Memorandum

Date MAY 17 1999

From June Gibbs Brown
Inspector General

Subject Review of Medicare Part B Mutually Exclusive Procedure Codes at Hospital Outpatient Departments (A-01-98-00507)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of the U. S. Department of Health and Human Services, Office of Inspector General's report entitled "Review of Medicare Part B Mutually Exclusive Procedure Codes at Hospital Outpatient Departments." The objective of our review was to determine the potential dollar savings that could be realized if the Health Care Financing Administration (HCFA) required fiscal intermediaries to include edits for Medicare Part B mutually exclusive procedure codes in their claims processing for hospital outpatient services.

We found that while HCFA established edits to preclude payment for certain mutually exclusive services provided by doctors' offices or clinics, payment for the same type services were not prevented when provided in a hospital outpatient department. We recommended that HCFA instruct fiscal intermediaries to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes. Based on our review of payments for radiology and pathology/laboratory services made in 1996 and 1997 by fiscal intermediaries, we believe these edits would result in savings to Medicare of approximately $29.1 million over a 2 year period. We also recommended that HCFA notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

Officials in your office have generally concurred with our recommendations, as set forth on page 7 of the attached report, and agreed to take corrective action.

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 contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-98-00507 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART B MUTUALLY EXCLUSIVE PROCEDURE CODES AT HOSPITAL OUTPATIENT DEPARTMENTS

JUNE GIBBS BROWN
Inspector General

MAY 1999
A-01-98-00507

Memorandum

Date MAY 17 1999

From June Gibbs Brown
Inspector General

Subject Review of Medicare Part B Mutually Exclusive Procedure Codes at Hospital Outpatient Departments (A-01-98-00507)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report presents the results of our Review of Medicare Part B Mutually Exclusive Procedure Codes at Hospital Outpatient Departments. The objective of our review was to determine the potential dollar savings that could be realized if the Health Care Financing Administration (HCFA) required fiscal intermediaries (FI) to include edits for Medicare Part B mutually exclusive procedure codes in their claims processing for hospital outpatient services.

We found that while HCFA established edits to preclude payment for certain Medicare Part B mutually exclusive services provided in doctor's offices or clinics, payment for the same type services was not prevented when provided in a hospital outpatient department. Unlike Medicare carriers, the FIs were not provided written instructions to implement edits which would preclude payment of the same type mutually exclusive procedure codes to hospital outpatient departments. We recommend that HCFA instruct FIs to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes. Based on our review of payments for radiology and pathology/laboratory services made in 1996 and 1997 by FIs, we believe these edits would result in savings to Medicare of approximately $29.1 million over a 2 year period. We also recommend that HCFA notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

Officials in your office have generally concurred with our recommendations, as set forth on page 7, and agreed to take corrective action. However, the implementation of mutually exclusive procedure code edits at Medicare FIs will be delayed until after HCFA has completed its Year 2000 (Y2K) responsibilities. In the interim, HCFA will issue a Program Memorandum, using information supplied by the Office of Inspector General (OIG), to advise FIs and hospital outpatient departments of the OIG's findings regarding mutually exclusive procedure codes. Officials in your office also questioned whether our estimate of potential savings was too large because hospitals and FIs were not required to use modifier codes during our audit period. Our review of this matter disclosed that hospitals were (1) provided with modifier codes and related instructions through the Current Procedural

Terminology (CPT) Manual and (2) using modifier codes in their billings to the Medicare program. As a result, we have not changed our estimated savings amount.

INTRODUCTION

BACKGROUND

With the implementation of Medicare Part B fee schedules in 1992, it became increasingly important to assure that uniform payment policies and procedures were followed by carriers so that when the same service was rendered in different jurisdictions it was paid in the same way. In August 1994, HCFA contracted with AdminaStar Federal, Inc. to develop correct coding methodologies to help control improper coding of Medicare Part B claims by health care providers. The resulting guidelines are referred to as the "National Correct Coding Initiative" (NCCI). The guidelines cover a variety of different types of services, including: (1) surgical; (2) physician rendered medicine, evaluation, and management; (3) anesthesia; (4) pathology/laboratory; and (5) radiology. The policies developed were based on: (1) coding conventions defined in the American Medical Association's CPT manual; (2) national and local policies and edits; (3) coding guidelines developed by national societies; (4) analysis of standard medical and surgical practice; and (5) reviews of current coding practices.

