- **Medicare Hospital Outpatient Prospective Payment:** The Department will soon release a report to Congress on a proposal to replace Medicare's current cost-based payment system for hospital outpatient services with a prospective payment system. The Department expects press and beneficiary interest to focus on the growing financial coinsurance liability for Medicare beneficiaries under the current payment system. However, the report estimates that fixing this problem immediately will cost the Medicare program $26.8 billion over five years and $134.7 billion through FY 2005. The report details less costly options for incremental changes.

FYI: Fortuna Jennings Klein

- **Revised Policy on OTC Home Specimen Collection Kits for HIV Testing:** On February 23, FDA published a notice that removes the restriction limiting home specimen collection kit systems for HIV-1 testing to professional use. In June 1994, FDA's Blood Products Advisory Committee found that the potential benefits of over-the-counter (OTC) home specimen collection kits outweighed the potential risks. FDA agrees and is revising its previous guidance for OTC products accordingly to allow the use of OTC home specimen collection kits for HIV testing. The notice also delineates the criteria that FDA will use in approving these kits.

FYI: Flemm

- **Physicians Cited for Excessive Billing of Medicare Beneficiaries:** For the first time, HCFA has cited physicians for willfully and repeatedly overcharging Medicare beneficiaries for services. Physicians and suppliers cannot charge Medicare patients more than 115 percent of the Medicare fee schedule amount for an item or service. Those who do so knowingly and willfully "on a repeated basis" are subject to exclusion from the Medicare program or civil monetary penalties of up to $2,000 for each occurrence. Last week, HCFA notified several physicians that they have violated these provisions. These physicians now have an opportunity to show cause why sanctions should not be imposed for these violations. Medicare beneficiary advocacy groups (e.g. AARP, Public Citizen), who in the past have criticized HCFA for not vigorously enforcing this provision, will be very supportive of this action. We do not expect a negative reaction from organized medicine as HCFA proposes to sanction only a small number of physicians.

- **Criticisms of Vaccines for Children:** The Department expects that the GAO will release a report sometime in the next month which is critical of the Vaccines for Children (VFC) program. The criticisms and the Department's responses, which will be outlined in a letter from David Satcher, head of CDC, to the GAO, are indicated below. GAO will report that:

1) Provider enrollment in VFC is lagging. The Department responds that considering that the enrollment of doctors is ongoing, the enrollment is impressive. To date, 7,270 public and 19,671 private provider sites are enrolled.

2) CDC's accountability system is inadequate to assure that vaccines are given only to eligible children. The Department responds that accounting each dose would require an unacceptable amount of paperwork. Instead CDC requires states to submit accountability plans, provide technical support and determine optimal accounting methods.

February 27, 1995

MEMORANDUM TO BRUCE LINDSEY

FROM: CAROL H. RASCO

SUBJECT: Mark Pryor's Proposal on CPT Codes for Medicare

As part of the Regulatory Review Initiative of Reinventing Government II, a "health industry" working group is considering ways to simplify Medicare coding and reimbursement. I have forwarded to them Mark Pryor's proposal to revise the current procedural terminology (CPT) code definitions.

CPT is a systematic listing and coding of more than 7000 physician services that provides uniform language to describe these services for physicians, payors and patients. CPT codes are used by both public programs and private insurers. Mark Pryor proposes to simplify CPT code definitions for the Medicare program so that payment would be linked only to diagnosis.

While the health industry working group has found that there is certainly room for improvement in Medicare billing, my initial view is that this proposal is not the best way to reduce costs and complexity in the Medicare program. First, many of the problems identified in Mark Pryor's letter have already been solved by revisions in CPT (as he acknowledges). In addition, a system that limits payment for a procedure to a specific diagnosis will not reflect the complexities and variation in medical practice. The same diagnosis can require different treatment options depending, for example, on a patient's condition. The system he envisions might automatically deny payment for a treatment if it is not *the* treatment linked to *the* diagnosis. Finally, because the CPT system is used by private payors as well as Medicare and Medicaid, a change in Medicare will require payors to maintain two coding systems and may actually increase paperwork and costs.

Please let me know if you have any additional questions or concerns. Also, please feel free to contact Jennifer Klein at 6-2599.

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Jennifer Klein **PHONE:** _____	**FROM:** Jennifer Boulanger OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201 **PHONE:** 202-690-~~6726~~ 9502 **FAX :** 202-690-6262

TOTAL PAGES:	**ADDRESSEE'S FAX MACHINE NUMBER:**	**DATE:**
2		2/15/95

REMARKS:

Background information on CPT and response to Mark Pryor's proposal. Please give me a call if you need additional information.

Briefing Material for the White House
to respond to Mark Pryor's
Medicare Part B Proposal

The proposal received from Mr. Pryor is seriously flawed, would engender political problems with physicians, private insurers, and states, and could result in substantial increases in Medicare outlays.

Background

- Physicians' Current Procedural Terminology (CPT) is a systematic listing and coding of more than 7000 services provided by physicians. CPT provides uniform language to accurately describe these services thereby improving communication among physicians, payors, and patients nationwide. CPT is the most widely accepted nomenclature for the reporting of physician services by private and government payors. Copyrighted by the American Medical Association, CPT was first published in 1966 and has been updated annually since 1983.

- CPT codes are used by physicians, hospital outpatient departments, private insurers, state Medicaid programs and researchers. Medicare began making payments using CPT coding on the billing form in 1983. All state Medicaid programs are required to use CPT coding for their Medicaid bills.

- The Medicare physician fee schedule, implemented in 1992, is based primarily on CPT coding. Medicare paid $32 billion in 1994 for physician services that are paid based on CPT codes.

- HCFA, private health insurers, and practicing physicians representing national medical specialty societies participate in the AMA's process to update CPT procedure codes. The Department of Health and Human Services has a formal agreement with the AMA permitting use of CPT in the Medicare and Medicaid programs. That agreement permits HCFA to establish procedural terminology and codes when CPT does not meet our needs. However, copyright law and our agreement with the AMA preclude HCFA or a HCFA contractor from establishing procedure codes which are frank modifications of CPT.

Proposal

- As the proposal acknowledges, virtually all of the specific problems with CPT which have been identified to date have been solved by revisions in CPT. For example, the section on laboratory medicine has been extensively revised to reflect current technology and to eliminate ambiguous or unclear terminology. Furthermore, HCFA has had a "correct coding" initiative underway since 1991 to identify and correct coding and billing problems.

- The approach outlined in the proposal could be perceived by physicians as intrusive by limiting them to practicing medicine following a "cookbook" written by the government. Currently, the AMA and national medical specialty societies provide advice to HCFA on proposed policies which reflect the contemporary practice of medicine and provide advice to HCFA about payment amounts. HCFA's collaboration with the AMA and medical specialty societies is well accepted by the physician community. It is an example of true collaboration between government and one of its partners.

- The proposal to limit payment for each procedure to certain specific diagnoses is unworkable and would not produce the anticipated savings. This approach does not recognize the complexity and variation in medical practice and medical problems. The same diagnosis could lead to different treatment options depending on such factors as the patient's condition. Medical policy needs to be much richer than simply identifying diagnoses which will result in automatic payment or denial.

- Implementation of this proposal would result in major disruptions to public and private payors. It would require extensive systems changes for the private insurance companies contracted with by HCFA to process Medicare claims. State Medicaid programs would be required to make systems changes, possibly resulting in an unfunded mandate. Private insurers could decide whether or not to follow the change. If they did, the private insurers would have to make major systems changes. If they did not, physicians would have to use two different coding systems to bill for services provided, resulting in Federal government-induced physician hassle.

- Rather than saving money, these changes could likely result in substantial outlays for the program. Further, an error in judgment about how physicians would use the new codes could result in additional expenditures in the millions of dollars.

- Finally, the change suggested in this proposal would enrage the American Medical Association. Their copyright of the CPT codes earns them millions of dollars and as a result, they will vigorously fight any attempt to discontinue its use.

Contact: Jennifer Boulanger
HCFA
202-690-8502

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

07-Feb-1995 03:13pm

TO: Ann M. O'Leary

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jennifer L. Klein
CC: Kamarck, Elaine C.

SUBJECT: Note to Bruce Lindsey

Bruce:

I have received your memo with attached letter from Mark Pryor regarding Medicare. I am forwarding it to Jennifer Klein to evaluate and make initial recommendations to me by Feb. 17 and I will then be in touch with you...I have asked Jennifer to coordinate with Elaine.

Thanks.

NOTE TO ELAINE and JENNIFER:

Please note his references to this issue being shopped on the Hill and particularly to the Sen. Committee on Aging staff....this writer is the son of Sen. Pryor. Also, please note in his letter he makes reference to Marjorie MacFarlane of the VP's office with whom the Executive Order has already been shared as well. Thanks.

6 6486

February 3, 1995

MEMORANDUM

To: ✓ Carol Rasco
Elaine Kamarck

From: Bruce Lindsey
Subject: Executive Order for Medicare

I know HHS has had some discussions regarding this matter. I don't know enough about the substance to know whether this proposal has merit, but it sounds like something we should evaluate.

J. KLEIN (please coordinate w/ Elaine per my E Mail
PLEASE evaluate and do
short response to BRUCE
for CHR by 2/17.
Thanks.

ROZ : TICKLER

EDWARD L. WRIGHT
(1903-1977)
ROBERT S. LINDSEY
(1913-1991)
RONALD A. MAY
ISAAC A. SCOTT, JR.
JAMES M. MOODY
JOHN G. LILE
GORDON S. RATHER, JR.
TERRY L. MATHEWS
DAVID M. POWELL
ROGER A. GLASGOW
C. DOUGLAS BUFORD, JR.
PATRICK J. GOSS
ALSTON JENNINGS, JR.
JOHN R. TISDALE
KATHLYN GRAVES
M. SAMUEL JONES III
JOHN WILLIAM SPIVEY III
LEE J. MULDROW
WENDELL L. GRIFFEN
N. M. NORTON, JR.
EDGAR J. TYLER
CHARLES C. PRICE
CHARLES T. COLEMAN
JAMES J. GLOVER
EDWIN L. LOWTHER, JR.
BEVERLY BASSETT SCHAFFER
CHARLES L. SCHLUMBERGER
SAMMYE L. TAYLOR
WALTER E. MAY

WRIGHT, LINDSEY & JENNINGS
ATTORNEYS AT LAW

200 WEST CAPITOL AVENUE
SUITE 2200
LITTLE ROCK, ARKANSAS 72201-3699

(501) 371-0808

FAX (501) 376-9442

OF COUNSEL
ALSTON JENNINGS
GEORGE E. LUSK, JR.

ANNA HIRAI GIBSON
GREGORY T. JONES
H. KEITH MORRISON
BETTINA E. BROWNSTEIN
WALTER McSPADDEN
ROGER D. ROWE
NANCY BELLHOUSE MAY
JOHN D. DAVIS
JUDY SIMMONS HENRY
KIMBERLY WOOD TUCKER
MARK L. PRYOR
RAY F. COX JR.
HARRY S. HURST, JR.
TROY A. PRICE
PATRICIA SIEVERS LEWALLEN
JAMES M. MOODY, JR.
KATHRYN A. PRYOR
J. MARK DAVIS
CLAIRE SHOWS HANCOCK
KEVIN W. KENNEDY
MARK A. ROGERS
JERRY J. SALLINGS
M. TODD WOOD
R. GREGORY ACLIN
FRED M. PERKINS III
WILLIAM STUART JACKSON
MICHAEL D. BARNES
STEPHEN R. LANCASTER
FRED ANDREW WOOD
JUDY M. ROBINSON
BETSY MEACHAM
AINSLEY H. LANG

January 31, 1995

Mr. Bruce Lindsey
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

VIA UPS NEXT DAY AIR

RE: Executive Order For Medicare

Dear Bruce:

Enclosed for your review is a draft Executive Order. It provides for a way to cut Medicare, Part B, costs while not reducing Medicare services.

Since Medicare is different from most government programs, let me offer this brief explanation of the problem and the solution. By way of background, the foundation for the Medicare Part B reimbursement payments is the Current Procedural Terminology (CPT) Codes developed by the American Medical Association as medical records codes and adopted by the Health Care Finance Administration (HCFA) as reimbursement payment codes. These codes have some imprecision and incompleteness as payment codes and HCFA has been slow to make adjustments. As an example, it has been estimated that 30 percent of the reimbursement payments in the Medicare Part B system are improperly coded.

This proposal would revise the CPT code definitions based on input from the provider level, so that those codes are accurate reimbursement codes. If implemented, a private group would delineate and define each medical action, technology, and method in concise language that is understood by HCFA, providers and carriers. Then, each would be connected to a medically necessary diagnosis and each definition/diagnosis would be tied directly to a single reimbursement payment code.

In addition to fixing a faulty foundation, other benefits of this proposed request for proposals would be:

- Achieve roughly six percent reduction (over $3,000,000,000) in current Medicare Part B reimbursement payments, without reducing medical services.

- Curtail the roughly eleven percent potential growth (more than $6,000,000,000) resulting from "gaming" the present codes.

- Reduce the "hassle factor" and claim rejections for providers, therefore getting payments to them sooner and increasing their claims efficiency.

- Provide methods to adopt to future changes in clinical protocols in medical technologies.

