each procedure, based upon the procedure code. The PS&R system compiles the provider's Medicare paid claims data and summarizes it for use in the Medicare cost report. The FIs are required to furnish year-to-date summary reports to the provider within 60 days of the end of the provider's fiscal year. The accumulated ASC payment amount is reported on Line 1 of Worksheet E, Part C of the Medicare Cost Reporting Forms For Hospitals (see Exhibit). For cost settlement, the aggregate amount of payments for facility services furnished in a hospital outpatient department for covered ASC surgical procedures is equal to the lower of the reasonable cost, customary charges, or the blended amount. According to section 1833(i) of the Act, the blended amount consists of hospital-specific cost or charge data (42 percent) and an ASC payment amount (58 percent after consideration of beneficiary deductibles and coinsurance).

## SCOPE

This review was made in accordance with government auditing standards. The objective of this review was to determine whether FIs' controls over processing of claims for ASC approved surgical services are adequate to ensure that the correct amount of Medicare reimbursement is computed for payment to hospitals upon cost settlement. The period covered by our computer analysis is the HCFA paid claims processing dates of January 1991 through December 1992.

As part of our examination, we obtained an understanding of the internal control structure surrounding the processing of claims for ASC services furnished in hospital outpatient departments. We concluded, however, that our consideration of the internal control structure could be conducted more efficiently by expanding substantive audit tests, thereby placing limited reliance on the internal control structure.

To accomplish our objective, we:

- reviewed applicable laws and regulations relative to the payment of claims for covered ASC procedures;

- reviewed the policies and procedures used by the Region I FIs for the payment of claims for covered ASC procedures;

- examined the Arkansas claims processing system with several test transactions. The Region I FIs utilize the Arkansas claims processing system either under a shared system arrangement with other FIs or as a stand-alone system;

- o utilized a simple random sample technique to validate our data at Region I FIs;

- o reviewed the PS&R report for the randomly selected ASC approved surgeries to determine if the inappropriate claims resulted in overstating the ASC payment amount for that service;

- o discussed results of pilot reviews with various provider audit groups at the Region I FIs; and

- o utilized the nationwide Medicare Part A paid claims file processed by HCFA for the period January 1991 through December 1992 and, through a series of matching applications, identified potential multiple claims for ASC approved surgeries.

In completing our pilot reviews at selected FIs, we established a reasonable assurance on the authenticity and accuracy of the computer generated data. Our audit was not directed towards assessing the completeness and validity of the HCFA payment file for the period January 1991 through December 1992 from which the data was obtained.

Our reviews were completed during Fiscal Years 1993 and 1994, at Blue Cross of Massachusetts, Braintree, Massachusetts; Blue Cross of Connecticut, Meriden, Connecticut; Associated Hospital Service of Maine, South Portland, Maine; New Hampshire-Vermont Hospital Service, Concord, New Hampshire; Blue Cross of Rhode Island, Providence, Rhode Island; Travelers, Hartford, Connecticut; and Aetna, Farmington, Connecticut. In addition, the review was performed at the Boston Regional Office and Hartford Field Office of the Office of Inspector General and Boston Regional Office of HCFA.

We currently have field work being conducted at Blue Cross of Western Pennsylvania. The results of this review will be addressed under a separate report to the HCFA Regional Office in Region III. As such, we have not included any data for Blue Cross of Western Pennsylvania in the figures contained in Appendix II.

The results of this review indicated that for the areas covered, the FIs complied with the applicable laws and regulations, except for those conditions cited in the FINDINGS AND RECOMMENDATIONS section of this report. With respect to the items not tested, nothing came to our attention to suggest that the untested items would produce different results.

The draft report was issued to HCFA on May 27, 1994. The HCFA's written comments, dated August 5, 1994, are appended to this report (see Appendix III) and are addressed on page 9.

# FINDINGS AND RECOMMENDATIONS

We conducted pilot reviews at all of the FIs in Region I. We determined that providers who omitted charges for an ASC approved surgery from a previously submitted claim would often submit one or more additional claims for these charges. Thus, some providers were splitting services among two or more claims resulting in potential Medicare overpayments.