Included within the NCCI are edits for "mutually exclusive procedure codes." These procedures represent medical services that cannot reasonably be done in the same session, to the same patient, by the same provider. The codes are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedure could be performed at the same session. Quarterly updates on mutually exclusive codes are available to carriers and healthcare providers through the Department of Commerce's National Technical Information Service.

Effective January 1, 1996, HCFA required Medicare carriers to implement edits for mutually exclusive procedure codes in their claims processing systems. When the edits identify pairs of mutually exclusive codes, the procedure with the lowest work relative value unit is allowed and the matching procedure is denied. However, HCFA did not require FIs to implement similar controls in their processing systems for hospital outpatient claims, even though the procedures performed in a hospital outpatient department are similar to those performed in a doctor's office or free standing clinic.

SCOPE

We conducted our nationwide review in accordance with generally accepted government auditing standards. The objective of our review was to determine the potential dollar savings that could be realized if HCFA required FIs to include edits for mutually exclusive procedure codes in their claims processing for hospital outpatient services. Our initial survey of payments for mutually exclusive procedure codes in five States (Massachusetts,

Connecticut, Florida, California, and Ohio) showed that the Medicare Part B services most affected were radiology and pathology/laboratory. Accordingly, we limited the scope of our audit coverage to radiology and pathology/laboratory services provided during Calendar Years (CY) 1996 and 1997.

As part of our review, we obtained an understanding of the internal control structure relative to the processing of claims containing mutually exclusive procedure codes. However, the objective of this audit did not require an assessment of these internal controls at either the Medicare carriers or FIs.

To accomplish our objective, we:

- identified the mutually exclusive procedure codes for radiology and pathology/laboratory services by researching the tables contained in the NCCI manual for each quarter of CY 1996 and 1997;

- reviewed the NCCI guidelines on grouping the codes into pairs and identifying the allowable and unallowable codes within the pair;

- reviewed the "modifier codes" related to radiology and pathology/laboratory services, as discussed in the 1996 CPT manual, and identified 33 modifier codes that could make the entire pair of mutually exclusive codes allowable under Medicare;

- extracted payments for radiology and pathology/laboratory services that were included in the mutually exclusive code tables in the NCCI manual from HCFA's Decision Support Access Facility (DSAF) payment files for nationwide hospital outpatient services;

- selected a sample of claims from each of the categories under review to validate the accuracy of the computerized payment information that we obtained from the DSAF and to determine the dollar amount of savings for each sampled item;

- contacted the FI that had processed the original Medicare claim and requested supporting documentation;

- calculated the potential savings for mutually exclusive codes included in the sampled payment instances based on the supporting documentation provided by the FIs and the guidelines in the NCCI manual;

- used the sample results to project the total nationwide potential savings using a variable sample appraisal methodology.

In completing our review of the sample, we established a reasonable assurance on the authenticity and accuracy of the data. Our audit was not directed towards assessing the completeness of the file from which the data was obtained.

Our extract included mutually exclusive procedure codes for only radiology and pathology/laboratory services. In addition, our extract included procedure codes that were paid (and not subsequently offset by adjustments) for services performed on the same date by the same provider on behalf of the same beneficiary. Further, we considered procedure codes with one of the 33 modifier codes discussed above to be an allowable payment, even though we did not request supporting data on the appropriateness of the modifier code. In this regard, the 33 modifier codes describe services that were provided (1) in different care sessions, (2) on different body parts or anatomical sites, (3) by different providers, or (4) because they are mandatory services. With regard to just pathology/laboratory services, we did not extract claims related to any procedure code combinations that we had previously reported to HCFA as part of our studies on unbundled and duplicate laboratory claims in our report entitled "Review of Clinical Laboratory Tests Performed by Hospital Outpatient Departments (A-01-96-00527)."

We limited our calculation of potential savings for radiology services to the interim payment that is made when the initial billing is processed. As a result, our estimates do not reflect any increases or decreases that would be due to the hospital based on year end cost settlements.

Our audit took place in our Boston Regional Office and HCFA's headquarters in Baltimore, Maryland between April 1998 and November 1998.

