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-07-03-02662

Office of Inspector General

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CIN: A-07-03-02662
December 9, 2002

Jay Martinson
Vice President
Noridian Mutual Insurance Company
4305 13th Avenue, S.W.
Fargo, ND 58103

Dear Mr. Martinson:

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. Noridian Mutual Insurance Company's portion of the total overpayments was approximately $455,113.

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 Noridian Mutual Insurance Company's systems failed to identify such instances, which resulted in provider overpayments for calendar years 1999 through 2001 (1997 and 1998 were removed) of approximately $99,346, $81,447, and $142,758 ($323,551), respectively. Included in the identified overpayments is approximately $65,439 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 Noridian Mutual Insurance Company:

1. Recover the $258,112 ($323,551- $65,439) 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.

Noridian performed a 10 percent validation of the information and concurred that payment errors were encountered. However, Noridian expressed concern about the time and cost of recouping the overpaid ASC claims but stated that they would pursue recovery if CMS concurred. We have amended recommendation 1. to remove 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. Noridian Mutual Insurance Company's portion of the total universe was $5,478,997. 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 Noridian Mutual Insurance Company for calendar years 1997 through 2001 indicated overpayments in 1,895 out of 5,751 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately $455,113 out of approximately $5,478,997 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately $92,088 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 Noridian Mutual Insurance Company:

1. Recover the $258,112 ($323,551- $65,439) in Medicare overpayments to ACSs;

Noridian's Comments

Noridian performed a 10% validation of the information and concurs that payment errors were encountered. Noridian's processing system has audits in place to identify and suspend ASC claims for manual pricing situations when not all of the ASC codes are billed on the same claim. However, Noridian was able to confirm that certain codes were missing from the audits and is taking action to correct the audits. Noridian encountered a few instances in the 10% sample in which Noridian felt the dollar amount in question was not accurately stated….

In addition to the hours spent reviewing 10% of the information on the CD, Noridian has done a high-level preliminary cost analysis for the research and recovery of these funds. To research each case prior to the recovery process, we estimate 767 hours of time costing over $18,000. To carry out the recovery process, we estimate 959 hours of time costing over $22,500. Noridian's response, in it's entirety, is attached to this report (see Appendix A).

OIG's Response

According to CFR 42 416.120, *if 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.* We ranked each surgical session then eliminated the highest procedure and reduced the remaining procedures 50 percent to estimate the amount overpaid. Paying claims according to CFR 42 416.120 will eliminate the majority of claims paid incorrectly. We have amended recommendation 1. to remove overpayments applicable to 1997 and 1998.

The cost of recouping the overpayment is small relative to the overpayment.

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

Noridian's Comments

If recommendation #1 above is pursued, Noridian will instruct the ASC's to refund related coinsurance as part of the demand letter used in the recoupment (recovery) process.

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;

Noridian's Comments

Noridian does not maintain a comprehensive in-house paid claims history database for claims research. As such, Noridian does not have an effective means of identifying these overpayments. It will be necessary to request assistance from the Program Safeguard Contractor (western Integrity Center) or from the system maintainers (EDS & Verizon). There most likely will be costs associated in obtaining the data. In addition, the same type of costs associated in the research and recovery described in Recommendation #1 above would apply to these recoveries also.

OIG's Response

The cost of recouping the overpayment is small relative to the overpayment.

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

Noridian's Comments

Noridian concurs with this recommendation.

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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-07-03-02662 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
For Audit Services

HHS Action Official
Mr. Alex Trujillo
Regional Administrator, Region VIII
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November 22, 2002

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

Re: Response to Draft OIG Audit CIN: A-07-03-02662

Dear Mr. Aasmundstad,

This response is in regards to your letter dated October 24, 2002 containing a draft OIG report entitled *"Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgery Centers"*.

Your letter provides Noridian with the opportunity to offer written comments relative to the validity of the facts and the reasonableness of the recommendations presented.

