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

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A-07-03-02666

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JAN 21 2003

Mr. George F. Grode
Executive Vice President, Government Business & Corporate Affairs
HGSAdministrators
P.O. Box 890065
Camp Hill, PA 17089-0065

Dear Mr. Grode:

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. HGSAdministrators' (HGSA) portion of the total overpayments was approximately $35,836.

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 HGSA's systems failed to identify such instances, which resulted in provider overpayments for calendar years 1997 through 2001of approximately $1,169, $6,037, $13,635, $10,053 and $4,942 ($35,836), respectively. Included in the identified overpayments is approximately $7,178 in beneficiary overpayments for coinsurance. These amounts represent significant reductions based on our review of HGSA's response to our draft report. 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 HGSA:

1. 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;

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

HGSA stated that *as part of your nationwide analysis to assess the effectiveness of claims processing systems in identifying payment reductions for multiple ASC procedures, some 253 instances involving claims processed by HGSA were identified as being processed incorrectly. Our detailed inspection of these claims leads us to believe that the number of claims processed incorrectly is much lower. Using instructions published in the Medicare Carriers Manual, our preliminary review indicates 37 claims were not processed correctly.* HGSA's response, in it's entirety, is attached to this report (see Appendix A).

We reviewed HGSA's claims and excluded those claims that, based on HGSA's response, appeared to have been paid correctly. As a result, we removed two recommendations contained in the draft report because the overpayment amount decreased to an insignificant amount.

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. HGSA's portion of the total universe was $1,317,851. 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 HGSA for calendar years 1997 through 2001 indicated overpayments in 253 out of 1,353 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately $35,836 out of approximately $1,317,851 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately $7,178 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 HGSA:

1. 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;

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

HGSA's Comments

HGSA stated that *as part of your nationwide analysis to assess the effectiveness of claims processing systems in identifying payment reductions for multiple ASC procedures, some 253 instances involving claims processed by HGSA were identified as being processed incorrectly. Our detailed inspection of these claims leads us to believe that the number of claims processed incorrectly is much lower. Using instructions published in the Medicare Carriers Manual, our preliminary review indicates 37 claims were not processed correctly.* HGSA's response, in it's entirety, is attached to this report (see Appendix A).

HGSA agreed with our current two recommendations and upon receipt of the final report will undertake these activities.

OIG's Response

We reviewed HGSA's claims and excluded 147 claims that, based on HGSA's response, appeared to have been paid correctly. We have removed two recommendations from the report because the overpayment decreased to an insignificant amount. A detailed reply to HGSA's response is included as Appendix B.

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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-07-03-02666 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
For Audit Services

Enclosure

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CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Medicare
Part B

November 22, 2002

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

Dear Mr. Aasmundstad,

This letter is in response to your October 24, 2002 correspondence and related material addressed to Mr. George F. Grode, Executive Vice President, Government Business & Corporate Affairs at Highmark, Inc. relative to a draft report entitled *Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgical Centers (ASC).* As Vice President of Program Managment at HGSAdministrators (HGSA), the Medicare Part B contractor for Pennsylvania, your letter was referred to me for research and response. Thank you for the advance opportunity to review and respond to the draft report.

As part of your nationwide analysis to assess the effectiveness of claims processing systems in identifying payment reductions for multiple ASC procedures, some 253 instances involving 260 claims processed by HGSA were identified as being processed incorrectly. Our detailed inspection of these claims leads us to believe that the number of claims processed incorrectly is much lower. Using instructions published in the Medicare Carriers Manual, our preliminary review indicates 37 claims were not processed correctly.

To facilitate a reconciliation and understanding of the different numbers, we have summarized the pertinent processing guidelines in Attachment I. This attachment includes the MCM references as well. Using the categorization provided in the attachment, our review of the 260 claims indicates that as many as 223 claims were processed correctly for the following reasons:

I.	Exempted Procedure	29 claims
II.	Special Pricing Rules	26
III.	Multiple Surgery Rule	124
IV.	Payments Resulting from Appeal Determinations	26*
V.	Correct Coding Initiative Preemption	4
VI.	Number of Services	3
VII.	Recoupment Identified and Initiated	9
VIII.	No apparent issue	2

* There were 26 claims involving appeals. Due to time constraints, we did not conduct a detailed analysis of these cases. It is possible that this number could change slightly upon inspection.