FINDINGS AND RECOMMENDATIONS

We found that, while HCFA established edits to preclude payment for certain Medicare Part B mutually exclusive services provided in doctor's offices or clinics, payment for the same type services was not prevented when provided in a hospital outpatient department. Unlike Medicare carriers, the FIs were not provided written instructions to implement edits which would preclude payment of mutually exclusive procedure codes to hospital outpatient departments. We recommend that HCFA instruct FIs to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes. Based on our review of payments for these codes in 1996 and 1997, we believe these edits would result in savings to the Medicare program of approximately $29.1 million over a 2 year period. We also recommend that HCFA notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

Officials in your office have generally concurred with our recommendations, as set forth on page 7, and agreed to take corrective action. However, the implementation of mutually exclusive procedure code edits at Medicare FIs will be delayed until after HCFA has

completed its Y2K responsibilities. In the interim, HCFA will issue a Program Memorandum, using information supplied by the OIG, to advise FIs and hospital outpatient departments of the OIG's findings regarding mutually exclusive procedure codes. Officials in your office also questioned whether our estimate of potential savings was too large because hospitals and FIs were not required to use modifier codes during our audit period. Our review of this matter disclosed that hospitals were (1) provided with modifier codes and related instructions through the CPT Manual and (2) using modifier codes in their billings to the Medicare program. As a result, we have not changed our estimated savings amount.

HCFA Instructions

Effective January 1, 1996, HCFA established NCCI edits (including mutually exclusive procedure code edits) in its Medicare Part B program for services provided outside of a hospital setting (e.g., in a doctor's office or clinic). The associated payments for such services are processed by carriers under contract with HCFA. The carriers were instructed to implement the edits in Program Memorandum B-95-7. However, HCFA did not provide similar instructions to FIs to establish NCCI edits in Medicare Part B for services provided in a hospital outpatient department. Payments for such services are processed by FIs under contract with HCFA. Based on our contacts with 32 FIs, we found that the FIs did not implement mutually exclusive procedure code edits on their own initiative.

Officials from HCFA advised us that the primary reason why HCFA did not establish NCCI edits at the FIs in 1996 is that HCFA did not have an accurate estimate of the program savings that could be obtained by requiring NCCI edits for hospital outpatient services. As a result, HCFA could not determine whether the program savings would justify the expense of implementing the NCCI edits. In this regard, services rendered outside of a hospital are reimbursed based on fee schedule amounts for the specific services provided. Conversely, most of the services provided in a hospital outpatient department are reimbursed based on the total reasonable cost of the outpatient services provided. An exception to this practice is pathology/laboratory services associated with an outpatient department. These services are paid based on the same fee schedule used for pathology/laboratory services provided outside of the hospital. While the fee schedules identify the specific amounts paid for individual procedures, the reasonable cost approach commingles the payments for all services into one overall payment per date of service. Accordingly, it is difficult to determine the amount of potential overpayments for specific outpatient services.

Preliminary Corrective Actions

On April 22, 1998, we met with HCFA officials to discuss our proposed audit. At that time, we advised HCFA that our preliminary work had indicated that there were more than 200,000 potential overpayments for mutually exclusive radiology services during CY 1996 and 1997. In response to the meeting, HCFA initiated a Change Management Plan to implement NCCI edits for hospital outpatient bills. The edits were to be operational at the

FIs by October 1, 1998. This effort along with the proposed January 1, 1999 implementation of a prospective payment system (fee schedules) for hospital outpatient services was intended to preclude payments for the types of payments identified by our review. The prospective payment system was required by section 4523 of the Balanced Budget Act of 1997.

Although HCFA has initiated corrective action on NCCI (mutually exclusive code) edits, it has encountered a significant delay in making the edits operational for hospital outpatient department services. The delay results from a drain on computer system resources brought about by Y2K activities. On August 13, 1998, HCFA set forth a strategy on coping with the competing demands on its computer systems and those of its carriers and FIs. In the strategy, Y2K activities were given the highest priority and the implementation of several other initiatives were delayed. Among the delayed initiatives was the prospective payment system for hospital outpatient services, which HCFA estimated might not be implemented until after the first 3 months of CY 2000.

Potential Savings

We reviewed nationwide Medicare Part B payments for radiology and pathology/laboratory services provided in a hospital outpatient department, to determine the extent of Medicare payments for mutually exclusive procedure codes during CY 1996 and 1997. To estimate potential savings, we extracted claims containing radiology and pathology/laboratory mutually exclusive procedure codes from HCFA's DSAF payment files for nationwide hospital outpatient services. For each of the extracted claims in our review, we compared the mutually exclusive codes to one another using the mutually exclusive code guidelines contained in the NCCI manual. For radiology services, we identified 197 different code pairs that each had at least 1 opportunity to realize savings if edits were employed to preclude payment for mutually exclusive procedure codes during the audit period. Similarly, we identified 121 different mutually exclusive code pairs for pathology/laboratory services, that each had at least 1 opportunity for similar savings. Our review identified 227,110 such claims for radiology services and 270,005 such claims for pathology/laboratory services.

