Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FRAGMENTED PHYSICIAN CLAIMS

SEPTEMBER 1992

OFFICE OF INSPECTOR GENERAL

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This report was prepared by the Health Care Branch, Office of Evaluation and Inspections. The following persons participated in the project:

Cathaleen A. Ahern
David C. Hsia, M.D., J.D., M.P.H.
Brian P. Ritchie

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EXECUTIVE SUMMARY

PURPOSE

The Office of Inspector General (OIG) conducted this study to examine patterns of physician billing in certain cases in which a Medicare beneficiary underwent more than one surgical procedure on the same day.

BACKGROUND

This study illustrates the types of claims discussed in a September 1991 OIG report, "Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursement." Another Office of Inspector General inspection, of liver biopsies, identified a high rate of fragmented claims - those in which a physician billed for opening the abdomen and removing the gallbladder as well as biopsying the liver, for example. In this example, only the gallbladder removal should be billed for; the biopsy should not be since it was not a "separate procedure" as defined in the guidelines of Physicians' Current Procedural Terminology (CPT-4) and the laparotomy (incision) should not be as it was only an approach to the gallbladder.

Because 63 percent of all surgical cases in that sample were fragmented, the OIG examined billing and payment data for other, similar surgeries, using 1988 claims.

METHODS

From a list of codes for exploratory surgery and biopsies, 6 codes with potential for incorrect billing were selected for further review. The 6 codes for biopsy and/or exploration were claimed 240,800 times for $54,660,400 (projected); another surgical code was billed on the same day 160,300 times, for $79,653,600 (projected). These codes were further examined. An OIG physician determined which surgical procedures could reasonably be performed and properly billed on the same day. The remaining combinations of procedures are discussed in this report.

FINDINGS

Physicians frequently billed for biopsies and/or explorations which were part of another surgical procedure, realizing as a result more than $12 million in overpayments in 1988:

- Projected overpayments associated with two exploratory surgery codes, and with surgical biopsies of the liver and pancreas, total $7,620,565 for 1988.

- Projected overpayments for "separate procedures" claimed inappropriately totalled $3,404,100.

- Projected overpayments for secondary procedures that should have been denied as duplicative or mutually exclusive totalled $1,721,600.

RECOMMENDATION

The Health Care Financing Administration should require carriers to deny or adjust payment for:

(1) "exploratory" surgery performed incidently to a procedure separately billed,

(2) biopsies performed in the course of more major surgery in the same body cavity,

(3) "separate procedures" billed with another procedure,

(4) mutually-exclusive procedures, and

(5) claims by assistants for procedures denied when billed by surgeons.

Proper denial of such claims can be accomplished by creating screens which reject exploration codes billed with any related code, adjust biopsy codes when billed with more major surgery, reject codes for "separate procedures" unless they are the only procedure claimed, reject duplicative and mutually-exclusive procedures, and pay assistants only when the surgeon may be paid for a procedure.

In HCFA's response to the draft report, they concurred in part with these recommendations and identified additional steps they have taken which address some of these concerns. We removed from the overpayment calculation two sets of codes dealing with breast biopsies and bone marrow biopsies. While we continue to believe these represent fragmented billing, HCFA believes they represent permissible coding. We have retained the recommendation dealing with payments to assistants at surgery, and will more fully develop this issue in a future inspection. The HCFA's comments are included in their entirety as appendix E.

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INTRODUCTION

PURPOSE

The Office of Inspector General (OIG) conducted this study to examine patterns of physician billing in certain cases in which a Medicare beneficiary underwent more than one surgical procedure on the same day.

BACKGROUND

Other OIG Studies This study illustrates the types of claims discussed in the September 1991 OIG report, "Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursement."

In another inspection, on liver biopsies, the OIG selected a random 1 percent sample of claims for Medicare patients who underwent liver biopsies (procedure codes 47000 and 47100). This process identified 329 claims, representing 273 patients and 290 biopsies. In all but 17 cases, the OIG was able to identify the hospital in which the biopsy took place. The OIG requested the entire medical record from each of the hospitals. The final sample consisted of 289 claims for 237 patients representing 253 procedures.