According to section 3626.4 of the MIM, one claim is required for all services provided on the day the procedure is performed. For each additional claim a provider submits for services for ASC approved surgery, the FIs, through the PS&R system, accumulate the ASC payment amount. The accumulated ASC payment amount is reported by FIs to providers at yearend for cost-settlement purposes. Submitting two or more claims for an ASC approved surgery results in the ASC payment amount reported by FIs to providers to be overstated. In the cost-settlement process, this equates to potential overpayments.

The results of our pilot reviews prompted us to determine if the condition exists on a nationwide basis. As such, we conducted a series of computer applications and identified instances similar to those found in Region I.

## PILOT REVIEWS AT REGION I FIs

We conducted our reviews at seven FIs in Region I (see Appendix I).[1] We identified an overstatement of the accumulated ASC payment amount of approximately $381,000. Our reviews disclosed instances:

- where late charge claims were processed by FIs after implementation of an edit which should have denied these claims;
- where multiple claims involved various ASC bill types; and
- where omitted charges as well as previously submitted charges were submitted on a second claim for the same surgery.

We also found instances where duplicate claims caused the ASC payment amount to be accumulated more than once.

Currently the Region I FIs use the Arkansas claims processing system either under a shared arrangement with other FIs or on a stand-alone basis. This claims processing system is designed to automatically deny claims for ASC approved surgeries if the provider indicates a "late charge" (bill type 835) for a previously submitted claim.

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[1] A report on our reviews was issued to the HCFA regional office in final on June 4, 1993.

provider indicates a "late charge" (bill type 835) for a previously submitted claim. Providers are required to cancel the previously processed claim and resubmit only one claim for all services associated with the ASC approved surgery. An edit to deny late charges was implemented in September 1991. The edit was intended to prevent the ASC payment amount from being accumulated twice. We found no mechanism, however, in the processing system to deny multiple claims for an ASC approved surgery if the provider used other bill types.

To illustrate this latter issue, consider the following example (see Table 1): A beneficiary receives ASC approved surgery on April 11, 1991. On Claim A, the hospital submitted an original claim (bill type 831) for ASC approved surgery - other (hospital revenue center code (RCC) 499). The ASC payment amount of $363 was accumulated by the FI because of the ASC surgical procedure code. On Claim B, also an original claim, the hospital submitted a claim for the remaining services, pharmacy, intravenous therapy, medical surgical supplies, laboratory, and gastrointestinal (RCCs 250, 260, 270, 310 and 750, respectively). The ASC payment amount was accumulated by the FI for a second time in the amount of $363. The accumulated amount of $726 would then be included in the amount reported on Line 1 of Worksheet E Part C of the hospital's cost report (see Exhibit).

| CLAIM | DATE OF SERVICE | RCC | ASC SURGICAL PROCEDURE CODE | CHARGED AMOUNT | ASC PAYMENT AMOUNT | TYPE OF BILL |
|---|---|---|---|---|---|---|
| A | 04/11/91 | 499 | 45385 | 29.70 | 363.00 | 831 |
| | | 001 | | 29.70 | | |
| B | 04/11/91 | 250 | | 13.74 | | 831 |
| | | 260 | | 9.97 | | |
| | | 270 | | 38.71 | | |
| | | 310 | | 48.31 | | |
| | | 750 | 45385 | 359.10 | 363.00 | |
| | | 001 | | 469.83 | | |
| Accumulated ASC payment amount for this ASC surgery | | | | | 726.00 | |

Table 1 - Example of splitting services between two claims.
Note: RCC 001 represents Total Charges for the claim.

In order for us to validate the results of the computer applications, we reviewed random samples of ASC approved surgeries. We provided each of the FIs with a listing of the split claims for ASC approved surgeries and requested that the FIs provide us with the appropriate PS&R report for ASCs for each claim identified. We reviewed the detailed PS&R report for each sampled ASC approved surgery to confirm that more than one claim was submitted and the ASC payment amount was accumulated more than once. We discussed the results of our review with each of the FIs and with Region I HCFA officials. Both the FIs and HCFA concurred with our findings and initiated recovery of potential overpayments.

The PS&R system compiles providers' Medicare paid claims data and summarizes it for use in preparing the individual hospital's Medicare cost report. The FIs are responsible for providing this data to the providers at yearend. Discussions with various provider audit groups disclosed that (1) provider audit does not routinely review the PS&R report in detail due to its volume and (2) it is not possible to perform an edit routine to identify instances where ASC payment amounts have been accumulated more than once for a single ASC approved surgery.