We selected a sample of claims containing potential savings from each of the categories under review using a random number generator; i.e., 100 of the 227,110 radiology claims and 100 of the 270,005 pathology/laboratory claims. We selected the samples to validate the accuracy of the computerized payment information that we had obtained from HCFA's DSAF payment files and to determine the dollar amount of potential savings for each sampled claim. To accomplish this, we contacted the FI that had processed the original Medicare claim and requested supporting documentation on (1) the original billing by the hospital, (2) the claims history - including any adjustments to the original billing, (3) the remittance advice, and (4) the cost-to-charge ratio used to calculate the interim payment for radiology services. In this segment of our review, we contacted 32 different FIs that process Medicare claims under 42 different FI numbers.

For each sampled claim, we computed the amount that would have been saved if an edit was implemented to eliminate the code from being considered in the FI's payment calculation. An example of the manner in which savings were computed for both radiology and pathology/laboratory is contained in APPENDIX A. We then projected the average savings per claim to the population. As a result, we estimate that the Medicare program could have saved $29.1 million over the 2 year audit period for radiology ($25.7 million) and pathology/laboratory ($3.4 million) services if FIs had been required to withhold payment for mutually exclusive codes (see APPENDIX B).

Conclusion

We believe that HCFA should require mutually exclusive procedure code edits for hospital outpatient services, as soon as possible. Alternative methods may be needed to overcome the temporary shortage of available computer system resources caused by Y2K activities. In this regard, HCFA may want to limit the mutually exclusive code pairs that are tested for radiology and pathology/laboratory services to only those combinations that had a high incidence of errors in our review. Specifically, 464,597 claims (93 percent of the 497,115 total claims involving potential savings) included 73 mutually exclusive code pairs (23 percent of the 318 pairs involving potential savings) (see APPENDIX B). The HCFA may also want to consider whether the mutually exclusive code edits should be conducted on a post-payment rather than a pre-payment basis. At a minimum, HCFA should formally advise hospitals that Medicare Part B will no longer pay for mutually exclusive procedure codes associated with radiology and pathology/laboratory services rendered in an outpatient setting. While such a notice would not provide the same level of protection as FI edits, it should provide some reduction in the number of mutually exclusive codes that are currently being billed to the Medicare program.

RECOMMENDATIONS

We recommend that HCFA instruct FIs to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes. Based on our review of payments for these codes in 1996 and 1997, we believe these edits would result in savings to Medicare of approximately $29.1 million over a 2 year period. We also recommend that HCFA notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

HCFA COMMENTS

In its written response to our draft report, HCFA agreed with our report recommendations (See APPENDIX C). However, HCFA advised us that "...the moratorium on system changes necessitated by Y2K prohibits implementing the National Correct Coding Initiative edits on either a prepayment or postpayment basis in order to enforce correct billing for hospital outpatient services...." The HCFA also indicated that, as soon as possible after

January 1, 2000, HCFA intends to require mutually exclusive procedure code edits that are appropriate for hospital outpatient services concurrent with implementation of the hospital outpatient Prospective Payment System. In the interim, HCFA will issue a Program Memorandum to FIs in which it reiterates HCFA's long-standing policy that hospitals are expected to code correctly. In this regard, HCFA requested a listing of the 73 mutually exclusive code pairs that our review identified as having a high incidence of errors so that HCFA can include these code pairs in the Program Memorandum as problem areas that are deserving of special attention by hospitals.

The HCFA also commented on the potential savings estimate in our draft report. Specifically, HCFA pointed out that neither hospitals nor FIs were required to recognize modifier codes during our audit period. This is significant because the proper use of appropriate modifiers allows payment on both claims in a mutually exclusive pair. The HCFA stated that "Had providers been instructed to use modifiers correctly and the FI systems been updated to apply the program logic...it is highly likely that the potential savings cited in this report would be considerably reduced."