- Establish a continuing educational communications system at the grass roots level and at the carrier level.

- Establish an ongoing monitoring system for identifying errors and abuses.

- Provide accuracte data for HCFA in making future decisions.

For your review, I am providing a few examples of coding problems with Medicare Part B. Please note that some of the these problems have already been corrected by HCFA, but they are illustrative of what is going on out there in the field. As you can tell, this proposal could save billions of dollars in Medicare.

I pass along this rough draft executive order as a starting point. I certainly understand that it is important for the White House to feel comfortable with its language. Please feel free to contact me if you have any questions or suggestions or feel free to get some of the staff in touch with me if they have questions.

PLEASE NOTE. It is my belief that time is of the essence with this proposal. Since we last talked, this idea has been shopped around with several majority members' staffs at the House of Representatives. In addition to individual members, the Ways and Means Committee staff has also seen information relating to the proposal. They are aware that we have passed along a draft executive order, but it was not provided to them. I am told there is a high degree of interest on Capitol Hill in this proposal. Also, the Democratic staff for the Senate Aging Committee has been contacted about the same idea.

It is my belief that this proposal fits neatly into the reinventing government program pushed by this Administration. In that regard, I have passed this same rough draft of the executive order along to Marjorie MacFarlane at the Vice President's office.

I hope you will give this matter strong consideration and send it through the proper channels at the White House.

We look forward to working with you, the White House staff and the Vice President's staff to make these reforms become a reality. If I can be of any further assistance, please do not hesitate to contact me.

Cordially,

WRIGHT, LINDSEY & JENNINGS

Mark Pryor

Mark L. Pryor

MLP:jas
Enclosures

1:jas1235.064

ROUGH DRAFT-FOR DISCUSSION PURPOSES ONLY

Executive Order _____ of _____ , of 1995.

Increasing Efficiency In The Medicare Part B System

WHEREAS, this Administration is determined to accomplish meaningful health care reform because it is in the best interest of the American People;

WHEREAS, the Medicare system (42 U.S.C. § 1381 et seq.) is a significant part of America's health care system and represents a significant expenditure of tax dollars;

WHEREAS, causing the Medicare system to operate more efficiently will bring about substantial savings and will also increase the quality and consistency of American health care;

WHEREAS, this Administration is committed to re-inventing government in such a way as to forge partnerships with private industry and thereby increase efficiency in delivering services;

WHEREAS, the Current Procedural Terminology (CPT) codes developed by the American Medical Association as medical records codes, have been adopted by the Health Care Financing Administration (_____ U.S.C. § _____) as payment codes, also known as Health Care provider Codes (_____ U.S.C. § _____);

WHEREAS, accurate and detailed CPT payment codes, reflecting clinical and technical services at the provider level, are the necessary foundation of effectively administering the Medicare Part B system;

WHEREAS, there is a continuing and expanding sizable error factor in Medicare Part B coding which is becoming increasingly unmanageable;

WHEREAS, a large portion of this error factor is attributable to the lack of precision and completeness in the CPT payment codes to adequately describe the complexity of delivering current health care services to patients;

WHEREAS, the existing CPT code system lacks the ability to adjust to changing clinical protocols and medical technologies;

WHEREAS, due to the shortcomings of the existing CPT payment codes, they are incapable of providing sufficient detection of abuses and errors;

WHEREAS, the current CPT payment codes are vague and ambiguous, not always reflecting what the providers are really doing in the field, and therefore, often producing inconsistency of coding, billing and reimbursement.

WHEREAS, this lack of precision and completeness in the current CPT payment codes permits "gaming" which is when providers choose among several loosely applicable codes in order to obtain the highest reimbursements;

WHEREAS, gaming results in quasi-arbitrary reimbursements, produces inequity in the Medicare system, provides false usage numbers to administration, and adds significantly to the total cost of Medicare;

WHEREAS, gaming has been one of the largest reasons for growth in expenditures related to the Medicare B reimbursements;

WHEREAS, an August 1993 General Accounting Office report (GAO/PEMD-93-27) examined the reliability of claims processing and determined that substantial variation exists in how similar

claims are treated and that these variations occur among carriers and among geographic regions;

WHEREAS, on March 29, 1994, the General Accounting Office testified before Congress (GAO/T-PEMD-94-17) concerning inconsistent denial rates for and determinations of medical necessity within the Medicare System;

WHEREAS, this Administration, beginning in 1993, tried to informally accomplish the things in this executive order, but said efforts have been met with resistance within the Health Care Financing Administration;

WHEREAS, accurately detailed modification of the current CPT payment codes at the provider level with provisions for changes in clinical protocols and medical technologies is a practical, no-nonsense way to make the Medicare Part B system operate more efficiently, reduce confusion, mitigate gaming and save billions of Medicare dollars;

WHEREAS, HCFA is organized as a hierarchial bureaucratic operation dealing with special interest groups reporting to represent various providers rather than dealing directly with the providers themselves;

WHEREAS, HCFA uses special interest group consensus meetings, study groups, crude survey and statistical methods to determine changes and adjustments to codes;

WHEREAS, HCFA is not in direct touch at the provider level where Medicare charges are generated;

WHEREAS, HCFA continues to expand upon such ineffective methods that not only are not working overall, but that are actually making the situation more confusing and more costly;

WHEREAS, therefore, methods herein anticipated, working at and with the provider level, where the medical charges are created, is a common-sense approach to the CPT coding problems and is key to the successful fixing of the Medicare foundation; and

WHEREAS, this executive order has considerable bipartisan support in the Congress and this order is timesensitive. The order must happen on the schedule ordered.

Therefore, by the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered on the schedule specified, as follows:

Section 1. Within thirty days of the issuance of this order, the Director of the Health Care Financing Administration shall issue and publish in accordance with established laws and regulations a Request For Proposals (RFP) (_____ U.S.C. § _____) for the Medicare Part B system which shall include the following items:

(a) For a plan of action for a private entity ("the private party") to work at the provider level to identify, define and delineate each medical action, technology, method and result in concise language that will be uniformly understood by providers and carriers and connect each to a medically necessary diagnosis.

(b) For the private party to use the identifications and definitions to tie each line item to a clearly defined CPT payment code and providing both written and computer software-based documentation.

(c) For the private party to work out with the provider led a consistent method to incorporate new clinical protocols and new medical technologies into the reimbursement system as they occur;

(d) For the private party to implement the modifications with providers, carriers and proper government agencies through an educational program in the proper use of the modified CPT payment codes.

(e) For the private party to establish an ongoing educational system at the provider level and carrier level which reinforces a continuing uniform and proper execution of reimbursement rules.

(f) For the private party to establish an ongoing monitoring system which determines Medicare savings, provider benefits, provider acceptance and that identifies gross abuses and major errors.

(g) For the private party to begin to generate Medicare savings within the first nine months and complete the project within thirty-six months of the issuance of the contract.

Section 2. The request for proposals shall have a deadline for receiving proposals no later than sixty days after its issuance.

Section 3. The Director of the Health Care Financing Administration, upon the expiration of the sixty-day proposal receiving period, shall within fifteen days thereafter authorize and order the entering into a contract for services (_____ U.S.C. § _____) with the private party who can best accomplish the task using the methodology outlined above.

Section 4. This project is to be paid for within the existing Health Care Financing Administration budget through reprioritization, not the Federal Supplementary Medical Insurance Trust Fund (_____ U.S.C. § _____), and it is anticipated that savings resulting from these changes will greatly exceed the cost of paying for them. This Administration will consider a separate appropriation for the project into future fiscal years.

Section 5. It is anticipated that this project will take three years to complete and may cost in excess of $70 million. It is expected that this project will generate Medicare Part B payment reductions in excess of $3 billion and ongoing dynamic Medicare Part B budget restraint in total "gaming" growth of up to $6 billion. Reprioritizing by HCFA to accomplish the task using the above methodology is considered key in health care reform and will be supported by this Administration by every means at its disposal.

This order shall be effective immediately.

g:nsp4351.083

This example assumes that the fee schedule amount for code 80058 will be capped by HCFA for 1993 at the average of all carrier's fees or $17.68. If HCFA does not cap such newly defined codes (they have not yet instructed carriers concerning this matter), payments will increase even more.

Panels such as the above are among the most commonly submitted claim for lab tests, millions of claims are processed and paid each year. CPT code 80019 is the most common laboratory procedure submitted to Medicare for payment. The economic impact from the above example could be over $60 million per year.

Laboratory example I, 19 automated tests

The fol' wing expansion of the "unbundling" rule would be stated regarding panel .d profile coding:

In e y combination of tests, all automated chemistry tests must first be bun .e.J together and coded as such. Automated tests may not be reported in ' or bination with organ and disease panels.

ECONOMIC CONSEQUENCES

The results of many antibody titers are negative since it is common practice to order a number of such tests to determine both the type of virus causing the problem as well as the degree of infection.

Whenever a titer code is submitted and paid, and the result is negative, Medicare pays $3.85 more than it should.

If approximately 50,000 titers are ordered in Louisiana each year and 70% are negative, (Most such tests are negative since multiple tests are run to determine the type of infection as well as its severity) Medicare will pay $134,750 in excess under common coding practice. (35,000 X $3.85 = $135,750)

Extended over all 57 carriers, total overpayments would be approximately: $6,064,000

Laboratory example--II, Fluorescent Immunoassay.

The following instruction would be included regarding use of these codes.

If the result of the test is negative, the procedure should be reported as a qualitative screen, 86255

If the result of the test is positive AND a titer is also performed, the procedure should be reported as a titer, 86256.

EXAMPLE: SURGICAL PATHOLOGY CODING

In surgical pathology the UNIT OF SERVICE is defined as A SPECIMEN,

Each separately identified tissue submitted for individual examination is considered a separate unit of service and assigned the appropriate CPT code.

EXAMPLE A:

A dermatologist removes 6 skin growths during a routine cosmetic surgery. The 6 tissue specimens are sent to a pathology lab labeled "skin tags".

The pathologist make slides of each tissue specimen, performs a microscopic exam and prepares a report on his findings. His work is submitted to Medicare using the following code:

88304 LEVEL IV Surgical Pathology $29.38

EXAMPLE B:

Another physician performs the same procedure but submits the 6 skin growths individually labeled as separate specimens.

The pathologist performs exactly the same work but is now able to submit code 88305 X 6 since each piece of tissue is separately identified.

6 X 88304 LEVEL IV Surgical Pathology $176.28

Further definition of a "specimen" is obviously needed to limit the temptation to "game" the system through specimen splitting.

Surgical pathology example : Examination of skin tags

Under surgical pathology, "skin growths", the following subclassification and coding instruction would be listed:

Routine examination of skin tags, unit of service is defined as follows:

1-3 growths, tags, etc. = 1 specimen
4-7 growths, tags etc. = 2 specimens
8-12 growths, tags etc. = 3 specimens

EXHIBIT A

Projected provider response to CPT code changes

Example: Elimination of "calculated codes".

Free Thyroxine Index (FTI) is a "calculated code" which is derived by simple mathematics from two other common tests; thyroxine and thyroid uptake. FTI is listed in the CPT and on all Medicare fee schedules.

Most Medicare carriers pay about $16.00 for this calculation even though the carrier manual clearly instructs them to NOT pay for calculations and ratios. In addition, a "Thyroid profile" is also listed on most Medicare fee schedules which is commonly defined as thyroxine, thyroid uptake, and FTI. Thus, providers have several ways to code a single group of common tests.

Using northern California as an example, if a thyroxine, thyroid uptake and FTI are requested and submitted to Medicare, the following choices are available. The approximate percentage of providers using each coding technique (based on our audit experience) is also indicated.

Tests performed:	Thyroxine, Thyroid uptake, FTI then calculated	
Test are submitted as:	% Submitting in this way	Medicare Payment
Thyroxine, Thyroid uptake, FTI	20%	$36.77
Thyroxine, Thyroid uptake	20%	$20.38
Thyroid Profile	40%	$35.52
FTI	20%	$16.39

Based on the above, the weighted average price paid by Medicare is $28.92

If the code and payment for FTI are eliminated, provider submissions are projected to be as follows:

Test will be submitted as:	% Submitting in this way	Medicare Payment
Thyroxine, Thyroid uptake	20%	$20.38
Thyroid Profile	80%	$35.52

The new weighted average price paid by Medicare will then be $32.49, an INCREASE of $3.57 for the same tests.

In Florida, the carrier requires that any time both thyroxine and thyroid uptake are performed, they must be submitted as an FTI and paid at $16.39. If the code and payment for FTI is eliminated, providers will then presumably have to submit the tests individually for a payment of $19.37 resulting in an INCREASE of $2.98 for the same tests.

Economic Consequences of 1993 Lab Coding Changes

Example: Assay: Fructosamine, by spectroscopy

Used to monitor diabetic blood sugar control, performed once each month.

Available 1992 Codes:

		Nat. Cap
82985	Glycoprotein, electrophoresis (not applicable, wrong method)	$23.00
84176	Protein, special studies (general, but applicable)	$16.28
84999	Unlisted chemistry procedure (often not paid)	$?????

Available 1993 Code:

82985	Glycated protein	$23.46

Clearly applicable, Medicare payment is increased by 44%

EXAMPLE: RADIOLOGY

A radiology technician makes records a fluoroscopic study of a recently implanted heart valve. The video tape is subsequently review by a radiologist to verify that the value is functioning correctly.