Validity of the Facts:

Noridian requested and received the detailed list, on CD, of the questioned claims. Noridian performed a 10% validation of the information and concurs that payment errors were encountered. Noridian's processing system has audits in place designed to identify and suspend ASC claims for manual pricing in situations when not all of the ASC codes are billed on the same claim. However, Noridian was able to confirm that certain codes were missing from the audits and is taking action to correct the audits. Noridian encountered a few instances in the 10% sample in which Noridian felt the dollar amount in question was not accurately stated. Noridian also identified a few cases in which the claims were processed correctly (no overpayment exists).

Reasonableness of the Recommendations:

1. *Recover the $363,025 ($455,113 - $92,088) in Medicare overpayments to ASCs:* In addition to the hours spent reviewing 10% of the information on the CD,

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Noridian has done a high-level preliminary cost analysis for the research and recovery of these funds. To research each case prior to the recovery process, we estimate 767 hours of time costing over $18,000. To carry out the recovery process, we estimate 959 hours of time costing over $22,500.

The following applicable MCM sections will need to be addressed prior to recovery procedures. Attempting to recover monies back to 1997 when the overpayment was caused by the contractor's audit and there is no indication that the physician was at fault will no doubt prompt provider concern. However, Noridian will proceed if concurrence from CMS to pursue recovery is received and funding to perform the applicable recovery processes is received.

7100.1 Time Limits on Recovery of Overpayments.--The two time limitations to consider in deciding whether to recover an overpayment are:

- Do not recover an overpayment not reopened within 4 years (48 months) after the date of payment, unless the case involves fraud or similar fault. (See §§7115B and 12100ff.)

- Do not recover an overpayment discovered later than 3 full calendar years after the year of payment unless there is evidence that the physician or beneficiary was at fault with respect to the overpayment. (See §7106.)

Refer to §7106 (Note) for exception to these rules.

7106. LIABILITY FOR OVERPAYMENTS DISCOVERED SUBSEQUENT TO THIRD CALENDAR YEAR AFTER YEAR OF PAYMENT

The law prescribes special rules when an overpayment is discovered (i.e., it is determined that a payment was incorrect) subsequent to the third calendar year after the year in which it was made. Under these rules, deem an overpaid physician without fault without further development in the absence of evidence to the contrary, i.e., if there is no indication that the physician was at fault. Where the beneficiary was liable, HCFA waives recovery from the beneficiary if he was without fault. (This provision provides limited relief to physicians since, in most cases, the facts which bring to light the overpayment are sufficient basis for determining whether the physician was at fault.) Do not deem a physician without fault under this provision with respect to overpayments for noncovered services which are part of a pattern of billing for similar services. In such cases, initiate necessary development to establish whether the physician was without fault.

See §§7116A and C, 7130.1C, 7130.2B, and 7142.4 for the processing of overpayments discovered subsequent to the third calendar year after the year of payment.

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2. *Instruct ASCs to refund related coinsurance as required in 42 CFR 416.30, section C;* If Recommendation #1 above is pursued, Noridian will instruct the ASCs to refund related coinsurance as part of the demand letter used in the recoupment (recovery) process.

3. *Identify and recoup all similar overpayments made between January 1, 2002 and the effective implementation of system changes....* Noridian does not maintain a comprehensive in-house paid claims history database for claims research. As such, Noridian does not have an effective means of identifying these overpayments. It will be necessary to request assistance from the Program Safeguard Contractor (Western Integrity Center) or from the system maintainers (EDS & Verizon). There most likely will be costs associated in obtaining the data. In addition, the same type of costs associated in the research and recovery described in Recommendation #1 above would apply to these recoveries also.

4. *Take necessary actions (such as edits, provider education and/or carrier in-house training) to preclude such overpayments in the future.* Noridian concurs with this recommendation. Corrective actions are in process. Noridian will be able to implement corrective actions prior to December 31, 2002

Noridian appreciates the opportunity to provide comments and will take the necessary actions when the final OIG Audit Report is received. If you have questions regarding this response, please contact myself, or Teresa English at 701-282-1020.

Sincerely,

Jay Martinson

Cc: Alex Trujillo