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

DECEMBER 2002
A-07-03-02664

Office of Inspector General

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Region VII
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CIN: A-07-03-02664

December 23, 2002

Ms. Marti Mahaffey
Executive Vice President and COO
TrailBlazer Health Enterprises, LLC
P.O. Box 660156
Dallas, TX 75266-0156

Dear Ms. Mahaffey:

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. TrailBlazer Health Enterprises' portion of the total overpayments was approximately $176,044.

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 TrailBlazer Health Enterprises' systems failed to identify such instances, which resulted in provider overpayments for calendar years 1999 through 2001of approximately $79,164, $51,665 and $45,215 ($176,044), respectively. Included in the identified overpayments is approximately $35,842 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 TrailBlazer Health Enterprises:

1. Recover the $140,202 ($176,044- $35,842) 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.

Trailblazer had *concerns regarding the accuracy of the amount reported as overpayments in the report. Based on our review of the claims in the report, it appears that the first claim entered into the claims processing system for a given beneficiary paid in full is the amount considered an overpayment in the report. When the second claim subject to the related multiple surgery reduction for that beneficiary came into the MCS system, Trailblazer reduced the allowable amount by 50% based on the first claim's initial allowable amount. Therefore, the claims that fall into this category were incorrectly reported as overpaid but actually paid correctly.* TrailBlazer's response, in it's entirety, is attached to this report (see Appendix A).

We agreed with Trailblazer and excluded 346 claims that appeared to be paid correctly. We also excluded all claims from 1997 and 1998. The amount in recommendation 1. was reduced 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. TrailBlazer Health Enterprises' portion of the total universe was $6,272,965. 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 TrailBlazer Health Enterprises for calendar years 1997 through 2001 indicated overpayments in 1,467 out of 7,659 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately $176,044 out of approximately $6,272,965 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately $35,842 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 TrailBlazer Health Enterprises:

1. Recover the $140,202 ($176,044- $35,842) in Medicare overpayments to ACSs;

Trailblazer's Comments

Trailblazer had *concerns regarding the accuracy of the amount reported as overpayments in the report. Based on our review of the claims in the report, it appears that the first claim entered into the claims processing system for a given beneficiary paid in full is the amount considered an overpayment in the report. When the second claim subject to the related multiple surgery reduction for that beneficiary came into the MCS system, Trailblazer reduced the allowable amount by 50% based on the first claim's initial allowable amount. Therefore, the claims that fall into this category were incorrectly reported as overpaid but actually paid correctly.* TrailBlazer's response, in it's entirety, is attached to this report (see Appendix A).

OIG's Response

We agreed with Trailblazer and excluded 346 claims that appeared to be paid correctly. We also excluded all claims from 1997 and 1998. We have reduced the amount in recommendation 1. to reflect Trailblazer's comments.

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

Trailblazer's Comments

Trailblazer will include verbiage in overpayment demand letters associated with this effort instructing ASC providers to refund excess coinsurance amounts.

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;

Trailblazer's Comments

A system Change Request (SCR) will be submitted to identify those claims with similar overpayments made after January 1, 2002. Results from this request will be reviewed and overpayments identified, if any, will be recouped as appropriate.

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

Trailblazer's Comments

As noted in our general comments above, we believe the edit being used to identify these claims (i.e., Audit 688A) is properly suspending claims for manual review as designed. Further, we believe other appropriate actions have been taken to preclude such overpayments in the future. Based on our review of example claims considered to be overpayments received from the OIG during the summer of 2001, we concluded that some of those claims did process correctly, and some did not. For those claims processed incorrectly, our review indicated that that a reduction was made for an incorrect amount. In light of the inconsistent processing, we determined that additional training was needed. A note was added to the Audit 668A resolution instructions to reinforce and remind the processors that ASC facility fee codes are subject to the multiple procedure criteria. This was also discussed in a training session (IMPAC meeting), and additional instructions were subsequently added to the Inquiries Manual. The IMPAC meetings are Coverage Policy's forum for internal training.

In addition, the Texas provider education department has developed a Provider Manual for ASCs. This is on the Trailblazer web site. An interactive internet training session with the ASC provider community is scheduled for December 18, 2002. The presentation includes reimbursement information for multiple procedures.

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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-07-03-02664 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
For Audit Services

Enclosure

HHS Action Official
James Rudolph Farris, M.D.
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Marti Mahaffey
Executive Vice President and
Chief Operating Officer

November 21, 2002

Mr. James P. Aasmundstad
Regional Inspector General
for Audit Services
Department of Health & 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-07-03-02664

Dear Mr. Aasmundstad:

In response to your draft audit report *Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgical Centers (ASC)*, we appreciate the opportunity to provide our comments for your consideration. We support your efforts to highlight the need to improve controls related to processing this category of ASC claims. In our comments, presented below, you will note some efforts we have taken to strengthen our ability to process these claims properly. In addition, our comments provide certain clarifications and other factors we believe should be considered to ensure the accuracy and reasonableness of your findings and recommendations including concerns regarding the amount of overpayment to be collected.