Given the discrepancy in our numbers, I believe it would be prudent to mutually explore the explanations offered prior to the issuance of the final report. I agree with the recommendations offered in the draft letter. Upon receipt of the final report, we will undertake those activities.

Again, we appreciate the opportunity to review this material. If you would like to discuss this matter further, please contact Charles Stokes at (717) 731-2727.

Sincerely,

David Vaughan
Vice President, Program Management
HGSAdministrators

Attachments

Cc: G. F. Grode
P. M. Kiley
C. Stokes
J. Martino

Attachment I

ASC Surgical Claim Payment Guidelines

The following is a summary of HGSA's ASC surgical claim payment guidelines:

I. **Exempted Procedures** -CMS determines if surgeries are subject to multiple surgery rules and publishes this information in the annual MPFSDB update. If a carrier is processing a claim for a surgery that is not subject to the multiple surgery rules (per CMS), then a reduction will not be taken for either procedure. Refer to MCM Section 4826.C.4

II. **Special Pricing Rules** - Special pricing may occur for claims that include modifiers reported by the ASC. The key modifiers identified in our analysis include:

a. 50 Modifier – Bilateral Surgery Pricing – Services are allowed at 1 ½ times the normal allowed amount. Refer MCM Section 4828
b. 52 Modifier – Reduced Services, Requires Manual Pricing by Medical Consultant– these services were manually priced by a medical consultant due to the unusual circumstances involved in performing the service. Refer to MCM Section 15028
c. 59 Modifier – Distinct Service – this modifier indicates that the service was separate and distinct, thus multiple surgery pricing rules do not apply. The provider must maintain and submit documentation upon request to justify the use of this modifier. Refer to MCM Section 4630.D.4.

III. **Multiple Surgery Rule Application**- When two services are reported for the same operative session on one claim, no special modifiers are reported and multiple surgical rules are applied based on the MPFSDB, the carrier is to allow the highest service at 100% of the normal fee schedule amount and allow the lesser service at 50% of the normal fee schedule amount.

If the services are submitted on two different claims and the lesser service is submitted first, we pay the lesser service at 100% of the fee schedule amount. When the higher service is submitted afterwards, we will reduce the allowed amount of the higher service by 50% of the lesser service's fee schedule amount in order to prevent an overpayment for the combined services.

For example:

(A) Two services submitted on the same claim:

1st Service: The normal allowed amount for higher code, 13132 = $486.62
2nd Service: 50% of the fee for lesser code, 15120 = $212.59
$699.21

(B) Two services submitted on two separate claims:
1st Service: Code 15120 is the lesser service and reported 1st. = $425.18
2nd Service: Code 13132 is the higher service and reported 2nd. = $274.03
Total Allowed = $699.21

In order to process the second claim in a way to prevent an overpayment from occurring, the normal allowed amount for the higher service ($486.62) was reduced by 50% of the normal allowed amount for the lesser service ($212.59), or $486.62-$212.59 = $274.03. Refer to MCM Section 15038.

IV. **Appeal Determinations** - Determine if special pricing was used as a result of an appeal of an original claim determination. If the provider submitted additional documentation on an appeal, the additional documentation may have warranted additional payment.

V. **Correct Coding Intiative Preemption** - Reductions were taken based on the Correct Coding Initiative (CCI) instead of multiple surgery rules. Refer to MCM Section 4630.K

VI. **Number of Service** – The number of services is greater than one and appears to be the reason for the allowance.

VII. **Recoupment Identified & Initiated** – Due to the inability to adjust payment for the second service to fully satisfy the reimbursement rules and in accordance with internal guidelines, 9 claims were referred for recoupment activity.

VIII. **No Apparent Issue** – There were two claims that appear to be processed correctly and should not have been on the listing.

OIG's Response

We agree HGSA may have paid correctly, in total, many of the multiple ASC claims. Based on HGSA's detailed response we believe there were 106 instances where the claims were not properly processed.

I. Exempted Procedures – The OIG found 28 instances in which HGSA claimed there was no multiple surgery indicator thus multiple surgery rules did not apply based on the MPFSDB. The MPFSDB is applicable to physician claims for surgery (TOS 2) but not ASC facility (TOS F) claims. All 28 instances were included in the adjusted overpayment amount.