OIG RESPONSE

While we understand the pressure that HCFA is under to complete Y2K activities by December 31, 1999, we believe that HCFA must also do everything possible to stop or significantly reduce the mutually exclusive procedure code payments being made to hospital outpatient departments. In this regard, the interim Program Memorandum proposed by HCFA is a good first step in this direction, provided the memorandum is issued quickly. To aid in this project, we have provided HCFA with a listing of the 73 mutually exclusive procedure code pairs that we found to have a high incidence of errors. We continue to believe that the final solution to this issue is for FIs to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes.

We do not agree with HCFA's comments on hospitals not using modifier codes and their effect on the reported potential savings. Although HCFA did not require hospitals and FIs to recognize modifier codes, the CPT Manuals issued by the American Medical Association for our audit period (and several years prior to our audit period) contain a listing of the subject modifier codes and instructions on how the codes should be reported along with procedure codes. We have no reason to believe that a significant number of hospitals did not follow these instructions in the CPT Manuals, especially since the CPT Manuals are the primary source of procedure codes for pathology/laboratory and radiology services. We also point out that modifier codes are only used in exceptional situations and that the related claims are not routine or customary. Accordingly, only a fraction of the total claims we reviewed would be subject to the use of modifier codes. In this regard, our audit identified 7,271 instances where 1 of the 33 modifier codes we afforded special consideration was billed along with a radiology or pathology/laboratory procedure code. As discussed in the Scope section of this report, we considered all 7,271 of the associated procedure codes to be

allowable payments under the Medicare Part B program. For all of the above reasons, we do not believe that our reported potential savings would be materially changed if providers and FIs had been instructed by HCFA to use modifier codes correctly. As a result, we have not changed the potential savings amount reported in the body of this report.

APPENDICES

OUTPATIENT PAYMENT WORKSHEET
RADIOLOGY EXAMPLE

A. Fiscal Intermediary Calculation of Provider Reimbursement:

1.	Provider's Billed Charges			$1,566.75
	a. *Less* Non-covered Charges	$	-0-	
	b. *Less* Professional Component Charges	$	-0-	
	c. *Less* Diagnostic Lab Charges	$	-0-	-0-
2.	Charges Subject to Cost Reimbursement			$1,566.75
	a. *Times* Provider's Interim Reimbursement Rate			.53
3.	Charges Subject to Deductibles and Coinsurance			$ 830.38
	a. *Less* Part B Deductible to be Met	$	-0-	
	b. *Less* Part B Coinsurance (20 % of item A2)	$	313.35	313.35
4.	Reimbursement Based on Costs			$ 517.03
	a. *Plus* Diagnostic Lab Fees (from fee schedules)			$ -0-
5.	Medicare Reimbursement			$ 517.03

B. Office of Audit Services Calculation of Provider Reimbursement:

1.	Provider's Billed Charges			$1,566.75
	a. *Less* Non-covered Charges	$	-0-	
	b. *Less* Professional Component Charges	$	-0-	
	c. *Less* Diagnostic Lab Charges	$	-0-	
	d. *Less* Mutually Exclusive (Column 2) Code	$	355.50	$ 355.50
2.	Charges Subject to Cost Reimbursement			$1,211.25
	a. *Times* Provider's Interim Reimbursement Rate			.53
3.	Charges Subject to Deductibles and Coinsurance			$ 641.96
	a. *Less* Part B Deductible to be Met	$	-0-	
	b. *Less* Part B Coinsurance (20 % of item B2)	$	242.25	$ 242.25
4.	Reimbursement Based on Costs			$ 399.71
	a. *Plus* Diagnostic Lab Fees (from fee schedules)			$ -0-
5.	Medicare Reimbursement			$ 399.71

C. Amount of Potential Savings:

1.	Medicare Reimbursement per the Fiscal Intermediary (item A5)	$ 517.03
2.	*Less* Medicare Reimbursement per the OAS (item B5)	$ 399.71
3.	Potential Savings	$ 117.32