General Comments

1. We have concerns regarding the accuracy of the amount reported as overpayments in the report. Based on our review of the claims in the report, it appears that the first claim entered into the claims processing system for a given beneficiary paid in full is the amount considered an overpayment in the report. When the second claim subject to the related multiple surgery reduction for that beneficiary came into the MCS system, TrailBlazer reduced the allowable amount by 50% based on the first claim's initial allowable amount. Therefore, the claims that fall into this category were incorrectly reported as overpaid but were actually paid correctly.

2. TrailBlazer Health Enterprises, LLC assumed the Part B workload for the District of Columbia (DC) and Delaware (DE) in February 1998 and the workload for Virginia in September 2000. Prior to the conversion of the DC/DE workload to TrailBlazer using the MCS claims processing system, claims were processed in the Bradford system by Xact.

The Virginia workload was transitioned from UHC using the HPBSS system and is will be transitioned to the MCS system effective December 2, 2002. Some of the claims identified as overpayments by the OIG were processed by Xact or UHC and/or using a claims processing system other than MCS. Our comments only address the claims that were processed by TrailBlazer using the MCS system.

3. Since 1992, TrailBlazer has edited for multiple ASC procedures performed in the same operative session. Audit 688A is the current edit used to identify multiple ASC procedures performed in the same operative session but submitted on separate claims. Audit 688A works in the MCS standard system in the following manner: A claim entered into the MCS system reads beneficiary history for a different claim billed by the same provider of services, same date of service, same patient for any ASC procedure subject to the multiple procedure edit. If another claim is found during this search within the MCS system, audit 688A suspends the claim to a designated location for manual pricing. The claim it suspends against can be either pending or paid. This audit has been part of the MCS SCC files structure since 1993 when TrailBlazer converted to MCS. We researched some of the claims in the OIG sample and determined that overpayments were made because of human error. In some cases we identified attempts by the processor to reduce the payment for multiple procedures, but the amount of payment was incorrect. We did not find evidence of the edit not working properly.

Comments to Recommendations

Recommendation 1: Recover the $307,459 ($385,322 - $77,863) in Medicare overpayments to ASCs.

As stated in MCM 7100.1, the time limit for recovery of Medicare Part B overpayments is four years after the date of payment. There are 107 services listed on the OIG Access database with a payment date during 1997. TrailBlazer will not be able to request a refund on these claims. Some of the services paid during 1998 may also be too old for recovery. This will depend upon the claim paid date and the date the overpayment determination will be made.

As indicated above in our general comments, we believe some of the claims reported to be overpayments were, in fact, paid correctly. The final amount of overpayments arising from this effort will be dependent on our review of all the specific claims tested.

Recommendation 2: Instruct ASCs to refund related coinsurance as required in 42 CFR 416.30, Section C.

TrailBlazer will include verbiage in overpayment demand letters associated with this effort instructing ASC providers to refund excess coinsurance amounts.

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

A System Change Request (SCR) will be submitted to identify those claims with similar overpayments made after January 1, 2002. Results from this request will be reviewed and overpayments identified, if any, will be recouped as appropriate.

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

As noted in our general comments above, we believe the edit being used to identify these claims (i.e., Audit 688A) is properly suspending claims for manual review as designed. Further, we believe other appropriate actions have been taken to preclude such overpayments in the future. Based on our review of example claims considered to be overpayments received from the OIG during the summer of 2001, we concluded that some of those claims did process correctly, and some did not. For those claims processed incorrectly, our review indicated that that a reduction was made for an incorrect amount. In light of the inconsistent processing, we determined that additional training was needed. A note was added to the Audit 688A resolution instructions to reinforce and remind the processors that ASC facility fee codes are subject to the multiple procedure criteria. This was also discussed in a training session (IMPAC meeting), and additional instructions were subsequently added to the Inquiries Manual. The IMPAC meetings are Coverage Policy's forum for internal training.

In addition, the Texas provider education department has developed a Provider Manual for ASCs. This is on the TrailBlazer web site. An interactive internet training session with the ASC provider community is scheduled for December 18, 2002. The presentation includes reimbursement information for multiple procedures.

Again, we appreciate this opportunity to provide our comments. If you have any questions or need additional information concerning our comments, let me know.

Sincerely,

Marti Mahaffey
Executive Vice President and Chief Operating Officer

Cc: James Randolph Farris, M.D., CMS
John Delaney, CMS