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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Office of Inspector General

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Region VII
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CIN: A-07-03-02663
January 9, 2003

Roz Catoe
Vice President, Medicare Processing & Customer Service
Palmetto Government Benefits Administrators
17 Technology Circle, Mail Code: AG-A05
Columbia, SC 29202-9511

Dear Mr. Catoe:

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. Palmetto Government Benefits Administrators' portion of the total overpayments was approximately $46,351.

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 Palmetto Government Benefits Administrators' systems failed to identify such instances, which resulted in provider overpayments for calendar years 1997 through 2001of approximately $647, $2,860, $8,934, $9,191, and $24,719 ($46,351), respectively. Included in the identified overpayments is approximately $10,181 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 Palmetto Government Benefits Administrators:

1. Recover the $36,170 ($46,351- $10,181) 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.

Palmetto stated that *In conclusion, proper reductions were applied to many of the claims we reviewed…However, there were quite a few claims in which reduction payments were not applied properly. We feel that this error may have been the result of manual processing errors by the associates.* Based on Palmetto's statement, we readjusted claims that appeared to have been paid correctly. We reduced recommendation 1 to $46,351. Palmetto's response, in its entirety, is attached to this report (see Appendix A).

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. Palmetto Government Benefits Administrators' portion of the total universe was $593,645. 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 Palmetto Government Benefits Administrators for calendar years 1997 through 2001 indicated overpayments in 222 out of 609 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately $46,351out of approximately $593,645 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately $10,181 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 Palmetto Government Benefits Administrators:

1. Recover the $36,170 ($46,351- $10,181) in Medicare overpayments to ACSs;

Palmetto's Comments

In conclusion, proper reductions were applied to many of the claims we reviewed. For example; the claims that were billed with the 59 modifier were incorrectly noted as duplicate payments on the report. These claims were paid correctly because the 59 modifier identifies these services as a distinct procedural service. However, there were quite a few claims in which reduction payments were not applied properly. We feel that this error may have been the result of manual processing errors by the associates.

In addition, it appears that if the services come in on a separate claim, the system is not checking history; therefore, the services on the second claim are sometimes paying at 100%. We are in contact with our system maintainer to see if the logic can be changed to not only check for services within a claim but check claim history.

OIG's Response

Based on Palmetto's statement, the OIG eliminated claims that appeared to have been paid correctly and reduced recommendation 1 to $46,351. However, the OIG does not agree with the statement *that the claims that were billed with the 59 modifier were incorrectly noted as duplicate payments on the report*. OIG responds that modifier 59 does not exempt a procedure from multiple surgery pricing rules.

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

Palmetto's Comments

The overpayments department will also instruct the ASCs 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;

Palmetto's Comments

Finally, we will initiate recoupments for those claims that did process incorrectly from 1997 to present.

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

Palmetto's Comments

...Palmetto GBA does have correct processing guidelines to ensure ASC claims process correctly but we will ensure the associates understand the procedures. We will also have our system updated to check claims that are in history.

Palmetto's response, in its entirety, is attached to this report (see Appendix A).

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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-07-03-02663 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
For Audit Services

Enclosure

HHS Action Official
Ms. Rose Crum-Johnson
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

December 20, 2002

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

Dear Mr. Aasmundstad,

This letter is in response to the information sent to Mrs. Roz Catoe, Vice President of Medicare Processing and Customer Services on November 21, 2002 concerning the improper payments of multiple procedures that were performed in the same operative session in ambulatory surgical centers.

The results of our review of the claims are as follows:

- The system is correctly paying multiple ASC facility services at 100%, 50%, 50%, etc., when they are all billed on the same claim.

- If multiple ASC facility services are billed on separate claims, the claim usually hits the duplicate edit. Our processors then apply the following procedures for proper reduction:

  If an ASC with the lowest allowance is billed and paid first and the second claim is later billed with an ASC with a higher allowance, our procedure is to take the higher allowance and subtract 50% of the lower allowance. We then pay the difference on the second claim billed and use action code BT *(The approved amount represents a reduction because the service was incorrectly broken down into its component parts. Partial payment has previously been made).* Some of the examples in which these procedures were applied correctly are listed below:

HICN	CCN	Date of Service
		6/27/00
		9/11/00
		11/8/99
		4/19/00
		2/14/01
		4/02/01
		5/26/00
		1/25/01
		10/30/01
		10/4/99

- If the claim does not fire for duplicate services, our global desk procedures are applied to the multiple ASC facility services. The global procedures are outlined as follows:

  "If the incoming claim line reflects multiple surgery codes kicking against surgery codes with same dates of service of the surgery code in history, apply the following rule":

a) Determine the global surgery days for each surgery code on both the incoming and history claim.

b) If a minor surgery (10 global days) is billed *after* the major surgery (90 global days), calculate 50% of the claim in history and subtract that amount from the incoming surgery claim line. Add action code BT.

c) If a minor surgery is billed *before* the major surgery, release claim for payment.

"If it cannot be determined that a minor surgery is kicking against a major surgery, then determine which surgery code has the highest allowance. The highest allowance must be paid."

a) If the history claim has the highest allowable, calculate 50% of the incoming claim allowable and add modifier 51 with action code PV (*Multiple surgical procedure. Payment reflects the lower of the billed fee schedule).*

b) If the incoming claim has the higher allowable, calculate 50% of the claim in history subtract that amount from the incoming surgery claim line. Add action code BT.

c) If any of the steps above do not apply, complete an Action Request Form to recoup the money that was allowed on the surgery claim in history. Release current claim without any reductions applied.

Conclusion

In conclusion, proper reductions were applied to many of the claims we reviewed. For example; the claims that were billed with the 59 modifier were incorrectly noted as duplicate payments on the report. These claims were paid correctly because the 59 modifier identified these services as a distinct procedural service.

However, there were quite a few claims in which reduction payments were not applied properly. We feel that this error may have been the result of manual processing errors by the associates.

In addition, it appears that if the services come in on a separate claim, the **system** is not checking history; therefore, the services on the second claim are sometimes paying at 100%. We are in contact with our system maintainer to see if the logic can be changed to not only check for services within a claim but to check claim history.

In response to this draft report, Palmetto GBA does have correct processing guidelines to ensure ASC claims process correctly but we will ensure the associates understand the procedures. We will also have our system updated to check claims that are in history.

Finally, we will initiate recoupments for those claims that did process incorrectly from 1997 to present. The overpayments department will also instruct the ASCs to refund related coinsurance as required in 42 CFR 416.30; section C .

Our provider education department will personally contact each ASC provider identified in the report and will encourage them to file ASC services on the same claim for services rendered on the same day. They will also include a general article in the Medicare Advisory/Bulletin about filing ASC services.

Sincerely,

Saundra Smith

Saundra Smith
Director of Medicare Part B Claims

cc: Rose Crum-Johnson
Roz Catoe
John Dart