OUTPATIENT PAYMENT WORKSHEET
PATHOLOGY/LABORATORY EXAMPLE

A.	**Fiscal Intermediary Calculation of Provider Reimbursement:**			
1.	Provider's Billed Charges			$ 224.05
	a. *Less* Non-covered Charges	$ -0-		
	b. *Less* Professional Component Charges	$ -0-		
	c. *Less* Diagnostic Lab Charges	$ 224.05		224.05
2.	Charges Subject to Cost Reimbursement			$ -0-
	a. *Plus* Diagnostic Lab Fees (from fee schedules)			$ 78.86
3.	Medicare Reimbursement			$ 78.86
B.	**Office of Audit Services Calculation of Provider Reimbursement:**			
1.	Provider's Billed Charges			$ 224.05
	a. *Less* Non-covered Charges	$ -0-		
	b. *Less* Professional Component Charges	$ -0-		
	c. *Less* Diagnostic Lab Charges	$ 202.55		
	d. *Less* Mutually Exclusive (Column 2) Code	$ 21.50		224.05
2.	Charges Subject to Cost Reimbursement			$ -0-
	a. *Plus* Diagnostic Lab Fees (from fee schedules)			$ 66.64
3.	Medicare Reimbursement			$ 66.64
C.	**Amount of Potential Savings:**			
1.	Medicare Reimbursement per the Fiscal Intermediary (item A3)			$ 78.86
2.	*Less* Medicare Reimbursement per the OAS (item B3)			$ 66.64
3.	Potential Savings			$ 12.22

POTENTIAL SAVINGS

CODE PAIRS AUDITED			
	Radiology	Pathology/Laboratory	Total
Number of Code Pairs Audited	197	121	318
Number of Claims Containing a Code Pair	227,110	270,005	497,115
Potential Savings by Implementing Code Edits	$25.7 million	$3.4 million	$29.1 million
Sample Precision (90 percent confidence interval)	17.65 percent	30.17 percent	

TOP CODE PAIRS			
	Radiology	Pathology/Laboratory	Total
Number of Code Pairs Audited [1]	33	40	73
Number of Claims Containing a Code Pair	210,797	253,800	464,597 (93 percent)
Potential Savings by Implementing Code Edits[2]	$24.0 million	$3.2 million	$27.2 million (93 percent)

[1]Code pairs with 1,000 or more claims containing potential savings.

[2]Average savings per claim ($113.88 for radiology and $12.71 for pathology/laboratory) for those claims containing the 73 highest volume code pairs times the claims containing those code pairs in the population (210,797 for radiology and 253,800 for pathology/laboratory).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratic

The Administrator
Washington, D.C. 20201

DATE: MAR 23 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Medicare Part B Mutually Exclusive Procedure Codes at Hospital Outpatient Departments," (A-01-98-00507)

Thank you for the opportunity to review the above-referenced report on mutually exclusive procedure codes.

The Health Care Financing Administration (HCFA) agrees with the report recommendations and remains committed to applying all correct coding edits to claims submitted by hospital outpatient departments. The report acknowledges that a delay in implementing a prospective payment system for hospital outpatient services and its attendant claims processing edits is the result of Year 2000 (Y2K) compliance requirements. However, as soon as possible after January 1, 2000, we intend to require mutually exclusive procedure code edits that are appropriate for hospital outpatient services concurrent with implementation of the hospital outpatient PPS.

Our specific comments follow:

OIG Recommendations

HCFA should instruct fiscal intermediaries (FIs)to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes and should notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

HCFA Response

We concur. As stated above, the moratorium on systems changes necessitated by Y2K prohibits implementing the National Correct Coding Initiative edits on either a prepayment or postpayment basis in order to enforce correct billing for hospital outpatient services.

However, we will issue a Program Memorandum to FIs in which we will reiterate HCFA's long-standing policy that we expect hospitals to code correctly. We request that OIG furnish us with the list of 73 mutually exclusive code pairs that it found in its study to have a high incidence of error so that we can include these code pairs in the Program Memorandum as problem areas that are deserving of special attention by hospitals. Additionally, we will cite the OIG final report in the Program Memorandum so as to underscore the gravity and importance of provider attention to proper coding.

Additional Comment

In estimating the savings that could potentially be realized by implementing correct coding edits for hospital outpatient claims, we call attention to the fact that, for the time period covered by OIG's study, neither hospitals nor FIs were required to recognize modifiers. This is significant because the proper use of appropriate modifiers allows payment for two codes that, while they are included in the correct coding edits as "mutually exclusive," may nonetheless, under certain circumstances, be legitimately performed on the same day on the same patient. Had providers been instructed to use modifiers correctly and the FI systems been updated to apply the program logic in order to recognize when an appropriate modifier was acceptably delineating this scenario, it is highly likely that the potential savings cited in this report would be considerably reduced.