Thirteen percent (39 of 289 claims) were miscoded, claiming a wedge was performed when actually a needle sample was taken, or vice versa, or billing when no biopsy, or no procedure at all, was performed. Surgeons billed for both a biopsy and an exploratory laparotomy in 14 claims. In 82 of 128 claims, surgeons billed for a liver biopsy as well as a more major procedure such as a gallbladder removal. Our findings from this study are reported in the December 1991 OIG report, "Liver Biopsies."

These findings led us to further examine the payment for exploratory surgery and biopsies when performed with another surgical procedure.

Coding Concerns The most important coding issue discussed in this report is what is called "fragmentation." Even the simplest surgical procedure involves many steps, from the preparation of the skin to the incision to the control of bleeding and eventual suture of the incision. All of these steps are integral to the procedure itself; other, less obvious, links exist between the major procedure being performed and other minor procedures which, when performed alone, can be coded separately. Examples of the latter procedures are discussed in this report.

The guidelines given to surgeons in Physicians' Current Procedural Terminology (CPT-4), issued by the American Medical Association, discuss when a procedure may be considered a "separate procedure" for reporting and billing purposes.

> SEPARATE PROCEDURE: **Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.** (Physicians' Current Procedural Terminology, copyright 1988, 1990.)

A gastrostomy, for example, is the creation of an artificial opening in the stomach. It is usually done as a component of surgery in which a cancerous or ulcerated part of the stomach is removed. However, when performed independently of, and not immediately related to, other services, it may be listed as a separate service. This would occur, for example, when a malnourished patient had to have a tube for feeding placed directly into the stomach, through the skin.

If a carrier were to pay separately for an exploratory laparotomy (incision), a liver biopsy, and a cholecystectomy (removal of the gallbladder), as did occur in the sample of claims reviewed for the liver biopsy study, the surgeon would in effect be paid three times for opening the abdomen.

METHODS

The source of the data examined in this study is the 1988 BMAD file of procedures, a 1 percent sample of all procedures for which Medicare was billed. From a list of HCPCS codes for exploratory surgery and biopsies, 6 codes with potential for incorrect billing were selected for further review. The 6 codes selected were billed 199,500 times in 1988; total allowed amounts for these procedures exceeded $54 million (projected). Another surgical code was billed on the same day for the same patient 160,300 times, for more than $79 million (projected).

These claims include those in which an anesthesiologist billed a different code than the surgeon did, creating the appearance of multiple surgeries. These claims were eliminated. An OIG physician determined which surgical procedures could reasonably be performed and properly billed on the same day. These were also eliminated, along with instances in which too little information was provided to make an assessment. Thus the overall sample was reduced from 3,598 line items to 1,599, largely due to eliminating those cases in which the anesthesia bill gave the appearance of multiple procedures having been performed.

Limitations of the Data Since this inspection examined only billing data, errors in those data could distort the results. For example, claims by anesthesiologists were eliminated from the sample. If the codes for type of service or specialist were in error, some anesthesia claims may be intermingled with the claims for surgeons and their assistants. (Some anesthesia claims which were eliminated were shown as a "2" (surgery) for type of service, but as an "05" (anesthesia) for specialist type.) We did

not examine beneficiary histories to attempt to reconstruct a billing history, nor did we examine medical records.

The numbers of claims referred to in the sample have been projected to their numbers in the universe of 1988 claims. Numbers under 2,000 (i.e., 20 sample claims) have a wide margin of error. They are shown, however, since they may be easily identified by carriers' screening processes.

FINDINGS

Physicians frequently billed for biopsies and/or explorations which were part of another surgical procedure, realizing as a result more than $12 million in overpayments in 1988.

Projected overpayments associated with two exploratory surgery codes, and with surgical biopsies of the liver and pancreas total $7,620,565 for 1988.

The overpayments identified in this report are shown in detail in Appendices A through D. The spreadsheets are labeled with the code which triggered the review. The principal procedure for which this review determined payment could be allowed is identified in the left hand columns. When only "separate procedures" were billed, the procedure with the highest allowed amount was identified as principal and all others denied. The discussion below documents our findings and concerns, as well as identifying corrective measures taken by HCFA to address some of these issues.