The following three codes apply to this procedure:

		Medicare Payments:		
		Technical Component	Professional Interpretation	Total
76000	Fluoroscopy, up to 1 hr. physician time	$42.20	$7.80	$50.00
76125	Cineradiology, with routine exam	$25.63	$12.82	$38.45
93280	Cardiac fluoroscopy	$13.13	$30.36	$43.76

Assuming that a hospital bills Medicare for the technical component (for the technician's time and use of the equipment), and the radiologist bills Medicare for his professional interpretation; each party will tend to maximize their revenue by selecting the following codes:

HOSPITAL:	76000-TC	Fluoroscopy, technical component	$42.20
PHYSICIAN:	93280-26	Cardiac fluoroscopy, Prof. component	$30.63
		TOTAL MEDICARE PAYMENT:	$72.83

Specification of 76125 as the only proper code for use by both the hospital and radiologist would result in a total Medicare payment of only $38.45. A 47% reduction in cost for this procedure.

This example assumes that the fee schedule amount for code 80058 will be capped by HCFA for 1993 at the average of all carrier's fees or $17.68. If HCFA does not cap such newly defined codes (they have not yet instructed carriers concerning this matter), payments will increase even more.

Panels such as the above are among the most commonly submitted claim for lab tests, millions of claims are processed and paid each year. CPT code 80019 is the most common laboratory procedure submitted to Medicare for payment. The economic impact from the above example could be over $60 million per year.

Laboratory example I, 19 automated tests

The fol' wing expansion of the "unbundling" rule would be stated regarding panel .d profile coding:

In e y combination of tests, all automated chemistry tests must first be bun.'e.i together and coded as such. Automated tests may not be reported in (or bination with organ and disease panels.

ECONOMIC CONSEQUENCES

The results of many antibody titers are negative since it is common practice to order a number of such tests to determine both the type of virus causing the problem as well as the degree of infection.

Whenever a titer code is submitted and paid, and the result is negative, Medicare pays $3.85 more than it should.

If approximately 50,000 titers are ordered in Louisiana each year and 70% are negative, (Most such tests are negative since multiple tests are run to determine the type of infection as well as its severity) Medicare will pay $134,750 in excess under common coding practice. (35,000 X $3.85 = $135,750)

Extended over all 57 carriers, total overpayments would be approximately: $6,064,000

Laboratory example-II, Fluorescent Immunoassay.

The following instruction would be included regarding use of these codes.

If the result of the test is negative, the procedure should be reported as a qualitative screen, 86255

If the result of the test is positive-AND a titer is also performed, the procedure should be reported as a titer, 86256.

EXAMPLE: SURGICAL PATHOLOGY CODING

In surgical pathology the UNIT OF SERVICE is defined as A SPECIMEN,

Each separately identified tissue submitted for individual examination is considered a separate unit of service and assigned the appropriate CPT code.

EXAMPLE A:

A dermatologist removes 6 skin growths during a routine cosmetic surgery. The 6 tissue specimens are sent to a pathology lab labeled "skin tags".

The pathologist make slides of each tissue specimen, performs a microscopic exam and prepares a report on his findings. His work is submitted to Medicare using the following code:

88304 LEVEL IV Surgical Pathology $29.38

EXAMPLE B:

Another physician performs the same procedure but submits the 6 skin growths individually labeled as separate specimens.

The pathologist performs exactly the same work but is now able to submit code 88305 X 6 since each piece of tissue is separately identified.

6 X 88304 LEVEL IV Surgical Pathology $176.28

Further definition of a "specimen" is obviously needed to limit the temptation to "game" the system through specimen splitting.

Surgical pathology example : Examination of skin tags

Under surgical pathology, "skin growths", the following subclassification and coding instruction would be listed:

Routine examination of skin tags, unit of service is defined as follows:

1-3 growths, tags, etc. = 1 specimen
4-7 growths, tags etc. = 2 specimens
8-12 growths, tags etc. = 3 specimens

EXHIBIT A

Projected provider response to CPT code changes

Example: Elimination of "calculated codes".

Free Thyroxine Index (FTI) is a "calculated code" which is derived by simple mathematics from two other common tests; thyroxine and thyroid uptake. FTI is listed in the CPT and on all Medicare fee schedules.

Most Medicare carriers pay about $16.00 for this calculation even though the carrier manual clearly instructs them to NOT pay for calculations and ratios. In addition, a "Thyroid profile" is also listed on most Medicare fee schedules which is commonly defined as thyroxine, thyroid uptake, and FTI. Thus, providers have several ways to code a single group of common tests.

Using northern California as an example, if a thyroxine, thyroid uptake and FTI are requested and submitted to Medicare, the following choices are available. The approximate percentage of providers using each coding technique (based on our audit experience) is also indicated.

Tests performed:	Thyroxine, Thyroid uptake, FTI then calculated	
Test are submitted as:	% Submitting in this way	Medicare Payment
Thyroxine, Thyroid uptake, FTI	20%	$36.77
Thyroxine, Thyroid uptake	20%	$20.38
Thyroid Profile	40%	$35.52
FTI	20%	$16.39

Based on the above, the weighted average price paid by Medicare is $28.92

If the code and payment for FTI are eliminated, provider submissions are projected to be as follows:

Test will be submitted as:	% Submitting in this way	Medicare Payment
Thyroxine, Thyroid uptake	20%	$20.38
Thyroid Profile	80%	$35.52

The new weighted average price paid by Medicare will then be $32.48, an INCREASE of $3.57 for the same tests.

In Florida, the carrier requires that any time both thyroxine and thyroid uptake are performed, they must be submitted as an FTI and paid at $16.39. If the code and payment for FTI is eliminated, providers will then presumably have to submit the tests individually for a payment of $19.37 resulting in an INCREASE of $2.98 for the same tests.

Economic Consequences of 1993 Lab Coding Changes

Example: Assay: Fructosamine, by spectroscopy

Used to monitor diabetic blood sugar control, performed once each month.

Available 1992 Codes:

		Nat. Cap
82985	Glycoprotein, electrophoresis (not applicable, wrong method)	$23.00
84176	Protein, special studies (general, but applicable)	$16.28
84999	Unlisted chemistry procedure (often not paid)	$?????

Available 1993 Code:

82985	Glycated protein	$23.46

Clearly applicable, Medicare payment is increased by 44%

EXAMPLE: RADIOLOGY

A radiology technician makes records a fluoroscopic study of a recently implanted heart valve. The video tape is subsequently review by a radiologist to verify that the value is functioning correctly.

The following three codes apply to this procedure:

		Medicare Payments:		
		Technical Component	Professional Interpretation	Total
76000	Fluoroscopy, up to 1 hr. physician time	$42.20	$7.80	$50.00
76125	Cineradiology, with routine exam	$25.63	$12.82	$38.45
93280	Cardiac fluoroscopy	$13.13	$30.36	$43.76

Assuming that a hospital bills Medicare for the technical component (for the technician's time and use of the equipment), and the radiologist bills Medicare for his professional interpretation; each party will tend to maximize their revenue by selecting the following codes:

HOSPITAL:	76000-TC	Fluoroscopy, technical component	$42.20
PHYSICIAN:	93280-26	Cardiac fluoroscopy, Prof. component	$30.63
		TOTAL MEDICARE PAYMENT:	$72.83

Specification of 76125 as the only proper code for use by both the hospital and radiologist would result in a total Medicare payment of only $38.45. A 47% reduction in cost for this procedure.

United States General Accounting Office

GAO

Report to the Honorable
Ron Wyden, House of Representatives

August 1993

MEDICARE PART B

Reliability of Claims Processing Across Four Carriers

GAO/PEMD-93-27

Major Contributors to This Report

Program Evaluation and Methodology Division

Sushil K. Sharma, Assistant Director
Richard M. Lipinski, Project Manager
Brett S. Fallavollita, Advisor
Patrick C. Seeley, Reports Analyst

GAO

United States
General Accounting Office
Washington, D.C. 20548

Program Evaluation and
Methodology Division

B-251298

August 11, 1993

The Honorable Ron Wyden
House of Representatives

Dear Mr. Wyden:

You asked us to assess the methods being used to approve or deny Medicare Part B claims—including whether they are applied correctly and consistently—as well as describe the characteristics of claims denials that are appealed and of those that are reversed. In response to this request, we examined the process that four carriers used to review Medicare claims, focusing on the methods they used to determine the medical necessity of the service and the soundness of those methods. This letter presents our findings on this process. A later report will examine the characteristics of Medicare Part B denials that are appealed and of those that are reversed.

Objectives, Scope, and Methodology

To develop the information in this report, we visited and surveyed four carriers (California Physicians' Services, Northern California; Transamerica Occidental Life Insurance Company, Southern California; Connecticut General Life Insurance Company, North Carolina; Blue Cross and Blue Shield of South Carolina, South Carolina), met with Heath Care Financing Administration (HCFA) officials, and examined documentation provided by HCFA and the carriers.

The information we collected allowed us, first, to identify those methodological components of the claims review process where reliability is needed to ensure the consistent treatment of claims and, second, to determine whether the four carriers we studied had procedures and mechanisms in place that appropriately addressed the issue of reliability. Although our results cannot be generalized to all carriers, they provide important information about the potential of the current Medicare prepayment claims review system to allow inconsistencies in the way Medicare patients are treated.

We conducted our study in June and July of 1993 in accordance with generally accepted government auditing standards.

Summary of Results

The Social Security Act mandates that carriers pay only those Medicare Part B claims that are reasonable and medically necessary. Because HCFA

(the agency in charge of administering this program) does not dictate medical practice, it gives carriers broad latitude in defining the criteria for determining medical necessity. This latitude, in and of itself, provides for some degree of variability in how similar claims are treated across carriers representing different geographic areas. That is, a policy cannot, at the same time, both allow for local variation in what is or is not medically necessary and also produce uniform results.

HCFA policies also encourage carriers to process claims quickly and at low cost. In our study of four carriers, we found that these carriers did indeed process claims rapidly and inexpensively. Level 1 claims examiners, who primarily edited claims for consistency but in some instances made determinations of medical necessity, were expected to process up to 400 claims daily, and level 2 examiners, who exclusively reviewed claims for medical necessity, were typically expected to make determinations on about half that number. The typical educational level attained by claims examiners was high school, with perhaps some college. Given the time constraints under which these claims examiners operated, questions naturally arise concerning their ability to make reliable determinations of medical necessity.

The four carriers we visited medically reviewed an average of 10 percent of the claims they received in fiscal year 1992. However, in 1994, the proportion of medical reviews that HCFA has budgeted carriers to perform will decline to 5 percent. As a consequence, carriers can be expected to reduce their medical reviews correspondingly. Although this HCFA-mandated reduction is aimed at curbing Medicare administrative costs, it is not clear what other effects this change will have. HCFA has not conducted an evaluation of the effect of reducing the number of medical necessity reviews on either the way services are utilized or the carriers' ability to make reliable decisions regarding medical necessity.

We examined three tasks that carriers perform in the course of determining medical necessity to ascertain whether they had procedures in place that would appropriately address relevant reliability issues. With respect to developing medical policy, we found that carriers followed a formalized protocol that allowed for input from the local medical community. With respect to operationalizing medical policy, we found that, although carriers systematically tested their software for errors prior to implementation, they did not have a comparable methodology for testing the interpretability of the operational instructions used by claims examiners to make determinations of medical necessity. (Carriers did,

however, retrospectively assess instructions in order to correct problems.) Finally, we looked at how carriers applied medical policy and the procedures they followed to ensure that examiners reliably followed instructions in making claims determinations. We found that, in addition to audits conducted by HCFA, carriers had internal quality controls that assessed the performance of claims examiners. However, in both instances, the lack of a blind review limited the ability of these methods to detect areas of ambiguity in medical policy.

With regard to the reliability of the system, the human component was clearly the weakest link. Where medical coverage and medical necessity criteria were quantifiable, carriers had often translated such criteria into computer programs. As a method of disposing of claims, computer programs produce consistent results and are also economical. The task of applying less quantifiable criteria, of the type that are involved in making determinations of medical necessity, was assigned to claims examiners. However, because these examiners had to review claims quickly, and in most instances without benefit of a medical background, it may well have been difficult for them to conduct a substantively thorough review.

In summary, the carriers we visited had constructed a system that was able to process a large number of claims very efficiently. However, it is also the case that this system was less well structured for addressing the question of whether medical care is appropriate or not. Moreover, three factors taken together—the time constraints under which determinations for medical necessity were made, the decentralized way in which medical policies were being developed and operationalized, and the weaknesses in some quality control methods being used—raise questions about the system's potential for treating Medicare claimants inconsistently, both within and across carriers.

Background

The Medicare program was authorized by the Congress in 1965 with the passage of title XVIII of the Social Security Act. The program provides health care benefits to persons 65 years of age or older, certain disabled beneficiaries, and most persons with end-stage renal disease. Since its inception, the program has grown considerably: The number of people with coverage increased from 19 million in 1967 to over 35 million in 1992. In fiscal year 1992, the Medicare program paid for health care services for about 96 percent of those eligible. HCFA, within the Department of Health and Human Services, administers the Medicare program and establishes the regulations and policies under which the program operates.

