Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CLAIMS FOR MULTIPLE PROCEDURES PERFORMED IN THE SAME OPERATIVE SESSION IN AMBULATORY SURGICAL CENTERS

JANET REHNQUIST
INSPECTOR GENERAL

JANUARY 2003
A-07-03-02658

Office of Inspector General

http://oig.hhs.gov/

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CIN: A-07-03-02658

JAN 9 2003

William Foley
Vice President, Medicare Services
Empire Medicare Services
2651 Strang Blvd.
Yorktown Heights, NY 10598

Dear Mr. Foley:

This provides you with the results of our nationwide analysis entitled *Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgical Centers* (ASC). The objective of our analysis was to evaluate the effectiveness of carriers' claims processing systems in identifying payment reductions for multiple ASC procedures for calendar years 1997 through 2001. Nationwide, we identified 21,056 instances of overpayments totaling $5,103,361, out of a total 54,549 ($50,733,584) instances in which multiple ASC procedures performed during the same operative session were split between claims. Empire Medicare Services' portion of the total overpayments was approximately $126,082.

Regulations require that when multiple services are provided in the same operative session, the highest paying procedure is reimbursable at the full payment rate while the other procedures are reimbursable at one-half the normal payment rate. Our analysis showed that Empire Medicare Services' systems failed to identify such instances, which resulted in provider overpayments for calendar years 1997 through 2001of approximately $5,997, $16,507, $39,525, $40,165, and $23,888 ($126,082), respectively. Included in the identified overpayments is approximately $25,482 in beneficiary overpayments for coinsurance. Most of the overpayments occurred because the carrier's processing system did not identify multiple procedures performed during the same session when submitted on separate claims.

We are recommending that Empire Medicare Services :

1. Recover the $100,600 ($126,082 - $25,482) in Medicare overpayments to ACSs;

2. Instruct ACSs to refund related coinsurance as required in 42 CFR 416.30, section C;

3. Identify and recoup all similar overpayments made between January 1, 2002 and the effective implementation of system changes to ensure that multiple procedures performed during the same operative session are paid properly, and;

4. Take necessary actions (such as edits, provider education, and/or carrier in-house training) to preclude such overpayments in the future.

Empire Medicare Services stated that the claims file we mailed to Empire contained …*claims that were priced correctly because the first claim submitted by the ASC reported the lower paying procedure. When we received the second claim reporting higher paying procedure our staff reduced the allowance for that procedure by subtracting the overpayment amount and reimbursing the difference.* Empire's response, in it's entirety, is attached to this report (see Appendix A).

We agreed with Empire and excluded those claims that appeared to be paid correctly. We adjusted the final amounts in recommendation 1. accordingly.

INTRODUCTION

Background

An Ambulatory Surgical Center or ASC is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

To participate in the Medicare program as an independent ASC, a facility must meet the standards specified under section 1832(a)(2)(F)(I) of the Social Security Act (the Act) and 42 CFR 416.25. To be covered as an independent (distinct part) ASC operated by a hospital, a facility:

- Elects to do so, and continues to be covered unless CMS determines there is good cause to do otherwise;

- Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report, and;

- Meets all the requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs.

Medicare payment for outpatient surgical procedures generally consists of two components: the cost of services furnished by the facility where the procedure is performed (the facility or technical component), and the cost of the physician's services for performing the procedure (the professional component). The facility component includes non-physician medical and other health services.

As specified under section 1833(i)(1)(A) of the Act, Medicare pays only for specific surgical procedures. The ASC accepts Medicare's payment for such procedures as payment in full with respect to those services defined as ASC facility services in HCFA Pub. 14, section 2265.2. Generally, covered ASC facility services are items and services furnished in connection with

covered ASC surgical procedures. Covered ASC surgical procedures are listed in section 2266.2, Addendum A of the CMS Carriers Manual (HCFA Pub. 14). These procedures are classified into eight standard overhead amounts or payment groups, and payments to ASCs are made on the basis of prospectively set rates assigned to each payment group.

