

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-07-03-02653**

Office of Inspector General

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Office of Audit Services
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CIN: A-07-03-02653
January 30, 2003

Terri White
Manager of Medicare Administrative Support
Arkansas Blue Cross and Blue Shield
P.O. Box 1418
Little Rock, Arkansas 72203

Dear Ms. Crosby:

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. Arkansas Blue Cross and Blue Shield's portion of the total overpayments was approximately \$433,178.

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 Arkansas Blue Cross and Blue Shield's systems failed to identify such instances, which resulted in provider overpayments for calendar years 1999 through 2001 of approximately \$91,000, \$170,167, and \$172,011 (\$433,178), respectively. Included in the identified overpayments is approximately \$88,295 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 Arkansas Blue Cross and Blue Shield:

1. Recover the \$344,883 (\$433,178 - \$88,295) 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.

Arkansas's response stated that claims paid during 1997 and 1998 were beyond the collection period. The response also stated that all of their payment system audits were being rebuilt to ensure that all claims have been paid properly and all erroneous payments have been located. Arkansas's response, in its entirety, is attached to this report (see Appendix A).

We have amended recommendation 1. and removed overpayments applicable to 1997 and 1998.

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. Arkansas Blue Cross and Blue Shield's portion of the total universe was \$3,393,318. 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 Arkansas Blue Cross and Blue Shield for calendar years 1997 through 2001 indicated overpayments in 2,442 out of 3,371 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately \$433,178 out of approximately \$3,393,318 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately \$88,295 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 Arkansas Blue Cross and Blue Shield:

1. Recover the \$344,883 (\$433,178 - \$88,295) in Medicare overpayments to ACSs;

Arkansas's Comments

According to Section 7100.1 of the Medicare Carriers Manual, unless fraud is suspected, overpayments should not be pursued on claims that paid more than four years ago. Since the cause of the overpayment was not fraud related, we prefer not to pursue the collections for claims paid during 1997 and 1998.

The draft report requests that we search history for any 2002 claims that were paid incorrectly and collect the resulting overpayments. Research was performed to determine if an audit was in place to capture these claims and prevent incorrect payments. Unfortunately an audit was in place, but not functioning properly and some claims were allowed to pay incorrectly. We are presently in the process of rebuilding the audit for each of our five sites. In order to ensure that all claims have been paid properly and all erroneous payments have been located, we will research all claims up to the date of the finalization of the audit rebuild.

OIG's Response

We have amended recommendation 1. and removed overpayments applicable to 1997 and 1998.

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.

Arkansas's Comments

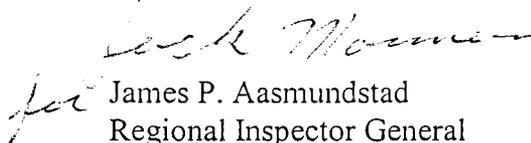
Over the last couple of years, we have received several requests, which require corrective action; however, we receive no additional funds or allowances for additional staff. These projects often prove to be very labor intensive and require resources above and beyond the norm required to accomplish our CMS mandated requirements. While we realize this is probably not a major concern with your office, we feel it important to mention that we will likely find it necessary to request additional funds from CMS to pursue this and any future collection activities. Arkansas's response, in its entirety, is attached to this report (see Appendix A).

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-07-03-02653 in all correspondence relating to this report.

Sincerely yours,


for James P. Aasmundstad
Regional Inspector General
For Audit Services

Enclosure

HHS Action Official

James Rudolph Farris, M.D.
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**MEDICARE**

Part A Intermediary

Part B Carrier

*Terri White**Manager**Government Programs Support**(501) 378-2820**E-mail: tlwhite@arkbluecross.com*

January 23, 2003

Mr. James P. Aasmundstad
Regional Inspector General
For 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 draft OIG audit report entitled "Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgical Centers", CIN: A-07-03-02653.

After reviewing the draft information, we have identified several issues on which we would like to comment.

- According to Section 7100.1 of the Medicare Carriers Manual, unless fraud is suspected, overpayments should not be pursued on claims that paid more than four years ago. Since the cause of the overpayment was not fraud related, we prefer not to pursue the collections for claims paid during 1997 and 1998.
- The draft report requests that we search history for any 2002 claims that were paid incorrectly and collect the resulting overpayments. Research was performed to determine if an audit was in place to capture these claims and prevent incorrect payments. Unfortunately an audit was in place, but not functioning properly and some claims were allowed to pay incorrectly. We are presently in the process of rebuilding the audit for each of our five sites. In order to ensure that all claims have been paid properly and all erroneous payments have been located, we will research all claims up to the date of the finalization of the audit rebuild.
- Over the last couple of years, we have received several requests, which require corrective action; however, we receive no additional funds or allowances for additional staff. These projects often prove to be very labor intensive and require resources above and beyond the norm required to accomplish our CMS mandated requirements. While we realize this is probably not a major concern with your office, we feel it important to mention that we will

likely find it necessary to request additional funds from CMS to pursue this and any future collection activities.

We appreciate the Office of Inspector General's review efforts and feedback. As soon as the final version of this review is distributed and received, we will make every effort to complete the collection process as quickly as possible.

Sincerely,

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ACKNOWLEDGMENTS

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

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