The Medicare program consists of two distinct insurance programs. Part A (Hospital Insurance Benefits for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Part B (Supplementary Medical Insurance for the Aged and Disabled) covers a wide range of medical services and supplies—including physician services, outpatient hospital services, and home health services not covered under Part A, as well as diagnostic laboratory tests, X-rays, and the purchase or rental of durable medical equipment.

The Medicare program cost about $128 billion in fiscal year 1992. Part B payments have recently been growing faster than Part A payments and accounted for about $50 billion of the Medicare expenditures in fiscal year 1992.

Part B coverage requires beneficiaries to pay monthly premiums, meet a $100 deductible, and pay 20 percent of coinsurance. There is no cap on out-of-pocket expenses for beneficiaries under Part B.

In accordance with title XVIII of the Social Security Act, as amended, HCFA contracts with 34 private insurance carriers to process and issue benefit payment on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1992, carriers processed about 550 million Part B claims submitted by nearly 900,000 physicians and suppliers. HCFA policy requires that carriers must approve or deny 95 percent of "clean" claims—that is, claims that do not require additional documentation—within 30 calendar days.[1] In addition, HCFA regulations require that 95 percent of all claims (clean plus all other kinds) must be approved or denied within 60 calendar days.

Carriers are required by regulation to pay only for services that are covered, and to reject or adjust the claim if they determine that the

[1]These figures may be further broken down as follows: (1) 95 percent of electronically submitted claims from participating physicians must be approved or denied within 15 to 17 days, (2) 95 percent of electronically submitted claims from nonparticipating physicians must be approved or denied within 15 to 24 days, (3) 95 percent of all clean paper claims must be approved or denied within 27 to 30 days.

services were "not medically necessary"; in 1992, approximately 8 percent of the dollar amount of denied claims was attributable to this reason.[2]

Section 1862(2)(1)(A) of the Social Security Act provides the general statutory basis for coverage at the same time that it prohibits Medicare payment for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Although the act specifically excludes certain services from coverage—such as cosmetic surgery and routine dental care—it does not provide a comprehensive list of services and equipment that are either covered or excluded from coverage. Rather, the act gives the Secretary of Health and Human Services the discretionary authority to identify medical services that are not medically reasonable and necessary.

HCFA has determined that a number of medical services and items are not covered by the Medicare program. It has been decided, for example, that cellular therapy, acupuncture, intravenous histamine therapy, vitamin B-12 injections to strengthen tendons and ligaments of the foot, and white canes for use by blind persons, are excluded services or items.

How Carriers Review Medicare Claims

The claims review process consists of a combination of computer algorithms and human decisions. Computer algorithms, commonly referred to as prepayment screens, are used as a way of both automatically assessing the validity of claims and channeling certain types of claims to examiners for further review. Review criteria that have straightforward "yes" or "no" answers can often be handled solely by the computer, which makes the final determination. To illustrate, one criterion that is applied to all Medicare Part B claims pertains to beneficiary entitlement: This criterion states that claims involving persons who are not covered by the Medicare program should not be approved, and thus these claims will be denied in all cases. Because this type of determination is unequivocal, it can be made entirely by computer.[3] When applicable, computerized screens of this type provide a quick and reliable way to process claims.

[2]In fiscal year 1992, carriers denied 116 million Part B claims in whole or part (21 percent of all claims processed) for a total of $16 billion (which represented 18 percent of all billed charges). The percentage distribution of dollar amount denied by reason was as follows: duplicate claim (27 percent), service not covered (17 percent), service not medically necessary (8 percent), claimant ineligible (7 percent), missing information (5 percent), rebundled (3 percent), Medicare not primary insurer (3 percent), filing limit exceeded (1 percent), and other (29 percent).

[3]Such computer-generated determinations are termed "auto-adjudications."

Carriers apply six coverage and medical necessity criteria, established by the Social Security Act and HCFA regulations, to determine whether a claim should be paid. (See table 1.)

Table 1: Six Criteria Used in Prepayment Screens

Criterion	Description
Beneficiary entitlement	Used to determine whether the beneficiary is entitled to Medicare coverage—for example, the beneficiary must meet certain age or disability requirements
Claim eligibility	Used to determine whether a claim meets certain basic requirements—for example, the claim must be submitted within a specified time frame and must not be a duplicate claim
Medicare primary coverage	Used to determine whether Medicare—here referred to as the Medicare Secondary Payor (MSP) Program—is the primary insurance carrier; for example, the MSP program is used to determine whether a beneficiary is covered under a spouse's or employer's health insurance plan; in addition, the MSP program reviews trauma codes—for example, massive head and/or kidney damage may indicate that injuries were sustained in an automobile accident, in which case the beneficiary's automobile insurance carrier would be responsible for primary coverage
Reasonableness of charge	Used to determine the appropriate amount of coverage that Medicare will pay claimant—for example, fee schedules for physicians and for durable medical equipment have recently been established by HCFA; these schedules are used to ensure that Medicare pays a reasonable amount relative to resources (for example, physician time and training, malpractice cost, and so on) that were required to perform the service
Medical condition coverage	Used to determine whether the injury or medical condition is covered by Medicare, which assigns a diagnostic code based upon the International Classification of Diseases, 9th Revision
Medical necessity of service	Used to determine whether equipment or services were reasonable and necessary for beneficiary's medical condition—for example, a carrier may determine that a service was unnecessary or that it was unreasonable for a beneficiary to receive treatment from more than one physician

Note: Application of the first five criteria to claims can often be automated by computer. The criterion of medical necessity, on the other hand, more often requires additional human review.

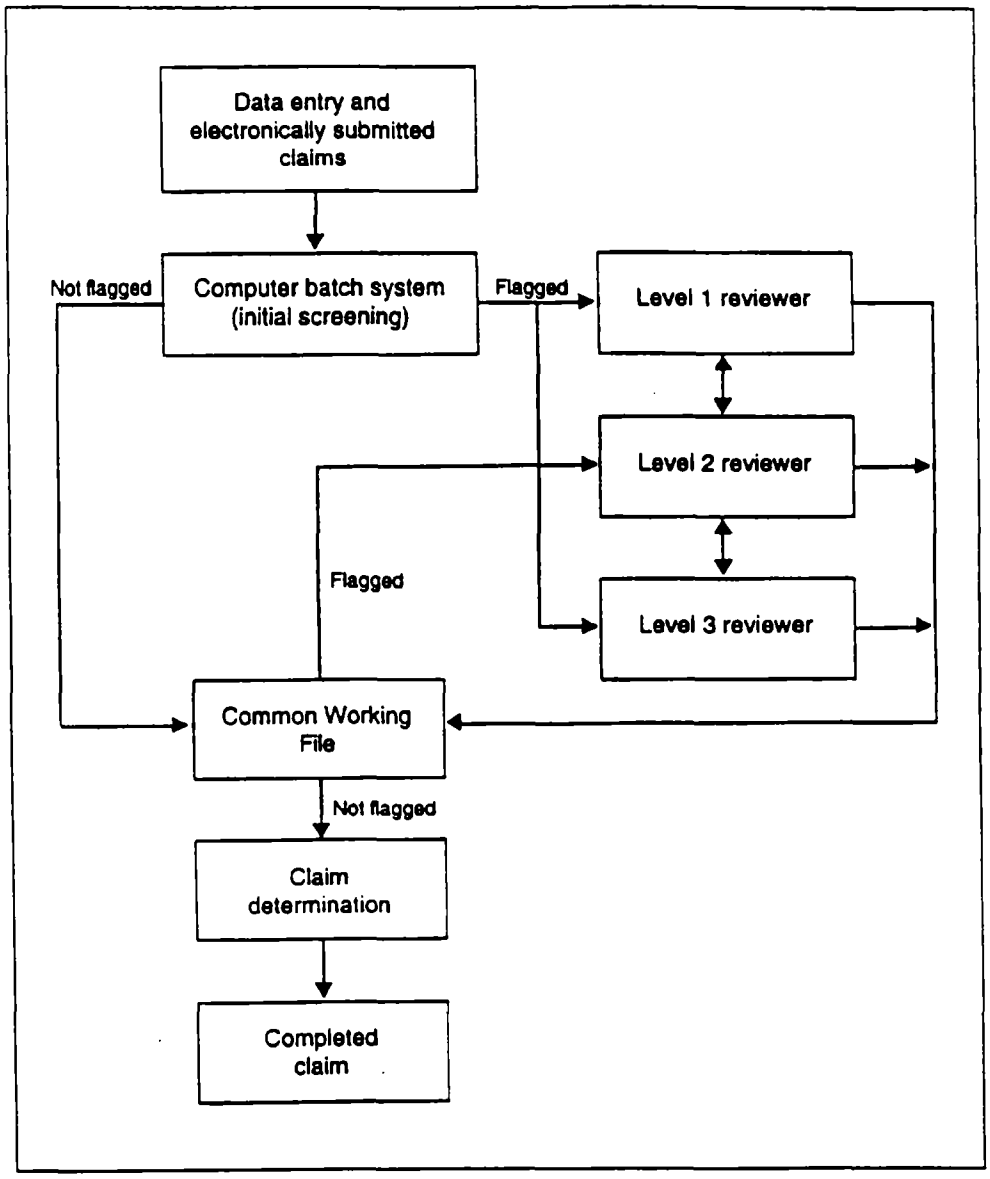
Overview of Claims Processing

Figure 1 depicts, in general terms, how the four carriers we visited structured the process of claims review. After receiving an initial

computer screening, an incoming claim either was routed to the Common Working File (CWF)—where additional automated eligibility checks were made using the beneficiary's past claims history—or, if flagged by a prepayment screen, to one of three levels of personnel who performed a medical review of the claim.[4] Claims flagged for medical review were reviewed by claims examiners using medical criteria developed by the carrier. Claims that could not be determined at one level of medical review might be referred to another level. For instance, if a level 1 examiner could not make a determination on a claim, he or she might pass it on to a more experienced level 2 examiner for determination.

[4]CWF, which is a computer data base maintained for nine regions that contains information on prior claims submissions, is used to determine whether applicable utilization criteria have been met. (For example, a beneficiary is allowed a particular service only once a year.)

Figure 1: Overview of Medicare Part B Claims Processing System



Medical Review

Level 1 examiners primarily performed clerical edits—that is, checked claims for consistency—and in some instances made determinations of medical necessity.[5] The four carriers we surveyed estimated that medical review constituted 5 to 25 percent of the workload of level 1 examiners. In contrast, the task performed by level 2 examiners was solely that of making determinations of medical necessity. Level 2 examiners were usually drawn from the ranks of those at level 1; to attain their position, level 2 examiners usually needed at least 2 to 3 years of prior claims processing experience. It should be noted that while level 1 and 2 examiners may perform what might technically be considered medical review, some tasks that they perform (for example, a comparison of the diagnostic code on the claim with the listed-procedure code) may not require a medical background.

We found a third level of personnel in the carriers we visited consisting of nurses and the medical director.[6] Because nurses command higher salaries than level 1 and level 2 claims examiners, these four carriers employed relatively few medical professionals to assess claims. Two carriers had five and six full-time nurses on staff, respectively; another carrier had one full-time and one half-time nurse on staff, and the last employed one full-time nurse.

The educational requirements for claims examiners were minimal. As shown in table 2, most level 1 and level 2 claims examiners did not have formal medical training; typically, they were high school graduates with perhaps some college experience. The South Carolina carrier was the sole exception: There, level 2 reviews were usually performed by nurses. It should be noted, however, that this carrier did not have nurses performing level 3 reviews—raising the possibility that it defined level 2 review differently from the other three carriers.

[5]Level 1 claims examiners also entered data from paper claims.

[6]HCFA requires that carriers hire a physician to fill the position of medical director. The medical director is responsible for developing medical policy and also may be called upon to examine claims.

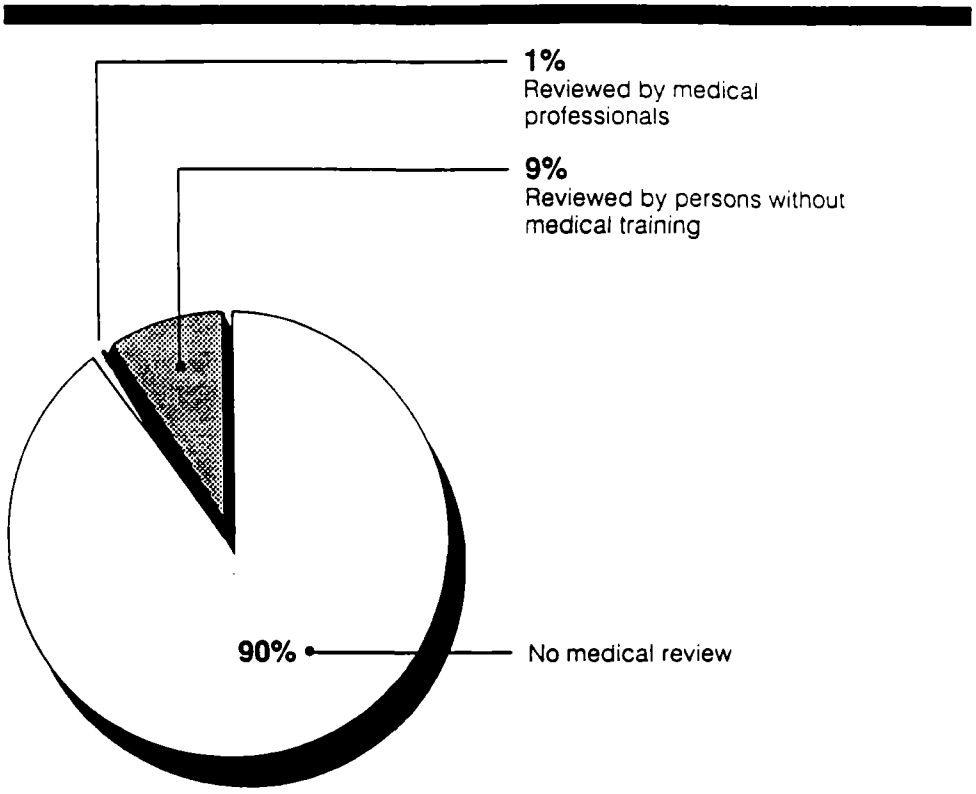
Table 2: Typical Educational Background of Claims Examiners for the Four Carriers

Carrier	Level 1 examiner	Level 2 examiner	Level 3 examiner
Northern California	High school +	High school +	R.N., M.D.
Southern California	High school, college	High school, college + experience	M.D.
North Carolina	High school + 1 year of processing	College or equivalent experience in health-related field	R.N., M.D.
South Carolina	High school + special training	R.N./L.P.N.	M.D.