Regulations regarding Medicare payments for multiple surgical procedures performed in an ASC are contained in Title 42 Part 416.120 of the Code of Federal Regulations (42CFR416.120). According to 42CFR416.120, when one covered surgical procedure is furnished to a beneficiary in an operative session, payment is based on the prospectively determined rate for that procedure. When more than one surgical procedure is furnished in a single operative session, payment is based on the full rate for the procedure with the highest prospectively determined rate and one half of the prospectively determined rate for each of the other procedures.

ASC facility services are subject to the Medicare Part B percent coinsurance and deductible requirements. Therefore, Medicare payment is 80 percent of the prospectively determined rate, adjusted for regional wage variations. The beneficiary's coinsurance amount is 20 percent of the assigned rate.

ASC facilities, under the *Terms of agreement with HCFA* (42CFR416.30, section C), agree to refund as promptly as possible any money incorrectly collected from beneficiaries or from someone on their behalf.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of this review was to determine whether the carriers' controls over processing ASC facility claims for multiple procedures performed in the same operative session are in accordance with Medicare rules and regulations.

Scope

Our review was performed in accordance with Government Auditing Standards. Through a series of matching applications utilizing the nationwide Medicare Part B claims file processed by CMS for calendar years 1997 through 2001, we identified 54,549 instances in which multiple ASC procedures performed during the same operative session were split between claims. The associated claims, which served as the universe for our review, amounted to a total of $50,733,584 in provider reimbursements, excluding deductible amounts. Empire Medicare Services' portion of the total universe was $2,850,241. Our review did not require an understanding or assessment of the complete internal control system.

Methodology

A computer application used CMS's National Claims History file for calendar years 1997 through 2001 to identify beneficiary claims for the same operative session that did not indicate

reductions for multiple surgeries. Preliminary results for 1997 through 1999 were forwarded to carriers in Missouri (Blue Cross & Blue Shield of Kansas and Missouri Medicare Services), California (National Heritage Insurance Co.), Florida (First Coast Service Options, Inc.), and Texas (Trail Blazer Health Enterprises, LLC) to verify that our analysis was correct.

We conducted our review during 2001 and 2002 at the Kansas City Regional Office, Kansas City, Missouri.

FINDINGS AND RECOMMENDATIONS

Findings

Our analysis of ASC facility charges for calendar years 1997 through 2001 indicates that carriers' control over processing claims for multiple ASC procedures performed in the same operative session are not in accordance with Medicare rules and regulations. Payments to ASC facilities for multiple surgeries performed in the same operative session were not being paid at the reduced rate.

Our review of ASC facility claims processed by Empire Medicare Services for calendar years 1997 through 2001 indicated overpayments in 574 out of 3,226 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately $126,082 out of approximately $2,850,241 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately $25,482 in beneficiary overpayments for coinsurance. Most of the overpayments occurred because the carrier's processing system did not identify multiple procedures performed during the same session when submitted on separate claims.

Computer applications used CMS's National Claims History file for calendar years 1997 through 2001 to identify beneficiary claims for the same operative session that did not indicate reductions for multiple surgeries for non-hospital based ASC facility services. Our analysis indicated the carriers' payment editors were not reducing the payments for multiple payments as required by 42CFR416.120. Preliminary results for 1997 through 1999 were forwarded to carriers in Missouri (Blue Cross & Blue Shield of Kansas and Missouri Medicare Services), California (National Heritage Insurance Co.), Florida (First Coast Service Options, Inc.), and Texas (Trail Blazer Health Enterprises, LLC) to verify that our analysis was correct.

Interviews with representatives for the five carriers mentioned above confirmed that program edits were not identifying all procedures subject to the rate reduction for multiple procedures performed during the same operative session when billed on separate claims. For example, beneficiary A has three multiple surgeries (in the same operative session) in ASC facility A. Facility A bills for two of the procedures on one claim. The carrier pays facility A the correct amount (the highest cost procedure is paid at 100 percent and the second procedure is paid at 50 percent of the rate), for the original claim. Facility A bills for the third procedure from the same operative session on a separate claim. Reimbursement for this procedure should also be reduced 50 percent. The carrier's payment editor did not recognize the procedure on the second processed claim as one of multiple procedures performed in the same session and therefore paid

the claim at the full surgical rate. According to representatives for two of the carriers interviewed, in some instances the program editor suspended the claims for manual review, but the manual processor erroneously overrode the edit because of lack of training.