## NATIONWIDE RESULTS

Based on the conclusions reached in the pilot reviews, we conducted the same computer analysis using HCFA's nationwide Medicare paid claims data for the period January 1991 through December 1992. Approximately 8 million claims for ASC approved surgeries were processed. These claims include original claims as well as various adjustment claims. We identified 9,661 instances where providers split the services among two or more claims. These claims potentially overstated the ASC payment amount by about $5 million. In the cost-settlement process, this overstatement could result in potential overpayments of as much as $2 million (see Appendix II).

Ambulatory surgical center approved surgical services are submitted on claims with a bill type series of 83X. These bill types must include an ASC approved surgical procedure code in order for the claims processing systems to accept them. The PS&R system will accumulate for cost-settlement purposes the ASC payment amount for each claim submitted with an ASC approved surgical procedure code. We performed an analysis of the split claims to determine what bill types were used (see Table 2). As our analysis shows, providers utilize various bill types for claiming services omitted from a previously submitted claim.

The largest examples of errors included providers using original claims (bill type 831) when claiming omitted services. These claims pass through the claims processing systems because the seven criteria (health insurance claim number, provider number, from and to dates of service, RCC, charges, and bill type) for suspecting/denying a duplicate claim are not all met. Since these claims are primarily for omitted charges and not for services previously claimed, they are not considered duplicate claims. As such, there are no controls to preclude these claims from being processed and the ASC payment amount from being overstated.

| Type of Bill | Number of Claims |
|---|---|
| 831 | 6,922 |
| 835 | 1,483 |
| 837 | 838 |
| 83I | 133 |
| 83P | 83 |
| 839 | 71 |
| All others | 131 |
| Total | 9,661 |

**Table 2** - *Bill types used for split claims.*

The MIM does provide for a means of handling omitted charges. Section 3664.1 of the MIM states, "Providers must also submit a debit-only adjustment request to you [FI] if they discover previously omitted charges on an already submitted bill for outpatient surgery subject to the ASC payment limitation...." Provider requested debit-only adjustments are submitted on bill type 837. Furthermore, section 3664.2 states that late charges should not be submitted on bill type 835, but rather, submitted as a "debit-only adjustment," bill type 837. During the period of our review, providers were required to submit a "cancel" claim along with the debit-only adjustment claim to credit any prior payments. If this was not done, the accumulated ASC payment amount would be overstated. Since the completion of our review, HCFA requires the FIs to generate the "cancel" claim automatically when a debit-only adjustment claim is submitted by a provider. This claims processing system change was implemented in October 1993.

The methodology for cost settlement of ASC approved surgical services is such that only one claim should be submitted for all services rendered. Requiring one claim for all services would obviously preclude the possibility of overstating the total accumulated ASC payment amount. With more and more ASC approved surgeries being performed and as the number of claims being processed increases, tighter controls are needed to avoid potential overpayments.

## RECOMMENDATIONS

We recommend that HCFA :

1) implement a computer system edit to ensure that the ASC payment amount is not accumulated subsequent to the original claim,

2) educate providers regarding the proper submission of ASC claims, and
3) instruct FIs to utilize the data from our computer applications to determine if adjustments to providers' cost reports are required. The Office of Inspector General will make available the data from our computer applications.

## HCFA'S COMMENTS AND OIG'S RESPONSE

In its response to our draft report, HCFA concurred with our recommendations and indicated that corrective actions have been taken or are planned to be taken.

We have one concern about corrective actions to be taken by HCFA with respect to our first recommendation. The HCFA stated that it will require FIs to install an edit to prevent processing of more than one 831 or 13X bill type for the same date of surgery, health insurance claim, and provider. As indicated in our report, providers use a variety of bill types for claiming services omitted from a previously submitted claim. We suggest that the edit to be required by HCFA should prevent all 83X bill types which could result in an overstatement of the ASC payment amount. With respect to HCFA's technical comment pertaining to the allowance of more than one claim for the same surgery, we have revised the final report to address their concern.