We found that the four carriers we visited had a tiered screening procedure whereby most claims for which a determination of medical necessity was required were reviewed by claims examiners at levels 1 and 2. As a result of this structure, only a very small number of claims (less than 1 percent) were reviewed by a nurse or medical director. However, to put this figure in context, it is important to recognize that most claims submissions were not flagged for medical review of any type. On average, the carriers we visited medically reviewed 10 percent of the claims they received in fiscal year 1992.[7] As shown in figure 2, in our sample of four carriers, approximately 90 percent of claims were not flagged for medical review by the computer edits, 9 percent were medically reviewed by nonmedical professionals, and fewer than 1 percent were reviewed by nurses or physicians.

[7]By carrier, the percentage of claims medically reviewed in 1992 was Northern California, 9 percent; Southern California, 10.5 percent; North Carolina, 12.9 percent; and South Carolina, 9 percent.

Figure 2: Percent of Claims Submissions Medically Reviewed, for Four Carriers



Note: Percentages are averages for the four carriers surveyed.

As shown in table 3, claims examiners were expected to review a large number of claims each day. The expected rate varied both by level of review and by carrier. Because the complexity of the claims review process increased level by level, level 1 examiners were expected to review more claims per day than level 2 examiners, who in turn were expected to process and review more per day than level 3 examiners. There were also significant differences among carriers; for example, the Southern California and South Carolina carriers expected level 1 reviewers to review about 400 claims daily—a rate equivalent to 50 claims per hour in an 8-hour working day. The Northern California and North Carolina carriers expected level 1 examiners to review about half that number of claims per hour.

Table 3: Expected Number of Claims Reviewed Each Day, by Level, for the Four Carriers

Carrier	Level 1 examiner	Level 2 examiner	Level 3 examiner
Northern California	175	130	18
Southern California	408	200	100
North Carolina	150	35	25
South Carolina	400	100	[a]

[a]Not applicable

National and Local Screens

Beyond identifying services that are not covered by Medicare, HCFA has targeted six medical services (routine foot care, mycotic nails, chiropractic treatments, concurrent care, inpatient rehabilitation medicine visits, and epoetin alpha) for increased scrutiny, and currently requires carriers to develop screens to assess claims for those services. These computerized screens "flag," or direct, some of these service for claims review by claims examiners who, in turn, rely on medical policy guidelines developed by the individual carriers to make determinations. It should be noted that HCFA only identifies services for additional scrutiny and provides certain coverage parameters (for example, number of services allowed per year): It does not provide carriers with the applicable policy guidelines for determining medical necessity—rather, HCFA requires each carrier to individually operationalize this parameter for each of these services.

In addition to the foregoing six nationally mandated prepayment screens, HCFA has granted carriers the authority to develop so-called "local screens" to identify and review other services, which may be of concern in a particular locality, for reasonableness and necessity. HCFA has defined "reasonable and necessary" as meaning

> "...whether the service has come to be generally accepted by the professional community as an effective and proven treatment for the condition for which it is being used. If it is, Medicare may make payment.

On the other hand, if the service or treatment is one that is not yet generally accepted, is rarely used, novel or relatively unknown, then authoritative evidence must be obtained to establish it as safe and effective before Medicare may make payment."[8]

In 1988, we reported that the total number of local screens used by carriers ranged from 5 to 177. The four carriers in the present study reported local screen totals ranging from 60 to 91 in number (Northern California, 91 screens; Southern California, 73 screens; North Carolina, 62 screens; and South Carolina, 60 screens).[9]

Reductions in Medical Necessity Reviews

Across the four carriers we visited, the proportion of claims that were reviewed for medical necessity was small (ranging from 9 to 13 percent) in relation to the total number of claims submitted.[10] (See figure 2.) In part, the number of screens—and thus the volume of claims reviewed for medical necessity—is determined by the amount of money that HCFA allots to carriers for the purpose of medical review. Currently, HCFA budgets for up to 9 percent of claims to be manually reviewed for medical necessity but has decided to reduce this level to 5 percent beginning in fiscal year 1994. The carriers told us that, as a result of this change in policy, they intended to turn off some of the screens that assess claims for medical necessity. While this action will certainly reduce administrative costs by eliminating some level 1 and 2 claims examiner positions, the effect that it will have on beneficiary payments and total Medicare expenditures is not known.

HCFA officials stated that the reduction in medical reviews was made to meet cuts in HCFA's appropriation and that this policy was aimed at reducing Medicare administrative costs.[11] They also told us that they have not conducted an evaluation of the potential effect that the reduction of the number of screens will have on utilization of services. Carrier officials we spoke with voiced concern that a reduction in the number of medical reviews might be shortsighted. They noted that any administrative savings

[8]HCFA Intermediary Letter No. 77-4 and 77-5. Medicare & Medicaid Guide (CCH) Para. 28 of 152. Quoted in National Advisory Council on Health Care Technology Assessment, The Medicare Coverage Process (Bethesda, Md.: 1988).

[9]U. S. General Accounting Office, Medicare: Improving Quality of Care Assessment and Assurance, GAO/PEMD-88-10 (Washington, D.C.: May 1988).

[10]It is important to note that a claim may include more than one service, in which case the claims examiner was expected to process each service individually.

[11]HCFA officials have encouraged carriers to conduct more post-payment focused medical reviews and educational programs for physicians to improve billing practices.

that might be achieved by reducing the number of medical reviews could be dwarfed by the costs incurred as a consequence of paying inappropriate claims.

Soundness of Methods of Determining Medical Necessity

Variations Among Carriers

The decision to structure Medicare to allow for variation in local medical practice clearly provided for some degree of variability in how similar claims would be treated by carriers representing different geographic areas. That is, a policy cannot both allow for local variation in what is or is not "medically necessary" and, at the same time, produce uniform results. Thus, one concern is that this method of determining medical necessity may result in too much variability—that is, similar claims may not be receiving sufficiently similar treatment. A second concern is that some screens may be operationally inefficient. Screens with low denial rates are inefficient in that they require disproportionate resources to medically review many claims in order to reject a few. In addition to the associated administrative costs, inefficient screens can impose a burden on providers and beneficiaries who, as part of the process of claims review, may be required to provide additional supportive documentation.

HCFA recognizes that the process by which nationally mandated and local screens are individually developed by carriers—because it reportedly includes input from local medical professionals—may lead naturally to differential health coverage among carriers. This problem is exacerbated in some cases by vague definitions of terms. For instance, carriers "A" and "B" may differ with regard to when they judge the number of claims for a particular service to be "unusually large." HCFA has stated in the Federal Register that "variation is consistent with the legislative intent that the administration of the program take into account both differences in local medical practice and the types of treatment feasible [for] individual patient situations."[12] However, while it may be acceptable for federal policy to lead to some variation in coverage across carriers, local variations can lead to differences in determination of similar claims across carriers.

[12]42 C.F.R. parts 400 and 405; 54 Fed. Reg. 18, January 30, 1989.

Differences Among Carriers in the Number of Claims Denied and Suspended by Prepayment Screens

To examine the extent of variability of claims determinations related to the use of prepayment screens, we analyzed data from HCFA's Medical Review System (MRS) data base for fiscal year 1992. The MRS data base contains carrier-specific information on the number of claims suspended and denied for each of 21 mandated prepayment screens.[13] Our analysis of these data showed that, for the vast majority of prepayment screens, carriers varied markedly in the number of claims they suspended and denied.[14] (See appendix I.)

The nature and magnitude of inter-carrier variation are illustrated by figure 3, which shows the number of claims suspended and denied for one prepayment screen—"mycotic nails"—for each of the four carriers that we visited.[15] It should be noted that, while the workloads of the California carriers were comparable in 1992, those of the North and South Carolina carriers were not.[16]

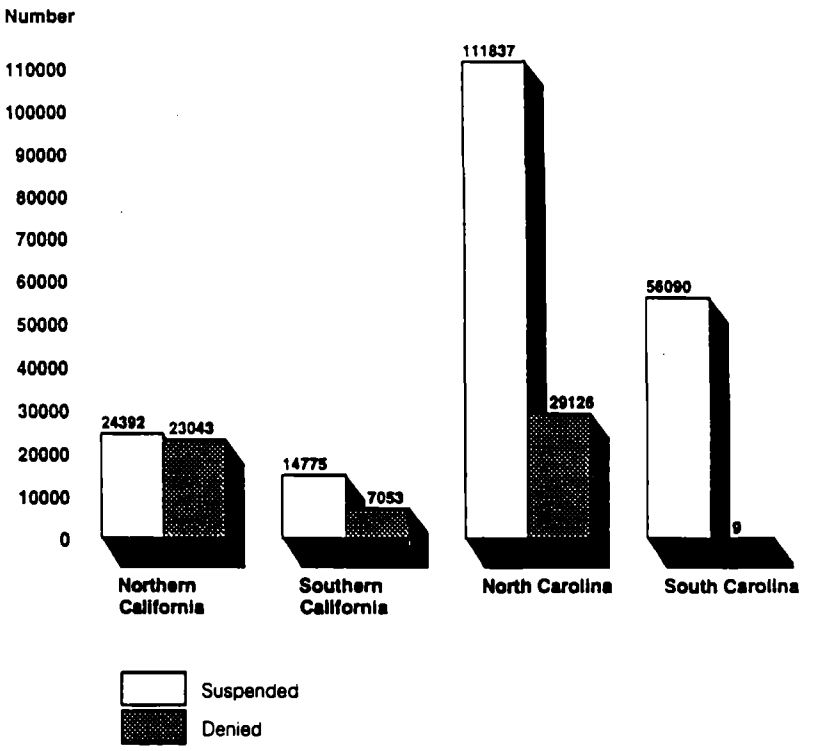
[13]In 1992, HCFA reduced the number of mandated screens—several screens were deactivated and others were classified as optional. A memorandum to regional administrators of Medicare contained the following statement: "Optional screens may be continued, inactivated or revised. It is not necessary to obtain regional office approval to alter or discontinue operational screens." Screens are now mandated only for the following services: routine foot care, mycotic nails, chiropractic services, concurrent care, inpatient rehabilitation medicine visits, and epoetin alpha.

[14]Suspended claims are those claims that are flagged by computer for manual review.

[15]Mycotic nails are a fungal infection of the nails of either hands or feet.

[16]The numbers of claims processed by these carriers in fiscal year 1992 were as follows: Northern California, 23,853,195; Southern California, 24,551,720; North Carolina, 16,606,107; and South Carolina, 5,871,730.

Figure 3: Number of Mycotic Nail Claims Suspended and Denied, for Four Carriers



Note: This graph is meant to illustrate differences in screen efficiency (denied-to-suspended ratio) across carriers. We do not have data on the total number of mycotic nails claims processed by these four carriers. Thus, these figures should not be construed as a comment on the overall denial rate of submitted claims for this service.

Source: HCFA MRS data

Figure 3 shows that the North and South Carolina carriers suspended a larger number of claims for mycotic nail treatments than did the California carriers. A large number of suspensions could be due to one or more of the following factors: (1) there may be regional differences in the prevalence of mycotic nail treatment; (2) carriers may suspect abuse of that service and thus target it for greater scrutiny by suspending more claims; or (3) the screens used by the carriers may not be extensively automated, thus resulting in a greater number of manual reviews. However, in terms of the rate of suspended claims that are eventually denied, a different order emerges. Northern California denies 95 percent of suspended claims, Southern California 48 percent, North Carolina 26 percent, and South

Carolina far fewer than 1 percent. This variability in their denial rates of suspended claims suggests that these four carriers did not employ these mandated prepayment screens in an equally efficient manner.

Carrier Quality Control Methods

Carriers are authorized to determine whether services listed on claims submissions are medically necessary. This entails (1) developing, (2) operationalizing, and (3) applying medical policy. In the following sections, we describe how we used the construct of reliability to identify methodological concerns that carriers should address to ensure the successful performance of each task. In our survey, we asked carriers to describe what procedures they had in place to address these concerns.