Fragmenting laparotomy claims:

"Laparotomy" is the term used for surgical incision of the abdomen; not to be confused with "laparoscopy," in which an instrument is inserted through a small slit into the abdomen. Some abdominal surgery, e.g., appendectomies, can be performed through small incisions. A laparotomy, however, is necessarily the first step in major surgery of the abdomen; an exploratory laparotomy is undertaken when the surgeon does not know what, if any, definitive surgery will be needed. Occasionally no further surgery will be performed, e.g., when cancer is so widespread that removing an organ would not help the patient. In such cases, the surgeon correctly bills Medicare for having performed an exploratory laparotomy.

When more major surgery is performed, however, the laparotomy is only the initial stage of that surgery. For example, if the surgeon discovers a cancerous condition which necessitates removing part of the colon, he or she would bill for the colectomy (removal of all or part of the colon), but not for the laparotomy, nor for biopsies or an incidental appendectomy. If, during the same surgery, the surgeon also created a colostomy (an opening from the colon to the surface of the body), he or she could bill for that, using the code which incorporates both the colectomy and colostomy. The same principle would apply to a third or fourth distinct procedure. It is perfectly appropriate to file claims for as many procedures as were performed, but not to fragment any one procedure into its component parts.

Particularly egregious use of the exploratory laparotomy code is in combination with those codes, such as 43605 (biopsy of stomach by laparotomy) and 49220 (staging celiotomy [laparotomy] for Hodgkins' disease or lymphoma [includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal node and/or bone marrow biopsies, ovarian repositioning]), in which the laparotomy is

inherent in the verbal description of the code. This may, however, represent an effort by the physician's billing staff to find codes describing what the procedure was, fully expecting the carrier to pay only the "correct" code.

Intra-operative breast biopsies:

The claims associated with incisional breast biopsies were for the removal of cysts or for mastectomies (removal of the breast). Draft Medicare Carriers Manual instructions provide for "rebundling" biopsies into payments for cyst excisions and for mastectomies, but do not require denial of multiple claims for excisions. While the methodology for claims review in this study allowed two mastectomy codes (as presumably involving both breasts), the manual instructions deny secondary mastectomy codes when the principal procedure is a mastectomy. Correct use of "left" and "right" modifiers should allow for more precise assessment.

The HCFA's response to the draft version of this report indicate that they believe biopsies billed with excisions and mastectomies are permissible (presumably referring to the "one-stage" approach to diagnosing and excising cancerous tumors). We have retained Appendix B detailing these procedures, but have deleted the amounts paid from the overpayment calculation.

Claims from two surgeons, neither an assistant:

A chance finding was 20 cases in which a second surgeon billed for the laparotomy, without indicating "assistant" status, and was paid as though s/he were the primary surgeon. The CPT instructions provide for two surgeons or for a surgical team in certain instances. One surgeon's billing for the laparotomy while another bills for a gallbladder extraction does not meet the criteria discussed in CPT.

For example, two surgeons billed for operating on the same patient on the same day. One was allowed $1342 for a hemigastrectomy (removal of half of the stomach); the other, although not identified as an assistant, $517. The first surgeon was allowed $245 for a liver biopsy; the second $219, plus $235 for an omentectomy (removal of abdominal tissue). Both the biopsies and the omentectomy are "separate procedures," not allowable when billed with more major procedures. The second payment for the hemigastrectomy is 42 percent of the first; the second liver biopsy payment is 89 percent of the first.

The Carriers Manual section referred to above would require denial of omentectomies, laparotomies, and various other incidental procedures when hemigastrectomy is the principal procedure. Several other major abdominal procedures (e.g., colectomy and cholecystectomy) have similar, although less extensive, lists of codes to be rebundled. This still allows for many of the overpayments identified in this report, both for major procedures for which rebundling is not required, and for those separate and incidental procedures not listed.