II. Special Pricing Rules -

a. 50 Modifiers – The OIG found 5 instances in which HGSA claims to have processed claims correctly based on modifier 50. In all but 1 instance, the lesser ranked procedure was apparently overpaid to correct an underpayment for the higher ranked procedure with the 50 modifier. The OIG found that 4 of the 5 instances were adjusted correctly and were excluded from the adjusted overpayment amount. One instance was adjusted in error and was included in the adjusted overpayment amount.

b. 52 Modifier – OIG found 16 instances in which HGSA claims to have processed claims correctly based on modifier 52. In all 16 cases, modifier 52 was attached to the highest ranked procedure which the OIG automatically excluded from overpayment calculations because the highest ranked procedure is payable at the full rate. The OIG excluded all 16 instances from the overpayment adjustment.

c. 59 Modifier – OIG found 10 instances in which HGSA claims to have processed claims correctly based on modifier 59. Modifier 59 does not exempt a procedure (for facilities) from multiple surgery pricing rules. Therefore, all 10 instances were included in the overpayment adjustment.

III. Multiple Surgery Rule – OIG found 110 instances in which HGSA claims that multiple surgery pricing rules were applied in the following fashion:

If the services are submitted on two different claims and the lesser service is submitted first, we pay the lesser service at 100% of the fee schedule amount. When the higher service is submitted afterwards, we will reduce the allowed amount of the higher service by 50% of the lesser service's fee schedule amount in order to prevent an overpayment for the combined services.

OIG responds that multiple surgery pricing rules require the ranking of procedures from highest to lowest in value, based on wage adjusted ASC payment groups, prior to applying multiple surgery pricing reductions. The higher service is then paid at 100% of the ASC group rate, and the lesser services are reduced by 50% of the adjusted group rate. (Note: fee schedule amounts apply to physician claims not ASC facility claims) The method used by HGSA to apply multiple surgery pricing rules results in the higher ranked procedure indicating an underpayment amount and the lesser ranked procedure indicating an overpayment amount. While we agree that this method could result in a correct total payment amount for a combination of claims, it distorts the data for claims taken individually. The OIG determined that the adjustments resulted in a correct, or

approximately correct, total payment amount for the combination of claims and excluded all 110 instances from overpayment adjustment.

IV. Payments Resulting from Appeal Determinations – OIG found 21 instances which, according to HGSA, involve appeals. OIG excluded 2 of these instances from overpayment calculations based on total payment amounts for the combined claims appearing correct. The remaining 19 instances were included in the overpayment adjustment because they indicated overpayments and OIG could not verify the appeals process.

V. Correct Coding Payment Imitative – OIG found 4 instances in which HGSA claimed to have applied the Correct Coding Initiative. In all 4 cases, the CCI reduction was applied to the highest ranked procedure which the OIG initially excluded from overpayment calculations because the highest ranked procedure is payable at the full rate. The OIG excluded all 4 instances from the overpayment adjustment.

VI. Number of Services – OIG found 4 instances in which HGSA claims that payment was correct based on adjustments for number of services. The method used by HGSA to adjust payment for these instances results in the higher ranked procedure indicating an underpayment amount and the lesser ranked procedure indicating an overpayment amount. While we agree that this method could result in a correct total payment amount for a combination of claims, it distorts the data for claims taken individually. The OIG was unable to determine whether or not the adjustments resulted in a correct total payment amount for the combination of claims but excluded all 4 instances from the overpayment adjustment.

VII. Recoupment Identified and Initiated – OIG found 9 instances in which HGSA admitted a processing error but claims to have requested a refund. The OIG was unable to verify that adjustments were made and did not exclude these 9 instances from overpayment adjustment.

VIII. No Apparent Issue – OIG found 2 instances that HGSA considered to be no apparent issue. OIG found that these instances actually involve duplicate claims, which HGSA says were denied. The NCH files, however, indicate full payment for two same procedures in both instances. The OIG did not exclude these 2 instances from overpayment adjustment.

IX. Rebundling - OIG found 7 instances in which HGSA claims to have rebundled a procedure with another service. In all 7 instances, the lesser valued procedure indicated an overpayment amount. The OIG was unable to determine whether or not the adjustments resulted in a correct total payment amount for the combination of claims but excluded all 7 instances from the overpayment adjustment.

X. Errors which HGSA did not identify recoupment – OIG found 37 instances in which HGSA admits errors but did not identify recoupment: 31 instances due to manual pricing errors and 6 due to back to back claims processing system errors. All 37 instances were included in the overpayment.

ACKNOWLEDGMENTS

This report was prepared under the direction of James P. Aasmundstad. Other principal Office of Audit Services staff who contributed include:

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