Developing Medical Policy

As discussed earlier, HCFA is required by law to delegate to individual carriers the authority for developing the medical policies used to assess claims. Although it might be more economical to have a central body responsible for developing medical policies that then could be used by all carriers, in view of regional differences in medical practices, the current system allows input from the local medical community. Given this local-input objective, then, it is clear that the protocol for developing medical policy should allow for local medical organizations' participation in the process.

To determine whether the procedures used by carriers addressed this concern, we asked carriers to list the steps that they went through to develop a new medical policy. The results of this survey are displayed in table 4.

Table 4: Steps Followed by Four Carriers to Create or Revise Medical Policy Guidelines

Northern California	Southern California	North Carolina	South Carolina
In conjunction with medical director, a new medical policy is proposed. Proposal passes through a series of review levels. Introductions and requests for comments are submitted to carrier advisory committee and all affected medical specialty societies. Organizations have a 45-day comment period. After new policy is finalized, and comments taken into consideration, a 30-day advance notice is published before actual implementation.	Carrier recognizes need for new policy. Consult medical experts and literature, professional associations, data from internal reports, C.P.T. protocol. Evaluate and interpret research data. Formulate policy. Request for comments from carrier advisory committee, professional associations. Organizations have 45-day comment period. After new policy is finalized and comments are taken into consideration, a 30-day notice is given to the medical community prior to implementation. Publication in newsletter bulletin when appropriate. Post-implementation evaluation.	Identify the problem that warrants a new medical policy. Research medical journals for guidelines in developing policy. Formulated policy is presented to associations and/or the carrier advisory committee for comment period of 45 days. After comment period, policy is published in Medicare bulletin. Edit screens are developed to identify services rendered that do not coincide with established policy. These screens are put into production 30 days after policy is published.	Identification of problem, new technology, or HCFA requirement. Identification of codes/specialties involved. Research literature. Draft policy. Send to providers for comment (45 days). Revise as necessary. Publish. Implement.

The approach used to develop a medical policy was generally equivalent among the four carriers we surveyed. The steps followed by carriers can be summarized as follows: (1) identify the need for a new policy; (2) research the area to determine accepted practice (for example, conduct a literature review and talk to experts in the field); (3) formulate the policy; (4) present the policy to the carrier advisory committee comprised of the affected medical specialty societies, which then have 45 days in which to comment; (5) consider and possibly revise the policy based on the committee's comments; and finally, (6) publish the policy 30 days prior to implementation.

The steps followed by carriers to develop new medical policies appear to provide ample opportunity for input from the local medical community. It is unclear, however, whether a decentralized approach to policy development is worth the cost of having carriers independently develop policies for the same services—that is, the amount of regional variation in

medical practice patterns may not be significant enough to justify this approach. HCFA is now in the process of developing a Request for Proposals to establish a clearinghouse of medical policies used by carriers throughout the nation. This clearinghouse, if established, will allow carriers to more easily share information on current policies. It would also allow for a systematic comparison of carrier medical policies, which might shed light on the magnitude of regional variation.

Operationalizing Medical Policy

After a medical policy has been developed, it must be operationalized so that it can be used to determine claims. Operationalizing medical policy involves translating policy statements into computer software and written operational guidelines, which then are used by examiners to make determinations on claims. Operational guidelines contain specific instructions and illustrative examples that aid examiners in interpreting medical policy.[17]

Because it is important that software and operational guidelines accurately reflect medical policy, we asked carriers (1) to describe what procedures they had in place to determine whether the computer software used to screen claims represented a correct translation of medical policy, and (2) to identify the extent to which medical policy rules were clear and interpretable to claims examiners. Carrier responses to these questions are presented in table 5.

[17]Operational guidelines are often referred to as internal medical review guidelines.

Table 5: Actions Taken by Four Carriers to Implement Medical Policy Guidelines

	Northern California	Southern California	North Carolina	South Carolina
How do you determine that the computer software used to screen claims represents a correct translation of medical policy?	Software instructions are reviewed by several different internal divisions (medical review, system support, and the system subcontractor). Once approved, program is tested in the "model office" (test system) to determine whether program will accurately apply policy. This procedure is followed prior to actual implementation.	The software is set up in a test system, and test claims with predetermined results are run through the test system. The results are then analyzed for proper functioning of the software. Adjustments to the software are made if necessary. When the software is functioning correctly, it is placed into production.	Extensive testing of claims against the edits are performed prior to finalizing the screen.	Only policies with clearly set forth criteria (for example, diagnoses, length of stay, and so on) are reduced to computer edits; more complex claims are forwarded to human review.
How do you identify the extent to which medical policy rules are clear and interpretable to claims examiners?	Once a new instruction is established or changed, examiner instructions are prepared. These instructions are reviewed by a network of people, including trainers, quality supervisors and front-line supervisors (and sometimes examiners), to ensure that they are clear, concise, and easily understood. Depending on the nature of the policy, classroom training may be initiated.	Before implementation of a medical policy rule by the claims examiners, a draft is submitted to quality council for clarity and content review. A corrected draft is then submitted to key personnel for clarity and interpretability review. The final implementation rule is then taught to the claims examiners by their section managers.	When new policies are established, draft instructions are issued to all claims supervisors for review and comment. Input from claims processors is obtained, and clarification of instructions is completed if needed. Final instructions are then issued and explained to claims processors.	The medical director is a full-time, licensed physician and is responsible for writing and presenting local medical policy in a manner that is clear and interpretable to both local claims examiners and the medical community. There is no test to determine whether claims examiners find the policies clear and interpretable.

Carriers reported extensively testing new computer software prior to implementation. Software testing involves running a variety of mock claims with predetermined adjudications through the computer. The computer-generated decisions are then compared with claims-examiner decisions to determine whether the software has any errors. If errors are detected, they are corrected before the software is placed into use. This method, properly conducted, appears to be a sound way to ensure the reliability of the computer software used to assess claims.

With regard to the methods used to ensure that written instructions are clear and interpretable to examiners, carriers performed what was essentially a face-validity check. That is, carriers reported having key persons or supervisory staff examine new medical policy instructions for clarity and interpretability prior to implementation. Several carriers stated

that they also solicited input from claims examiners during the preparation of instructions.

Although carriers had a precise methodology to test computer software, using a sample of dummy claims to pinpoint problems, they did not have a comparably rigorous method for identifying ambiguities in the operational instructions used by claims examiners prior to implementation. For instance, the South Carolina carrier reported that "only policy criteria that are clearly set forth (for example, diagnoses, length of stay, and so on) are reduced to computer edits; more complex claims are forwarded to human review." (See table 5.) However, as discussed earlier, since most claims examiners must process claims rapidly without the benefit of a medical background, it would be beneficial to have operational guidelines that are equally straightforward and unambiguous if they are to be used effectively.

In this respect, it appears that pretesting might have provided a more rigorous reliability test of claims examiners' ability to interpret operational instructions. This could be accomplished in a manner analogous to the way in which software is tested. For example, several examiners might be asked to review an identical and representative sample of dummy claims using newly written instructions. If the operational instructions are reliable, the determinations of all examiners should be identical; if they are not, a revision of the instructions might be warranted. Such a test should yield a better estimate of instructional interpretability under operational conditions.

Applying Medical Policy

Proper application of medical policy to actual claims requires that examiners reliably follow medical policy—as explained by the operational instructions developed by a carrier—in making claim determinations. We asked carriers to describe the types of internal quality controls they used to check whether claims examiners were correctly following policy. Carrier responses to this question are displayed in table 6.

Table 6: Actions Taken by Four Carriers to Ensure That Medical Policy Is Reliably Applied

	Action			
	Northern California	**Southern California**	**North Carolina**	**South Carolina**
What types of internal quality controls do you have to check whether claims examiners are correctly following policy?	In-line auditing procedures reveal how medical policy guidelines are being applied. Examiners are reviewed daily, with feedback given weekly. Error trends are charted and refresher training is developed when and where it becomes necessary. HCFA end-of-line quality assurance program ensures quality of processing and medical review through sample auditing of claims.	A quality control section's personnel, on a continual basis, check a set number of randomly selected claims per month (per claims examiner) to see that each examiner is correctly following policy. This is the same method used for the quality assurance system that is required by HCFA—that is, this is a separate but similar system. HCFA end-of-line quality assurance program.	Quality assurance program, using random selection, audits claims for accuracy. Errors that are detected are discussed with the supervisor of the employee making the error. Policy errors are discussed in weekly meetings that include representatives from claims processing, claim exception, medical review, and appeals departments. HCFA end-of-line quality assurance program.	Employ an elaborate quality assurance program designed by HCFA. Each week claims are randomly selected and receive a rigorous quality review by internal staff that are organized separately from the claims examiner staff. HCFA end-of-line quality assurance program.

The carriers' internal, together with HCFA's external, quality assurance programs were cited by all carriers as the principal method for ensuring the reliability of claims processing. This program checks for errors in each of the following six areas: (1) entitlement, (2) coverage, (3) reasonable charge, (4) payment, (5) documentation, and (6) coding or data entry. The quality assurance program uses two methods to estimate claims processing errors. In the first method, each carrier, using a HCFA-developed computer program, selects a random sample of claims processed during the preceding quarter. The carrier then reviews these claims to determine the accuracy of its initial claims processing. Each carrier uses its own set of mandated and local screens to reprocess a claim. Claim determinations from the reprocessed claim are then compared with how the claim was actually decided, to obtain an estimate of error.

The methodology used in the second component of the quality assurance program is similar to the first, except that a 9-percent subsample from the carriers' sample of claims is selected and then reprocessed, this time by HCFA regional staff. Again, decisions are based on the respective medical policies developed by carriers. Estimates of error from the carrier's

sample review are combined with findings from the regional office's subsample review to produce final error rates.[18]

In addition to the above-mentioned methods, carriers reported having internal quality assurance programs. One carrier that we visited had established an in-line auditing procedure that was able to review the performance of claims examiners on a daily basis. Using this system, this carrier was able to provide claims examiners with weekly feedback on the number and types of errors they were making.

To summarize, all carriers had several procedures in place to assess the performance of, and provide feedback to, claims examiners. These assessments were performed on a regular basis by quality control departments within carriers, as well as by HCFA regional staff. If the quality control methods used by carriers are susceptible to criticism, it is with respect to their failure to conduct blind reviews of claims. That is, the internal assessments, as well as those conducted by HCFA regional staff, reprocess a sample of claims to estimate reliability, yet in both instances, those persons reprocessing claims have access to the first examiner's decision. While appropriate for detecting quantifiable errors such as data entry mistakes, these assessments are less well suited for detecting ambiguities in the instructions used by claims examiners.

Agency Comments

We provided an oral summary of our findings and conclusions to responsible HCFA officials who offered several clarifications of points made in this report, which we have incorporated in the text where appropriate.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Director of the Office of Management and Budget, the Secretary of Health and Human Services, the U.S. Commissioner on Aging, and other interested parties.

[18]HCFA also conducts a Contractors Performance Evaluation Program (CPEP) to evaluate the quality of carriers' claims processing. CPEP does not have any measure of the validity of carriers' medical screens, which affect decisions on medical necessity and appropriateness. See our testimony entitled Medicare: HCFA Monitoring of the Quality of Part B Claims Processing, GAO/T-PEMD-92-14 (Washington, D.C.: September 23, 1992).

If you have any questions or would like additional information, please call me at (202) 512-2900 or Robert L. York, Director of Program Evaluation in Human Services Areas, at (202) 512-5885. Other major contributors to this report are listed in appendix I.