Claims from assistants at surgery:

In 13 cases in which a primary as well as an assistant surgeon billed for a laparotomy, the average amount allowed the assistant was $53, ranging from 11 to 33 percent of the respective surgeon's allowed amount. In the 23 cases in which an assistant billed for a laparotomy but a primary surgeon did not, the average amount allowed the assistant was $148. We did not attempt to determine how the carriers assigned allowed amounts to the solo bills of the assistants, but may study this issue separately. Medicare Carriers Manual instructions issued in October 1991 list procedures for which assistants may not bill. The only impact these instructions would have had on the claims reviewed in this study would have been denial of $29.41 for an assistant at an incisional breast biopsy.

Facility codes differing from surgeon's codes:

Twelve of the exempted claims were for facility fees as well as anesthesia and surgeon's fees for breast biopsies. In each case, the facility coded the biopsy code, although the surgeon indicated that the procedure was a cyst excision, or, in one instance, a mastectomy. The ambulatory surgical center (ASC) payment group for a biopsy is the same as the group which includes cyst excision, but lower than the payment the ASC could have received for a mastectomy.

Projected overpayments for "separate procedures" billed inappropriately totalled $3,404,100.

An examination of the codes billed on the same day for the same patient reveals numerous instances of combinations that are contrary to the guidelines expressed in CPT-4. For example, billing for code 44005, enterolysis (cutting internal adhesions) for bowel obstruction (separate procedure), at the same time as any other surgery violates CPT guidelines. Enterolysis is typically undertaken either because the adhesions are causing an acute bowel obstruction or incidental to another reason for having opened the abdomen, such as during gallbladder surgery. In either case, a laparotomy is merely an approach to the surgical field, and should not be paid for separately. Additionally, this code for lysis of adhesions is limited to use in those cases in which the lesions cause a bowel obstruction. Thus code 44005 should not be billed when the adhesions are removed incidentally.

See Appendix D for a list of "separate procedures," which should be denied when performed with any other procedure.

Projected overpayments for secondary procedures that should have been denied as duplicative or mutually exclusive totalled $1,721,600.

Since the codes for exploratory surgery include any biopsies that were performed, any claim for a biopsy of an abdominal organ on the same patient on the same day

represents duplicate billing. In these cases, either the biopsy claim or the exploration claim should be denied.

The primary reason for erroneous claims associated with bone marrow needle biopsies is billing for the actual aspiration of the material to be examined by more than one physician, or by one physician twice. In 86 instances, both codes 85095, bone marrow smear and/or cell block, aspiration only, and 85102, needle biopsy of the bone marrow, were billed simultaneously. Even if one was billed by a surgeon and the other by a pathologist, they clearly are both billing for performing the same action. The HCFA disagrees with this conclusion; we have retained Appendix B, but removed the payment amounts from the overpayment calculation.

As mentioned earlier, several of the claims associated with breast biopsies were for both a partial and a radical mastectomy. We assumed that this indicated surgery on both breasts, so both were allowed.

Multiple procedures within one code:

Thirteen claims (26 line items) were for duplicate codes 19120, excision of cyst, fibroadenoma, etc., ... , **one or more lesions.** We believe this description means that on any one occasion, this code should be used for all the cysts, etc., removed. In these cases, however, both were allowed. The codes were paid at the same rate once, one at half of the other eight times, and one at a reduced rate four times. They are shown as "deny secondary procedure" in Appendix B.

Mutually-exclusive procedures:

Cholecystectomies are the procedures most often fragmented in all the claims examined as part of this report. Several were reported in conjunction with cholecystenterostomies, a logical impossibility, since the cholecystectomy code means the gallbladder was removed, and the cholecystenterostomy code that the gallbladder was connected to the intestine. This concern is not addressed by the draft instructions.

RECOMMENDATION

The Health Care Financing Administration should require carriers to deny or adjust payment for:

(1) "exploratory" surgery performed incidently to procedure separately billed,

(2) biopsies performed in the course of more major surgery in the same body cavity,

(3) "separate procedures" billed with another procedure,

(4) mutually-exclusive procedures, and

(5) claims by assistants for procedures denied when billed by surgeons.

