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

NOVEMBER 2002
A-07-03-02659

Office of Audit Services
Region VII
601 East 12th Street, Room 284A
Kansas City, MO 64106
(816) 426-3591

CIN: A-07-03-02659
November 21, 2002

Mike Barlow
Vice President
Palmetto GBA
(Nationwide Mutual Insurance Company)
Medicare Operations, Palmento GBA
3400 Southpark Place, Suite F
Grove City, OH 43123

Dear Mr. Barlow:

This report 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. Nationwide Mutual Insurance Company's (previous contractor) portion of the total overpayments was approximately $150,751. Palmetto GBA is assuming the task of collecting overpayments because it has the current contract for this Part B Medicare claims processing area.

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 Nationwide Mutual Insurance Company's systems failed to identify such instances, which resulted in provider overpayments for calendar years 1997 through 2001of approximately $10,381, $30,485, $32,401, $47,378, and $30,106 ($150,751), respectively. Included in the identified overpayments is approximately $31,211 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 Nationwide Mutual Insurance Company:

1. Recover the $119,540 ($150,751 - $31,211) 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.

Palmetto GBA accepted our findings and recommendations. Palmetto's response stated that *upon receipt of the final report, we will confirm the number of cases, dollar amounts and providers with information available on our systems. Then we will request refund amounts overpaid from 1997 through 2001. We will also identify and request refund of any amounts overpaid during 2002. It should be noted that overpaid amounts have already been refunded in some cases. We will adjust our refund requests by those amounts, and we will instruct the ASCs to refund to beneficiaries any excess coinsurance amounts that were collected from beneficiaries from 1997 through 2002.* Palmetto's response, in it's entirety, is attached to this report (see Appendix A).

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. Nationwide Mutual Insurance Company's portion of the total universe was $3,271,222. 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 Nationwide Mutual Insurance Company for calendar years 1997 through 2001 indicated overpayments in 727 out of 4,165 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately $150,751 out of approximately $3,271,222 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately $31,211 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 Nationwide Mutual Insurance Company:

1. Recover the $119,540 ($150,751 - $31,211) 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.

Palmetto GBA accepted our findings and recommendations. Palmetto's response stated that *upon receipt of the final report, we will confirm the number of cases, dollar amounts and providers with information available on our systems. Then we will request refund amounts overpaid from 1997 through 2001. We will also identify and request refund of any amounts overpaid during 2002. It should be noted that overpaid amounts have already been refunded in some cases. We will adjust our refund requests by those amounts, and we will instruct the ASCs to refund to beneficiaries any excess coinsurance amounts that were collected from beneficiaries from 1997 through 2002.* Palmetto's response, in it's entirety, is attached to this report (see Appendix A).

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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-07-03-02659 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
For Audit Services

Enclosure

HHS Action Official
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Medicare
Palmetto GBA

Mike Barlow
Vice President

November 14, 2002

James P. Aasmundstad
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region VII
601 East 12th Street, Room 284A
Kansas City, MO 64106

Re: CIN: A-07-03-02659
Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgical Centers

Dear Mr. Aasmundstad:

Palmetto GBA, as current contractor for Ohio/WV part B Medicare claims, has reviewed the above-captioned report, and offers the following comments relative to it. The claims referenced in this review were processed when Nationwide Mutual Insurance managed this contract.

Based upon our initial review of the claims listing provided by Mr. Jack Morman, we have we found:

1. The ASC submitted multiple claims for services provided during the same surgical session, sometimes billing the primary surgical procedure after billing the secondary procedure(s).
2. A processing system audit properly identified, and suspended for manual review, multiple procedures performed during the same operative session when billed on single or multiple claims.
3. Most overpayments resulted from unclear processing guidelines that did not prevent examiners from allowing a surgical procedure at 100%, even though a surgical procedure on a previous claim had already been allowed at 100%. And the guidelines failed to direct examiners to pursue overpayments made on initial claims.

In response to this draft report, Palmetto GBA has corrected the processing guidelines to direct examiners to adjust the allowance on subsequent claims to ensure that the total payment on the primary and secondary procedure(s) does not exceed the limits provided in 42CFR416.120. We are also working to update the system audit logic to automatically adjust the payment on the primary procedure when the secondary procedure(s) were previously paid.

Upon receipt of the final report, we will confirm the number of cases, dollar amounts and providers with the information available on our systems. Then we will request refund of all confirmed amounts overpaid from 1997 through 2001. We will also identify and request refund of any amounts overpaid during 2002. It should be noted that overpaid amounts have already been refunded in some cases. We will adjust our refund requests by those amounts, and we will instruct the ASCs to refund to beneficiaries any excess coinsurance amounts that were collected from beneficiaries from 1997 through 2002.

Further, we will initiate educational measures to ensure that ASCs bill on one claim all surgical procedures performed in the same operative session or, where that is not feasible, to submit the claim for the primary surgical procedure before submitting claims for the secondary procedure(s).

Thank you for the opportunity to comment on this draft report. If you have any questions, please feel free to contact me directly at (614) 277-6400.

Sincerely,

Mike Barlow
Vice President
Medicare Operations, Palmetto GBA

cc: John Delaney
Dorothy Burk Collins