Sincerely yours,

Eleanor Chelimsky
Assistant Comptroller General

No page 25

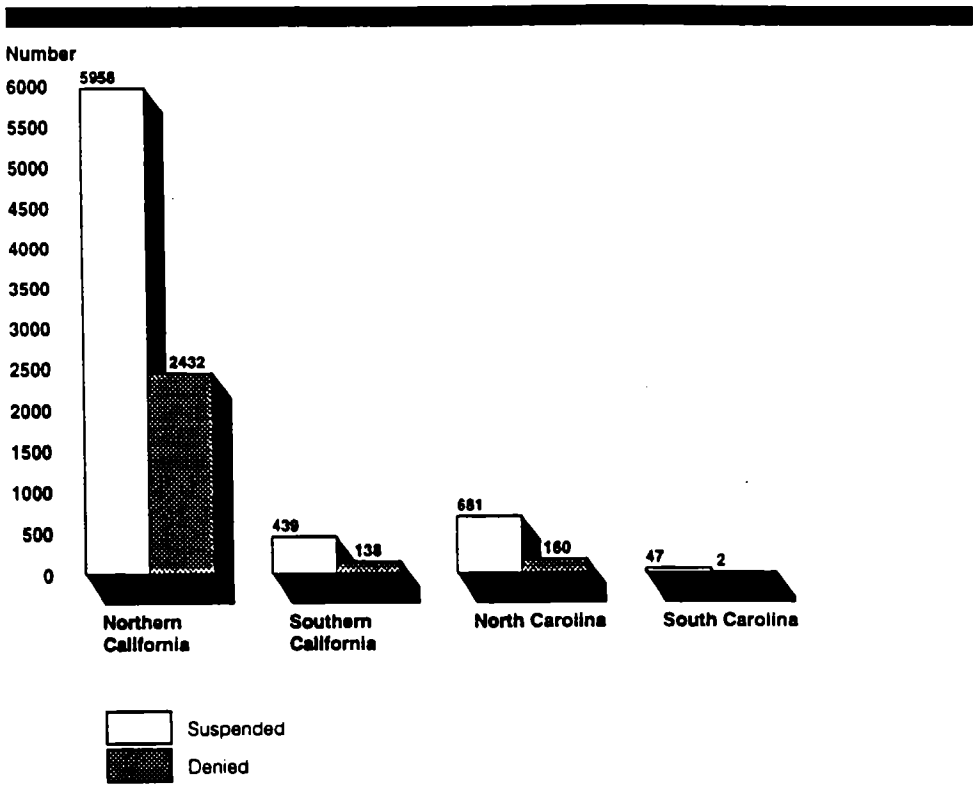
Contents

Abbreviations

CPEP	Contractors Performance Evaluation Program
CWF	Common Working File
HCFA	Health Care Financing Administration
GAO	General Accounting Office
MSP	Medicare Secondary Payor
MRS	Medical Review System

Suspension and Denial Frequencies for Five Nationally Mandated Screens

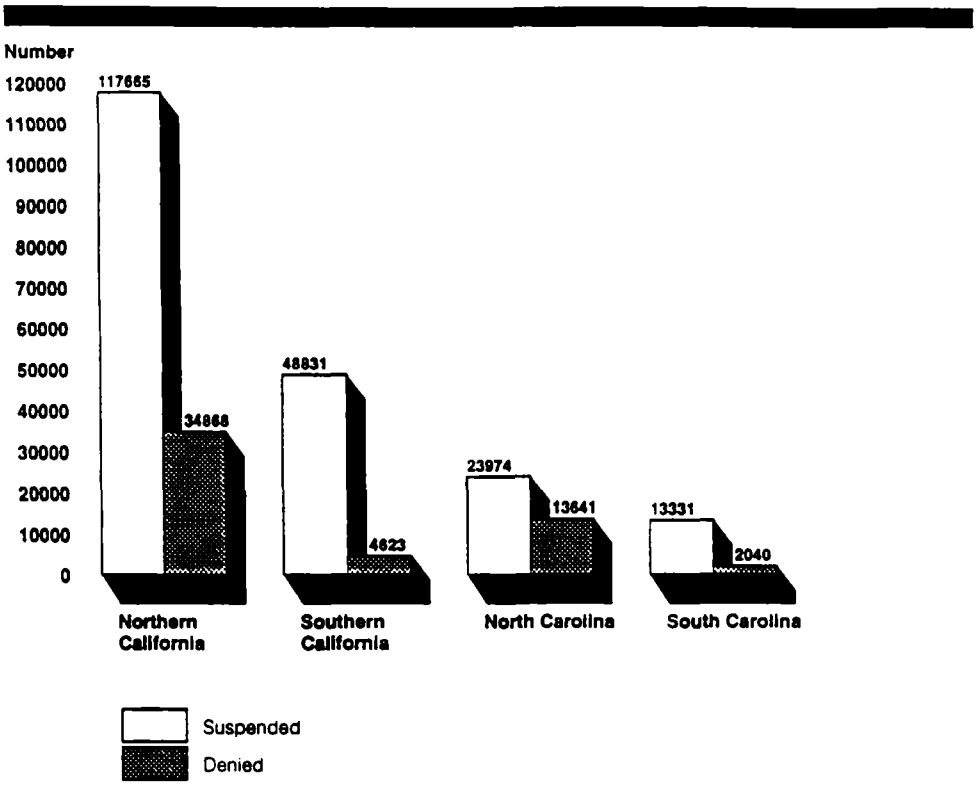
Figure I.1: Number of Routine Foot Care Claims Suspended and Denied, for Four Carriers



Note: This graph is meant to illustrate differences in screen efficiency (suspended-to-denied ratio) across carriers. We do not have data on the total number of routine foot care claims processed by these four carriers. Thus, these figures should not be construed as a comment on the overall denial rate of submitted claims for this service.

Source: HCFA MRS data

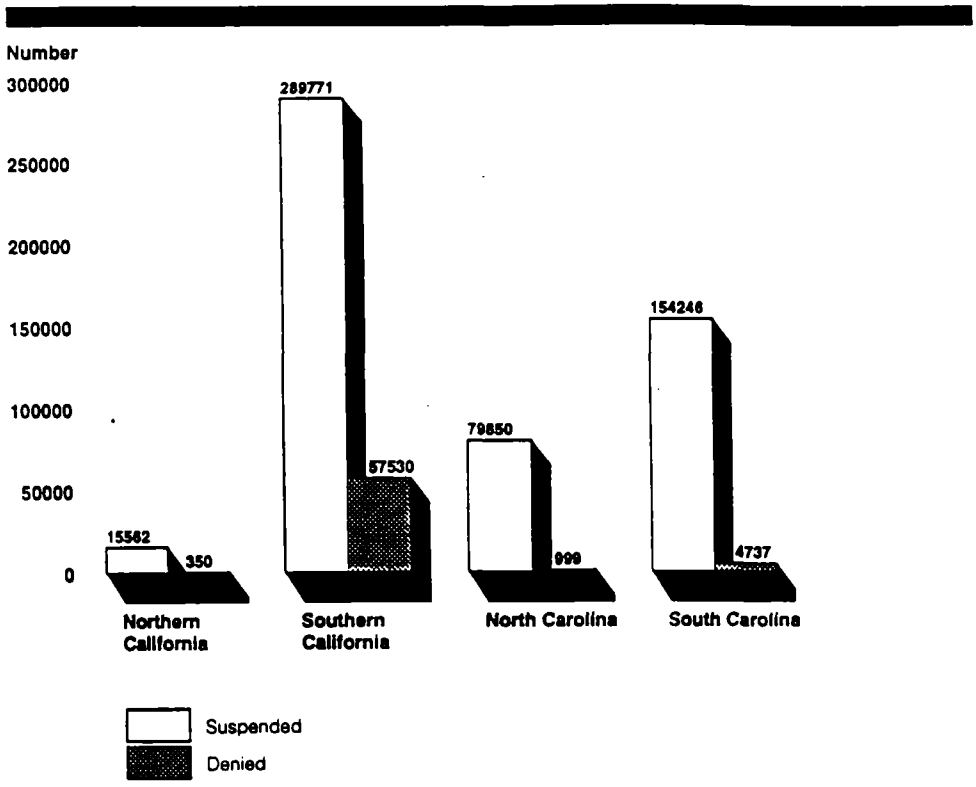
Figure I.2: Number of Chiropractic Treatment Claims Suspended and Denied, for Four Carriers



Note: This graph is meant to illustrate differences in screen efficiency (suspended-to-denied ratio) across carriers. We do not have data on the total number of chiropractic treatment claims processed by these four carriers. Thus, these figures should not be construed as a comment on the overall denial rate of submitted claims for this service.

Source: HCFA MRS data

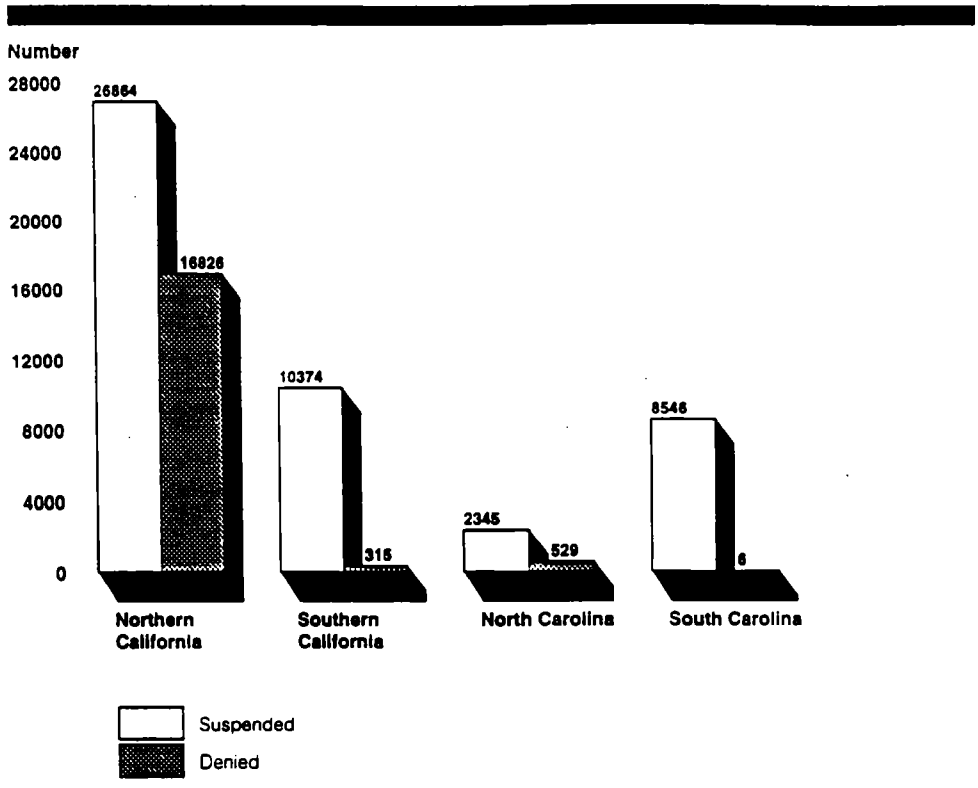
Figure I.3: Number of Concurrent Care Claims Suspended and Denied, for Four Carriers



Note: This graph is meant to illustrate differences in screen efficiency (suspended-to-denied ratio) across carriers. We do not have data on the total number of concurrent care claims processed by these four carriers. Thus, these figures should not be construed as a comment on the overall denial rate of submitted claims for this service.

Source: HCFA MRS data

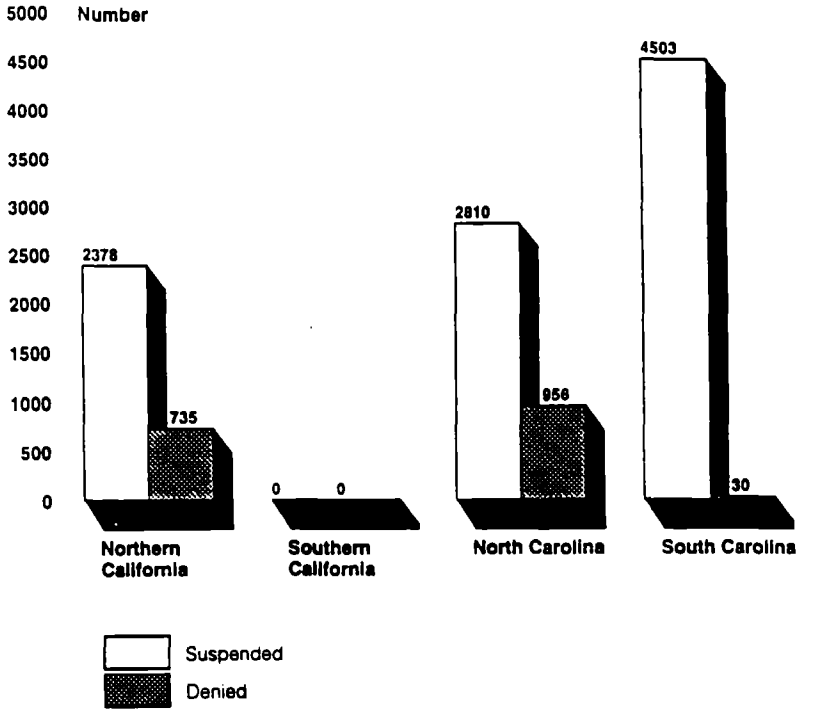
Figure I.4: Number of Inpatient Rehabilitation Visit Claims Suspended and Denied, for Four Carriers



Note: This graph is meant to illustrate differences in screen efficiency (suspended-to-denied ratio) across carriers. We do not have data on the total number of inpatient rehabilitation visit claims processed by these four carriers. Thus, these figures should not be construed as a comment on the overall denial rate of submitted claims for this service.

Source: HCFA MRS data

Figure I.5: Number of Epoetin Alpha Claims Suspended and Denied, for Four Carriers



Note: This graph is meant to illustrate differences in screen efficiency (suspended-to-denied ratio) across carriers. We do not have data on the total number of epoetin alpha claims processed by these four carriers. Thus, these figures should not be construed as a comment on the overall denial rate of submitted claims for this service.

Source: HCFA MRS data

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business, House of Representatives

For Release on Delivery
Expected at
9:30 a.m., EST
Tuesday
March 29, 1994

MEDICARE PART B

Inconsistent Denial Rates for Medical Necessity Across Six Carriers

Statement of Eleanor Chelimsky
Assistant Comptroller General
Program Evaluation and Methodology Division

GAO/T-PEMD-94-17

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be here to share with you the results of our ongoing work on the Medicare Part B claims processing system. As you requested, in our testimony today, we will present information on claims processed by six carriers that were denied for lack of medical necessity. To develop this information, we analyzed data provided to us by the Health Care Financing Administration (HCFA).

Before turning to the results of our work, let me briefly discuss the program and the process by which carriers determine medical necessity.