Proper payment of such claims can be accomplished by creating screens which reject exploration claims billed with any related code, adjust biopsy claims when billed with more major surgery in the same body cavity, reject claims for "separate procedures" unless they are the only procedure billed, reject claims for duplicative and mutually-exclusive procedures, and pay assistants only when the surgeon may be paid for a procedure.

This can best be done by creating software which examines claims according to a logical clinical sequence, rejecting for development (or outright denial) those claims which fail to pass the screens. The simplest version of this software would merely reject laparotomies and "separate procedures" done in conjunction with any other procedure, without further analysis.

The HCFA has created series of combinations, which address some of the problems identified in this report. For example, laparotomies, lysis of adhesions, and omentectomies are denied in conjunction with certain abdominal procedures, but not with many others.

The HCFA concurred with our recommendations concerning exploratory surgery and payment for separate and mutually-exclusive procedures. They disagree that biopsies should not be paid for when performed in the course of more major surgery, but have rather identified a lesser payment amount which does not pay the surgeon again for having opened the abdomen. In their technical comments they disagreed that demonstrated unbundling of breast biopsies and bone marrow biopsies. We have retained the appendices detailing these situations, but have removed the payments for them from our overpayment calculation. We will expand upon our examination of assistants at surgery in a future study.

APPENDIX A

Overpayments associated with code 49000, Exploratory Laparotomies, and with 49010, Retroperitoneal Laparotomies

49000	EXPLORATORY LAPAROTOMY, EXPLORATORY CELIOTOMY	OBS	DENY	ALLOW	ALLOW	DENY	DENY	DENY
	WITH OR WITHOUT BIOPSY(S),		LAP,	PRINCIPAL	SECONDARY	"SEPARATE	LAP,	SECONDARY
	SEPARATE PROCEDURE		SURGEON	PROCEDURE	PROCEDURE	PROCEDURE"	ASSISTANT	PROCEDURE
34151	RENAL EMBOLECTOMY (ABDOMINAL INCISION)	1		$1,925.30			$320.90	
38100	SPLENECTOMY (SEPARATE PROCEDURE); TOTAL	2	$695.20	$1,429.85		$352.20		
38564	LIMITED LYMPHADENECTOMY, FOR STAGING (SEP PROC)	1	$366.50	$411.50		$100.00		
38770	PELVIC LYMPHADENECTOMY (SEP PROC); UNILATERAL	1	$672.00	$212.50				
43500	GASTROSTOMY; WITH EXPLORATION	1	$1,069.60	$611.80		$534.80		$611.80
43605	BIOPSY OF STOMACH BY LAPAROTOMY	1	$336.00	$1,344.00		$1,123.10		
43630	HEMIGASTRECTOMY OR DISTAL GASTRECTOMY, WITHOUT VAGOTOMY	2		$2,704.30		$235.00	$345.45	
43635	HEMIGASTRECTOMY OR DISTAL GASTRECTOMY, WITH VAGOTOMY	1	$291.00	$1,187.00				
43640	VAGOTOMY INCLUDING PYLOROPLASY, WITH OR WITHOUT GASTRECTOMY	3		$3,067.45	$147.68	$865.40		$471.44
43820	GASTROJEJUNOSTOMY	1		$800.00	$437.50		$798.50	
43830	GASTROSTOMY, TEMP (TUBE,RUBBER,PLASTIC)(SEP PROC)	2	$1,254.10	$1,231.55			$152.10	
43840	GASTRORRHAPHY, SUTURE OF PERFORATED ULCER, WOUND OR INJURY	3		$1,833.20		$606.90	$53.50	
44005	ENTEROLYSIS FOR BOWEL OBSTRUCTION (SEP PROC)	11	$2,233.45	$8,606.55		$1,511.50	$396.64	
44010	DUODENOTOMY, FOR EXPLORATION, BIOPSY(S), OR FOREIGN BODY REMOVAL	1		$1,088.20		$879.55		
44021	ENTEROTOMY, SMALL BOWEL; FOR DECOMPRESSION	1	$280.90	$767.00			$56.20	
44050	REDUCTION OF VOLVULUS, INTUSSUSCEPTION, BY LAP	1		$1,069.60			$192.60	
44110	BIOPSY OF INTESTINE BY CAPSULE, TUBE, PERORAL	2	$336.00	$1,405.80	$432.00	$896.00		
44120	ENTERECTOMY, RESECTION OF SML INTESTINE; WITH ANASTOMOSIS	7	$1,603.30	$7,475.40	$365.60	$1,425.20		$3,014.65
44130	ENTEROENTEROSTOMY, ANASTOMOSIS (SEP PROC)	1		$1,180.00		$584.70		
44141	COLECTOMY, PARTIAL; WITH SKIN LEVEL CECOSTOMY OR COLOSTOMY	2	$175.00	$2,684.00			$164.70	
44143	COLECTOMY, PARTIAL; WITH END COLOSTOMY, CLOSURE DISTAL SEGMENT	8	$478.60	$8,665.25	$738.05	$1,530.50	$147.40	$2,580.30