EXHIBIT

# MEDICARE COST REPORTING FORMS FOR HOSPITALS
## WORKSHEET E PART C

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER NO. | PERIOD: FROM TO | WORKSHEET E PART C |
|---|---|---|---|

PART C - OUTPATIENT AMBULATORY SURGERY CENTER

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

| | HOSPITAL | | |
|---|---|---|---|
| 1 | Standard overhead amount (ASC fees) | 82,822 | 1 |
| 2 | Deductibles | | 2 |
| 3 | Subtotal (Line 1 less line 2) | 82,822 | 3 |
| 4 | 80 percent of line 3 | 66,258 | 4 |
| 5 | ASC portion of blend (See Instructions) | 34,430 | 5 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | |
| 6 | Outpatient ASC cost (From Wkst. D, Part III, col. 6A and 6B, line 104 | 92,739 | 6 |
| 7 | Return on equity capital (Titles V and XIX only) | | 7 |
| 8 | Total reasonable cost (Sum of lines 6, and 7) | 92,739 | 8 |
| 9 | Total charges | 144,883 | 9 |
| | CUSTOMARY CHARGES | | |
| 10 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | 10 |
| 11 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) | | 11 |
| 12 | Ratio of line 10 to line 11 (Not to exceed 1.000000) | | 12 |
| 13 | Total customary charges (See Instructions) | 144,883 | 13 |
| 14 | Excess of customary charges over reasonable cost (Complete only if line 13 exceeds line 8) (See Instructions) | 52,144 | 14 |
| 15 | Excess of reasonable cost over customary charges (Complete only if line 8 exceeds line 13) (See Instructions) | | 15 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 16 | Lesser of cost or charges (See Instructions) | 92,739 | 16 |
| 17 | Deductibles and coinsurance (See Instructions) | | 17 |
| 18 | TOTAL (See Instructions) | 92,739 | 18 |
| 19 | Hospital specific portion of blend (See Instructions) | 38,950 | 19 |
| 20 | ASC blended amount (Line 5 plus line 19) | 77,380 | 20 |
| 21 | Lesser of lines 18 or 20 (See Instructions) | 77,380 | 21 |

Line 1 contains the accumulated ASC payment amount which may be overstated as a result of providers submitting two or more claims for a single ambulatory surgery.

# APPENDICES

REPORTS BY THE OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
ADDRESSING CLAIMS PROCESSING FOR AMBULATORY SURGICAL
SERVICES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS

| CIN | Fiscal Intermediary | Time Period Covered | ASC Payment Amount |
|---|---|---|---|
| A-01-92-00517[2] | Blue Cross of Massachusetts | November 1990 through December 1991 | $160,122 |
| A-01-93-00503[3] | Blue Cross of Connecticut | November 1990 through December 1991 | $220,872 |
| | Associated Hospital Service of Maine | | |
| | New Hampshire-Vermont Hospital Service | | |
| | Blue Cross of Rhode Island | | |
| | Travelers | | |
| | Aetna | | |
| A-03-94-00005[4] | Blue Cross of Western Pennsylvania | January 1991 through December 1992 | $195,667 |
| A-01-93-00502 | All FIs Nationwide | January 1991 through December 1992 | $4,833,567 |

[2]This final report was issued to Blue Cross of Massachusetts on March 9, 1993.

[3]This final report was issued to the HCFA Regional Office on June 4, 1993.

[4]We currently have field work being conducted at Blue Cross of Western Pennsylvania. The results of this field work will be addressed under a separate cover to the HCFA Regional Office.