Recommendations

We are recommending that Empire Medicare Services:

1. Recover the $100,600 ($126,082 - $25,482) in Medicare overpayments to ACSs;

Empire's Comments

Empire Medicare Services stated that the Access file we mailed to the carrier contained …*claims that were priced correctly because the first claim submitted by the ASC reported the lower paying procedure. When we received the second claim reporting higher paying procedure our staff reduced the allowance for that procedure by subtracting the overpayment amount and reimbursing the difference.* Empire's response, in it's entirety, is attached to this report (see Appendix A).

OIG's Response

We agreed with Empire and excluded those claims that appeared to be paid correctly. We adjusted the final amounts in recommendation 1. accordingly.

Empire did not comment on the remaining recommendations.

2. Instruct ACSs to refund related coinsurance as required in 42 CFR 416.30, section C;

3. Identify and recoup all similar overpayments made between January 1, 2002 and the effective implementation of system changes to ensure that multiple procedures performed during the same operative session are paid properly, and;

4. Take necessary actions (such as edits, provider education, and/or carrier in-house training) to preclude such overpayments in the future.

*****

Final determinations as to actions taken on all matters will be made by the HHS official named below. We request you respond to the 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 final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 522, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made

available to members of the public to the extent information contained therein is not subject to exemptions of the ACT (see 45 CFR Part 5). As such, within ten business days after the final report is issued, it will be posted on the world-wide-web at http://oig.hhs.gov/.

To facilitate identification, please refer to the referenced Common Identification Number A-07-03-02658 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
For Audit Services

Enclosure

HHS Action Official
Gilbert Kunken, DMD
Regional Administrator, Region II
Centers for Medicare and Medicaid Services
26 Federal Plaza, Room 3811
New York, NY 10278-0063

From: EMS.Coordination@EMPIRE.empireblue.com
Sent: November 26, 2002 2:04 PM
To: Aasmundstad, James (OIG/OAS)
Cc: Morman, Alvin (OIG/OAS); Tilghman, Joe ;
CRDN.-.Part.B.NJ.Claims.Processing@EMPIRE.empireblue.com;
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Subject: 03-0343, OIG Audit 1997-2001: Multiple Services Performed in ASCs, CIN: A-07-03-02658

We are writing in response to the Office of Inspector General's (OIG's) draft report dated October 24, regarding the review of claims for multiple procedures performed in the same operative session in an Ambulatory Surgical Center.

Our New York and New Jersey staff reviewed claims and have the following findings:

New York (#00803)

We reviewed 258 claims identified by the OIG as having an overpayment and found the following:

58 were not overpayments (22.5%)
12 were underpaid (4.7%)
2 were not ASC providers (.8%)

We agree that the remaining 186 (72.0%) claims were overpaid ; however 155 were not calculated correctly.

Possible reasons for these miscalculations may be that providers realized their error and voluntarily re-submitted claims or refunded overpayments or we found the error proactively and recouped the overpayments.

New Jersey (#00805 and #00860)

We reviewed 179 claims identified by the OIG as having an overpayment and found the following:

71 claims were processed/priced correctly (39.7%)
12 claims were underpaid (6.7%)

We agree that the remaining 96 (53.6%) claims were overpaid.

The 71 claims were priced correctly because the first claim submitted by the ASC reported the lower paying procedure. When we received the second claim reporting the higher paying procedure our staff reduced the allowance for that procedure by subtracting the overpayment amount and reimbursing the difference.

We also found that 26 examples on the OIG report did not report the related claim and 12 examples did not list a provider number.

Please contact Loretta Conyers at (914) 248-2802 to discuss revising the overpayment before the final report is issued.

Sincerely,

Cindy Rifkin
Empire Medicare Services Coordination
ems.coordination@empireblue.com
(914) 248-2804

"Empire Health Choice Inc." made the following annotations on 11/26/2002 03:04:51 PM