44145	COLECTOMY, PARTIAL; WITH COLOPROCTOSTOMY	1		$1,571.90		$311.30		
44160	COLECTOMY WITH REMOVAL OF TERMINAL ILEUM AND ILEOCOLOSTOMY	1		$1,550.00		$820.90		
44300	ENTEROSTOMY, OR CECOSTOMY, TUBE (SEP PROC)	2	$1,077.30	$868.00		$264.00		
44320	COLOSTOMY OR SKIN LEVEL CECOSTOMY; (SEP PROC)	5	$1,389.16	$2,894.90			$423.01	
44345	REVISION OF COLOSTOMY, COMPLICATED	1		$567.70			$149.70	$131.60
44600	SUTURE OF INTESTINE, LARGE OR SMALL, SINGLE	1	$585.60	$213.42				
44605	SUTURE OF INTESTINE; WITH COLOSTOMY	1	$291.00	$645.40				
44625	CLOSE ENTROSTOMY WITH RESECTION & ANASTOMOSIS	2	$641.70	$2,153.90	$1,140.70	$429.40		
44799	UNLISTED PROCEDURE, INTESTINE	2	$442.90	$3,147.15			$110.70	$450.85
44900	I & D OF APPENDICEAL ABCESS, TRANSABDOMINAL	1		$734.20			$213.90	
44950	APPENDECTOMY	2	$671.80	$1,054.50		$895.70	$140.00	
44955	APPENDECTOMY; WHEN DONE WITH MAJOR PROCEDURE	1	$554.50	$97.50			$110.90	
47000	BIOPSY OF LIVER, PERCUTANEOUS NEEDLE	3	$1,776.90	$198.50			$58.20	
47120	HEPATECTOMY, RESECT LIVER; PARTIAL LOBECTOMY	1		$1,361.90			$156.80	
47420	CHOLEDOCHOTOMY WITH EXPLORATION, DRAINAGE OR REMOVAL OF CALCULUS	2	$300.00	$2,040.00				$680.55
47480	CHOLECYSTOTOMY WITH EXPLORATION, ETC. (SEP PROC)	3	$1,771.35	$1,300.36	$9.00			$500.00
47600	CHOLECYSTECTOMY	4	$1,172.15	$2,836.80	$287.50	$2,003.30	$64.20	
47605	CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY	5	$1,486.00	$4,081.50	$908.35	$1,124.12	$57.10	
47610	CHOLECYSTECTOMY, EXPLORATION OF COMMON DUCT	2	$321.00	$1,687.30		$259.20	$400.00	$300.00
47720	CHOLECYSTOENTEROSTOMY; DIRECT	2	$623.60	$1,795.00		$285.50		
47760	ANASTOMOSIS, DIRECT, EXTRAHEPATIC DUCTS & GI TRACT	1		$677.45	$306.66	$1,067.00		
48540	INT ANASTOMOSIS, PANCREATIC CYST TO GI TRACT; ROUX-EN-Y	1		$1,245.00	$552.40	$510.70		
49020	DRAINAGE OF PERITONEAL ABCESS, TRANSABDOMINAL	5	$1,243.80	$1,703.45		$1,656.65	$133.06	
49200	EXCISE, DESTRUCT INTRA-ABDOMINAL TUMORS, CYSTS, ETC.	2	$810.00	$1,249.00			$103.20	
49220	STAGING LAP FOR HODGKIN'S DISEASE OR LYMPHOMA	1	$543.20	$1,000.00				
49505	REPAIR INGUINAL HERNIA	2		$778.85		$898.50	$110.86	
49560	REPAIR INCISIONAL HERNIA (SEP PROC)	2	$321.00	$1,082.55	$66.34	$1,019.10		
49565	REPAIR INCISIONAL HERNIA, RECURRENT	1		$319.40			$149.10	$319.40