SUMMARY BY INTERMEDIARY
POTENTIAL OVERSTATEMENT OF ASC PAYMENT AMOUNT
FOR THE PERIOD JANUARY 1991 THROUGH DECEMBER 1992

| INTERMEDIARY | NUMBER OF PROVIDERS | NUMBER OF INAPPROPRIATE CLAIMS | POTENTIAL OVERSTATEMENT OF ASC PAYMENT AMOUNT |
|---|---|---|---|
| 00010- BC OF ALABAMA | 28 | 56 | $ 27,719 |
| 00020- BC OF ARKANSAS | 38 | 269 | 132,878 |
| 00030- BC OF ARIZONA | 25 | 93 | 46,338 |
| 00040- BC OF CALIFORNIA | 135 | 605 | 340,175 |
| 00050- COLORADO HOSPITAL SERVICE | 14 | 30 | 13,077 |
| 00060- BC OF CONNECTICUT | 17 | 98 | 53,378 |
| 00070- BC OF DELAWARE | 5 | 47 | 21,467 |
| 00090- BC OF FLORIDA | 124 | 1,143 | 531,038 |
| 00101- BC OF GEORGIA | 50 | 207 | 110,885 |
| 00121- HEALTH CARE SERVICE CORP ILLINOIS | 68 | 172 | 79,000 |
| 00130- MUTUAL HOSPITAL INSURANCE INC INDIANA | 48 | 189 | 85,321 |
| 00140- BC OF IOWA | 23 | 32 | 11,508 |
| 00150- BC OF KANSAS | 17 | 36 | 19,875 |
| 00160- BC OF KENTUCKY | 54 | 238 | 111,301 |
| 00180- ASSOCIATED HOSPITAL SERVICE OF MAINE | 8 | 13 | 4,603 |
| 00190- BC OF MARYLAND | 31 | 201 | 109,511 |
| 00200- BC OF MASSACHUSETTS | 42 | 133 | 71,990 |
| 00210- BC OF MICHIGAN | 78 | 683 | 358,966 |
| 00220- BC OF MINNESOTA | 29 | 121 | 59,870 |
| 00230- BC OF MISSISSIPPI | 15 | 47 | 22,169 |
| 00231- BC OF LOUISIANA | 24 | 116 | 55,142 |
| 00241- BC OF HOSPITAL SERVICE OF MISSOURI | 51 | 147 | 79,874 |

SUMMARY BY INTERMEDIARY
POTENTIAL OVERSTATEMENT OF ASC PAYMENT AMOUNT
FOR THE PERIOD JANUARY 1991 THROUGH DECEMBER 1992

| INTERMEDIARY | NUMBER OF PROVIDERS | NUMBER OF INAPPROPRIATE CLAIMS | POTENTIAL OVERSTATEMENT OF ASC PAYMENT AMOUNT |
|---|---|---|---|
| 00250- BC OF MONTANA | 9 | 30 | $ 15,996 |
| 00260- BC OF NEBRASKA | 5 | 6 | 4,151 |
| 00270- NEW HAMPSHIRE/VERMONT HOSPITAL SERVICE | 18 | 37 | 16,600 |
| 00280- HOSPITAL SERVICE PLAN OF NEW JERSEY | 55 | 367 | 209,246 |
| 00290- NEW MEXICO BC | 6 | 30 | 13,466 |
| 00308- EMPIRE BC | 86 | 346 | 153,779 |
| 00310- NORTH CAROLINA BC | 58 | 435 | 202,986 |
| 00320- BC OF NORTH DAKOTA | 2 | 10 | 5,870 |
| 00332- HOSPITAL CARE CORP OHIO | 121 | 1,366 | 675,773 |
| 00340- BC OF OKLAHOMA | 20 | 41 | 21,120 |
| 00350- NORTHWEST HOSPITAL SERVICE OREGON | 19 | 62 | 35,855 |
| 00351- BC OF IDAHO | 8 | 13 | 7,365 |
| 00362- BC OF GREATER PHILADELPHIA | 14 | 77 | 41,786 |
| 00370- BC OF RHODE ISLAND | 8 | 53 | 31,311 |
| 00380- BC OF SOUTH CAROLINA | 26 | 49 | 22,101 |
| 00390- BC OF TENNESSEE | 49 | 203 | 104,927 |
| 00400- BC OF TEXAS | 73 | 191 | 93,340 |
| 00410- BC OF UTAH | 13 | 29 | 15,291 |
| 00423- BC OF VIRGINIA | 47 | 208 | 93,308 |
| 00430- BC OF WASHINGTON ALASKA | 30 | 79 | 42,834 |
| 00441- BC HOSPITAL SERVICE INC WEST VIRGINIA | 1 | 1 | 363 |
| 00450- ASSOCIATED HOSPITAL SERVICE IN WISCONSIN | 29 | 114 | 63,583 |