49999	UNLISTED PROC, ABDOMEN, PERITONEUM AND OMENTUM	2	$855.70	$408.85	$177.36		$128.30	
50230	NEPHRECTOMY, RADICAL, REGIONAL LYMPHADENECTOMY	1	$638.80	$1,306.20				
50390	ASPIRATION &/OR INJECTION, RENAL CYST, PERCUTANEOUS	1	$1,000.00	$51.75			$200.00	
50800	URETEROENTEROSTOMY; UNILATERAL	1	$294.10	$992.00			$58.80	
51550	CYSTECTOMY, PARTIAL; SIMPLE	1	$320.90	$929.90				
51840	ANTERIOR VESICOURETHOPEXY (MARSHALL-MARCHETTI-KRANTZ); SIMPLE	1	$853.00	$1,191.80			$400.00	
51841	ANTERIOR VESICOURETHOPEXY; COMPLICATED (e.g., SECONDARY REPAIR)	1	$320.90	$705.90				
58150	TOTAL ABDOMINAL HYSTERECTOMY, WITH/WITHOUT SALPINGO-OOPHORECTOMY	9	$4,678.08	$10,213.40		$1,200.00		
58210	RADICAL HYSTERECTOMY	1		$2,231.60			$107.10	
58720	SALPINGO-OOPHORECTOMY, UNI- OR BILATERAL, SEP PROC	4	$1,985.50	$3,839.04		$356.50		
58920	WEDGE RESECTION OR BISECTION OF OVARY, UNILATERAL OR BILATERAL	1		$337.50		$844.25		
58925	OVARIAN CYSTECTOMY, UNILATERAL OR BILATERAL	2	$260.45	$1,008.50		$1,347.85		
58940	OOPHORECTOMY, PARTIAL OR TOTAL, UNILATERAL OR BILATERAL	3	$1,433.40	$1,559.50	$388.15			$778.00
58950	RESECTION OF OVARIAN Ca WITH SALPINGO-OOPHORECTOMY & OMENTECTOMY	2	$600.00	$1,016.35		$487.50		$1,417.35
58951	RESECTION OF OVARIAN Ca WITH TOTAL ABDOMINAL HYSTERECTOMY	1	$582.00	$1,365.00				
		141	$39,637.44	$115,713.17	$5,957.29	$26,426.32	$5,902.92	$11,255.94

49010	EXPLORATION, RETROPERINEUM,	OBS	DENY	ALLOW	ALLOW	DENY	DENY
	WITH OR WITHOUT BIOPSY(S),		LAPAROTOMY,	PRINCIPAL	SECONDARY	"SEPARATE	SECONDARY
	SEPARATE PROCEDURE		SURGEON	PROCEDURE	PROCEDURE	PROCEDURE"	PROCEDURE
38564	LIMITED LYMPHADENECTOMY, FOR STAGING (SEPARATE PROCEDURE)	1	$275.00	$411.50		$100.00	
38100	SPLENECTOMY (SEPARATE PROCEDURE); TOTAL	1	$200.00	$800.00			
43820	GASTROJEJUNOSTOMY	1	$1,500.00	$800.00	$437.50		
43832	GASTROSTOMY, PERMANENT, WITH CONSTRUCTION OF GASTRIC TUBE	1	$730.00	$859.80			
49200	EXCISION OR DESTRUCTION OF INTRA-ABDOMINAL TUMORS, CYSTS, ETC.	1	$532.30	$974.40			$782.20
49530	REPAIR INGUINAL HERNIA, INCARCERATED	1	$300.00	$667.00			
58150	TOTAL ABDOMINAL HYSTERECTOMY, WITH/WITHOUT SALPINGO-OOPHORECTOMY	1	$450.00	$895.80			
58200	TOTAL HYSTERECTOMY, INC. PARTIAL VAGINECTOMY	1	$250.00	$1,190.00		$75.00	
22842	REMOVAL OF SPINAL INSTRUMENT	1	$1,600.00	$3,307.50			$1,828.20
		9	$5,837.30	$9,906.00	$437.50	$175.00	$2,610.40