SUMMARY BY INTERMEDIARY
POTENTIAL OVERSTATEMENT OF ASC PAYMENT AMOUNT
FOR THE PERIOD JANUARY 1991 THROUGH DECEMBER 1992

| INTERMEDIARY | NUMBER OF PROVIDERS | NUMBER OF INAPPROPRIATE CLAIMS | POTENTIAL OVERSTATEMENT OF ASC PAYMENT AMOUNT |
|---|---|---|---|
| 00460- WYOMING HOSPITAL SERVICE | 6 | 10 | $ 6,539 |
| 00468- COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO | 3 | 4 | 1,916 |
| 17120- HAWAII GUAM MEDICAL SERVICE ASSOCIATION | 5 | 9 | 4,492 |
| 50333- TIC NEW YORK | 18 | 228 | 115,173 |
| 51051- AETNA CALIFORNIA | 50 | 111 | 54,691 |
| 51070- AETNA CONNECTICUT | 11 | 114 | 66,471 |
| 51100- AETNA FLORIDA | 4 | 17 | 6,286 |
| 51140- AETNA ILLINOIS | 10 | 53 | 25,919 |
| 51390- AETNA PENNSYLVANIA | 27 | 202 | 98,510 |
| 52280- MUTUAL OF OMAHA | 141 | 490 | 236,434 |
| TOTAL | 1,896 | 9,661 | $4,833,567 |
| ASC PORTION OF THE BLEND[5] | | | $2,242,774 |

[5]The ASC portion of the blend is equal to 58 percent of 80 percent of the total accumulated ASC payment amount. $4,833,657 x 80% = $3,866,853 x 58% = $2,242,774

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

# Memorandum

Date AUG 5 1994

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Review of Claims Processing for Ambulatory Surgical Services Performed in Hospital Outpatient Departments," (A-01-93-00502)

To June Gibbs Brown
Inspector General

We reviewed the subject report which examined fiscal intermediaries' controls over processing of claims for ambulatory surgical center approved surgical services. The purpose of the review was to determine if controls are adequate to ensure that the correct amount of Medicare reimbursement is computed for payment to hospitals upon cost settlement.

The Health Care Financing Administration concurs with the report's recommendations and is taking action to implement them. Additional comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please advise us if you would like to discuss our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Draft Report:
"Review of Claims Processing for Ambulatory Surgical
Services Performed in Hospital Outpatient Departments,"
(A-01-93-00502)

OIG Recommendation

HCFA should implement a computer system edit to ensure that the ambulatory surgical center (ASC) payment amount is not accumulated subsequent to the original claim.

HCFA Response

HCFA concurs. We will revise the Medicare Intermediary Manual to require that fiscal intermediaries install an edit to prevent processing of more than one "831" or "13X" bill type for the same date of surgery, health insurance claim number, and provider.

OIG Recommendation

HCFA should educate providers regarding the proper submission of ASC claims.

HCFA Response

HCFA concurs. We have already taken steps to carry out this recommendation. On September 20, 1993, we issued a letter to all intermediaries requesting them to advise their hospitals of the billing requirements for outpatient ASC services. Many intermediaries have subsequently issued guidelines in their newsletters on this subject. In addition, we plan to revise our Hospital Manual to clarify the billing requirements for outpatient ASC services.

OIG Recommendation

HCFA should instruct fiscal intermediaries (FIs) to utilize the data from our computer applications to determine if adjustments to providers' cost reports are required. We will make the data available from our computer applications.

HCFA Response

HCFA concurs. We will instruct the FIs to utilize the OIG's data to determine if adjustments to provider cost reports are required to recover improper payments.

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Additional Comments

We would like to point out that some of the improper payments identified by OIG have been recovered through our credit balance initiative. The fundamental issue addressed by OIG is the payment of duplicate claims, which should be reflected in the providers' accounting records as credit balances, and repaid pursuant to our mandatory credit balance reporting requirements. Therefore, to avoid any uncertainty as to whether or not improper payments are outstanding, we suggest that future claims payment reviews performed by OIG include the review of the providers' credit balance reports. This inclusion would identify the existence of outstanding amounts, and would substantiate provider compliance with our credit balance instructions.

Given the complexity of administering the blended payment methodology for surgical procedures, we suggest the report reference HCFA's plans to move to prospective rates for these services, as well as for radiology and other diagnostic services.

Additionally, we have one technical comment. On page 8, paragraph 2, the report states that section 3664.2 of the Medicare Intermediary Manual (MIM) "allows more than one claim to be submitted for the same ASC approved surgery." While we agree the MIM should be revised to not allow more than one claim for the same surgery, this statement implies no other measures are in place to avoid overpayments. OIG should note in its report that on October 1, 1993, the FIs implemented an automatic adjustment procedure, in which the prior bill is canceled when an FI accepts a debit-only request.