APPENDIX B

Overpayments associated with code 19101, Biopsy of breast, incisional and with code 85102, Bone marrow needle biopsy

19101	BIOPSY OF BREAST,	OBS	DENY	ALLOW	ALLOW	DENY	DENY
	INCISIONAL		BIOPSY,	PRINCIPLE	SECONDARY	BIOPSY,	SECONDARY
			SURGEON	PROCEDURE	PROCEDURE	ASSISTANT	PROCEDURE
19120	EXCISION OF CYST, ETC, BREAST, ONE OR MORE LESIONS	20	$1,059.03	$5,398.69		$220.00	$2,118.17
19160	PARTIAL MASTECTOMY	3		$1,143.10		$36.19	$368.60
19180	SIMPLE, COMPLETE MASTECTOMY	2	$574.10	$1,290.10	$671.90		
19200	RADICAL MASTECTOMY, INC. PECTORAL MUSCLES, AXILLARY LYMPH NODES	3	$448.00	$4,453.40			
19240	MODIFIED RADICAL MASTECTOMY, INC. SOME PECTORAL MUSCLES, AXILLARY LYMPH NODES	18	$2,372.90	$17,903.10	$520.00	$59.41	$274.85
		46	$4,454.03	$30,188.39	$1,191.90	$315.60	$2,761.62

85102	BONE MARROW NEEDLE BIOPSY	OBS	DENY	ALLOW	ALLOW	DENY
			BIOPSY,	PRINCIPLE	SECONDARY	BIOPSY,
			SURGEON	PROCEDURE	PROCEDURE	LABORATORY
20220	BONE BIOPSY, NEEDLE, SUPERFICIAL	9	$357.00	$754.30		$336.13
20225	BONE BIOPSY, NEEDLE, DEEP	5		$420.40	$110.55	$230.90
20245	BONE BIOPSY, EXCISIONAL, DEEP	1	$84.60	$72.00		
27447	TOTAL KNEE REPLACEMENT	1		$2,853.54		$82.90
85095	BONE MARROW SMEAR, ASPIRATION ONLY	86	$7,014.05	$4,164.63		$81.00
85100	BONE MARROW SMEAR, ASPIRATION, STAINING & INTERPRETATION	18	$1,107.65	$1,937.10		
85101	BONE MARROW SMEAR, ASPIRATION & STAINING	1	$130.00	$90.00		
		121	$8,693.30	$10,291.97	$110.55	$730.93

APPENDIX C

Overpayments associated with code 47100, Biopsy of liver, wedge (separate procedure) and with code 48100, Biopsy of pancreas (separate procedure)

Morning Report: _X_ **Yes** ___ **No**

Title: Implementation of State Child Support Certified Data Systems

Reference: OEI-04-96-00010 **Contact:** Mary Beth Clarke (202) 619-2481

We released a final report on implementation of State child support certified data systems. States appear to be well positioned to get their systems certified by the October 1, 1997 deadline. At the time of our review, six States had certified data systems. Forty-two States and territories anticipate having their systems certified by the deadline.

Most States attributed implementation delays largely to a requirement to share technology, short time frames, and ineffective State and contractor working relationships.

Despite the favorable outlook, continuing attention will be needed to ensure success. We recommended that ACF continuously monitor the status of each State's progress, provide technical assistance to States having difficulty meeting the revised deadline, and continue to monitor and provide technical assistance to States as they prepare to develop additional data systems required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The ACF agreed with our recommendations.