The Medicare program, authorized under title XVIII of the Social Security Act, is a nationwide entitlement program to provide health care benefits to persons 65 years of age or older, certain disabled beneficiaries, and most persons with end-stage renal disease. Once eligible, beneficiaries should not receive different benefits solely because their place of residence differs.

Since its inception, the program has grown considerably: The number of people with coverage increased from 19 million in 1967 to over 35 million. Currently, about 96 percent of those eligible for Medicare are enrolled. HCFA, within the Department of Health and Human Services, administers the Medicare program and establishes the regulations and policies under which the program operates.

The Medicare program consists of two distinct insurance programs. Part A (Hospital Insurance Benefits for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Part B (Supplementary Medical Insurance for the Aged and Disabled) covers a wide range of medical services and supplies--including physician services, outpatient hospital services, and home health services not covered under Part A, as well as diagnostic laboratory tests, x rays, and the purchase or rental of durable medical equipment.

In accordance with title XVIII of the Social Security Act, as amended, HCFA contracts with 34 private insurance carriers to process and issue benefit payments on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

The Social Security Act mandates that carriers pay only for services that are covered, and reject the claim if they determine that the services were not medically necessary. In fiscal year 1993, carriers denied 112 million Part B claims in whole or part

(19 percent of all claims processed) for a total of $17 billion (which represented 18 percent of all billed charges, a figure unchanged from the previous year). The percentage distribution by reason of the dollar amount denied was as follows: duplicate claim (30 percent), service not covered (14 percent), claimant ineligible (8 percent), missing information (10 percent), rebundled (6 percent), filing limit exceeded (1 percent), Medicare secondary payer (6 percent), and other (16 percent). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers.

With the exception of determination of medical necessity, the above reasons for denial are generally the result of routine administrative checks made during claims processing. Determining the medical necessity of a service, on the other hand, requires that carriers develop a medical policy that reflects local standards of medical practice and apply that policy in making determinations as to whether the billed service was performed in accordance with those standards. Carriers have been given broad latitude in this respect--that is, they have been given primary responsibility for defining the criteria that are used to assess the medical necessity of the services on a claim.

Concerning medical necessity, you asked us to assess whether there are differences among carriers with regard to the rates of claims denied for this reason, and to describe the characteristics of the types of claims denied. In response to your request, we analyzed data on claims processed by six carriers to ascertain rates of claims denied specifically for medical necessity. This testimony presents our results. Our analytical methodology is given in Appendix I. A forthcoming report will examine these issues as they relate to the question of claims appeals.

FINDINGS

Our study addressed the issue of consistency in denial rates for the 71 most utilized and costly services across the six carriers we examined. We have three findings to report.

First, we found sizable differences among the carriers with respect to denial rates for the services screened for medical necessity.[1] The denial rates for the top 71 services are

---

[1]For the purpose of our analysis, we assumed that, if a carrier denied at least one service for reason of medical necessity, that carrier must have had a screen in place for that procedure code. It should be noted that, while a medical necessity denial constitutes evidence of the presence of a screen, the absence of denials for a particular procedure code, though strongly suggestive, does not preclude the possibility that the carrier may

presented in table 1, and show notable variability across carriers. For instance, the first line shows the denial rates for code 99213, billed for an office or outpatient visit (see Appendix II for a glossary of service codes), among the six carriers. For example, the Northern California carrier denied 0.4 services for every 1000 they allowed, while the Southern California carrier denied 3.7 services for every 1000 they allowed.

---

have had a screen in place. However, given that the top 71 services generally have high utilization rates, such screens, if they existed, must have been fairly inefficient.

Table 1: Rates of Denial for Medical Necessity Per 1000 Services by Service Code and Carrier for 1992
(Top 71 Part B Service Codes, Ranked by Allowed Charges)

Code	N. CA	S. CA	NC	SC	IL	WI	*Sig.*
99213	0.4	3.7	0.3	0.0	3.7	9.7	*.01*
66984	0.2	10.8	5.5	0.0	1.1	0.0	*.01*
99232	0.9	13.7	0.4	1.7	11.9	17.1	*.01*
99214	0.2	4.4	0.3	0.3	3.8	8.2	*.01*
99231	0.3	12.4	0.3	2.2	13.4	21.5	*.01*
99212	0.6	7.9	0.5	0.0	5.5	18.4	*.01*
99233	0.8	22.9	0.3	2.1	9.1	20.4	*.01*
A0010	0.3	20.4	1.2	48.6	0.0	42.4	*.01*
93307	4.1	140.0	1.2	0.0	0.0	1.5	*.01*
88305	0.1	19.9	1.5	0.5	0.0	0.7	*.01*
99223	0.3	9.5	2.6	1.2	7.8	6.6	*.01*
99215	0.1	6.3	1.0	0.0	5.6	6.2	*.01*
99254	0.2	2.3	0.4	0.8	0.0	0.5	*.01*
66821	0.0	1.0	1.1	0.0	0.0	0.0	*N.S.*
A0220	0.4	10.8	0.0	47.2	0.0		*.01*
71020	0.4	12.4	0.9	0.2	103.2	0.9	*.01*
90844	0.2	9.9	1.0	0.0	0.0	0.7	*.01*
99222	0.6	11.3	1.5	3.1	9.8	2.5	*.01*
92014	0.1	2.8	1.0	0.0	2.5	83.5	*.01*
27447	0.0	2.9	0.0	0.0	0.0	0.0	*N.S.*
E1400	21.9	63.4	51.6	0.0	10.2	6.9	*.01*
99238	0.5	12.2	0.4	0.3	10.3	13.7	*.01*
93547	0.0	3.0	1.5	0.0	0.0	0.0	*N.S.*
80019	1.1	3.5	0.2	2.8	93.8	0.0	*.01*
99244	0.0	3.0	0.0	0.0	0.0	3.6	*.01*
A2000	77.1	72.2	173.9	116.5	142.8	18.3	*.01*
B4150		66.5		0.0	0.0		*.01*
77430	0.0	1.2	0.0	0.0	0.0	1.6	*N.S.*
B4035		66.8		0.0			*.01*
99255	0.4	2.6	0.0	0.0	0.0	0.0	*.01*
J9217	0.0	1.0	17.1	0.0	0.0	2.7	*.01*
90995	0.6	1.8	9.7	0.0	2.1	0.0	*.01*
93005	1.0	8.5	0.6	0.0	0.1	0.8	*.01*
92982	0.0	182.4	29.2	0.0	0.0	33.3	*.01*
99284	0.2	8.5	1.7	0.0	0.0	4.8	*.01*
99285	0.0	30.7	2.9	0.9	0.0	8.3	*.01*
45385	0.0	3.7	0.0	0.0	0.0	0.0	*N.S.*
92012	0.0	1.8	0.5	0.0	1.6	51.5	*.01*

Code	N. CA	S. CA	NC	SC	IL	WI	*Sig.*
45378	0.0	0.9	0.0	0.0	0.8	0.0	*N.S.*
99311	0.0	2.6	0.8	0.0	4.1	5.0	*.01*
71010	0.5	16.0	4.4	1.0	80.6	1.0	*.01*
00142	0.0	1.3	5.7	0.0	0.0	17.8	*.01*
E1401	22.4	35.5	17.7	0.0	19.6	14.0	*.01*
E1403	18.1	37.3	18.9	0.0	19.3	18.9	*.01*
33512	14.6	0.0	0.0	0.0	0.0	0.0	*N.S.*
99291	0.3	6.9	1.8	4.2	13.8	27.7	*.01*
Q0043	9.5	32.7	0.0	0.0	10.8	19.2	*.01*
93320	0.4	88.8	8.1	0.0	0.0	4.8	*.01*
99253	0.5	2.6	2.2	0.0	0.0	1.1	*.01*
52601	9.0	3.2	0.0	0.0	0.0	0.0	*N.S.*
99312	0.2	4.3	0.3	0.0	3.6	3.1	*.01*
99204	0.0	8.6	0.0	0.0	4.1	0.0	*.01*
93549	0.0	0.0	198.6	0.0	0.0	0.0	*.01*
99203	0.7	10.4	0.2	0.0	3.6	1.3	*.01*
43235	0.0	0.9	1.1	0.0	1.8	0.0	*N.S.*
43239	0.0	1.6	3.7	0.0	2.2	0.0	*N.S.*
A0020	6.2	74.3	1.4	18.4	0.1	49.5	*.01*
33513	3.9	0.0	0.0	0.0	0.0	0.0	*N.S.*
99283	0.1	12.5	1.0	0.8	0.0	14.7	*.01*
90843	0.2	14.7	1.6	0.0	0.0	1.0	*.01*
27130	0.0	4.7	0.0	0.0	0.0	0.0	*N.S.*
85025	0.9	5.2	0.2	0.0	0.0	0.3	*.01*
A0150	302.5	83.2	1.9	13.0			*.01*
84443	0.6	3.4	0.3	4.4	0.0	0.0	*.01*
93880	0.0	124.9	13.6	0.0	0.0	0.0	*.01*
36415	0.2	3.2	0.9	0.2	0.0	0.1	*.01*
99205	0.3	6.9	0.7	0.0	9.3	0.0	*.01*
00562	0.0	0.0	0.0	0.0	0.0	0.0	*N.S.*
76091	0.3	54.0	0.3	0.0	0.0	0.4	*.01*
83720	1.8	11.2	0.1	2.1	0.0	0.0	*.01*
99245	0.0	2.4	0.0	0.0	0.0	12.8	*.01*

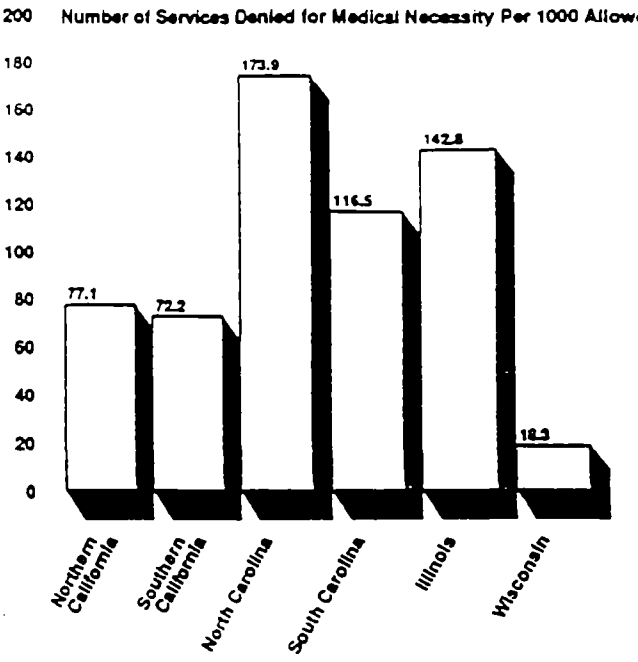
Note: Rates based on number of services denied for medical necessity per 1,000 allowed. Blank cells indicate that the code was not billed. Significance level is based on chi-square tests.

We found that for 58 of the 71 services shown in table 1, significant variations existed among carriers in the denial rates for medical necessity.

The following figures graphically illustrate this overall pattern by showing, across carriers, denial rates for three services: chiropractic (service code A2000); percutaneous transluminal coronary angioplasty, also known as PTCA (service code 92982); and critical care (service code 99291).

Looking at chiropractic services, we see that the rates of denial for medical necessity (per 1,000 services allowed) ranged from 18 to 174 among these six carriers. (See figure 1.) For PTCA, one carrier had a denial rate of 182, two had denial rates of about 30, while three carriers did not deny any services for medical necessity. (See figure 2.) Lastly, for critical care, while the overall range was smaller (0.3 to 27.7), there again was significant variation among carriers. (See figure 3.)

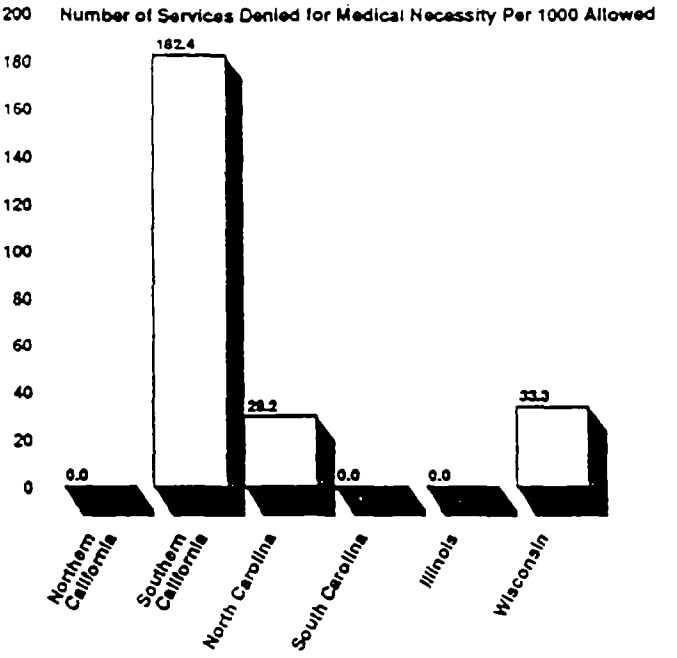
Figure 1: Variation in Denial Rates for Medical Necessity—Chiropractic Visits.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B Claims.

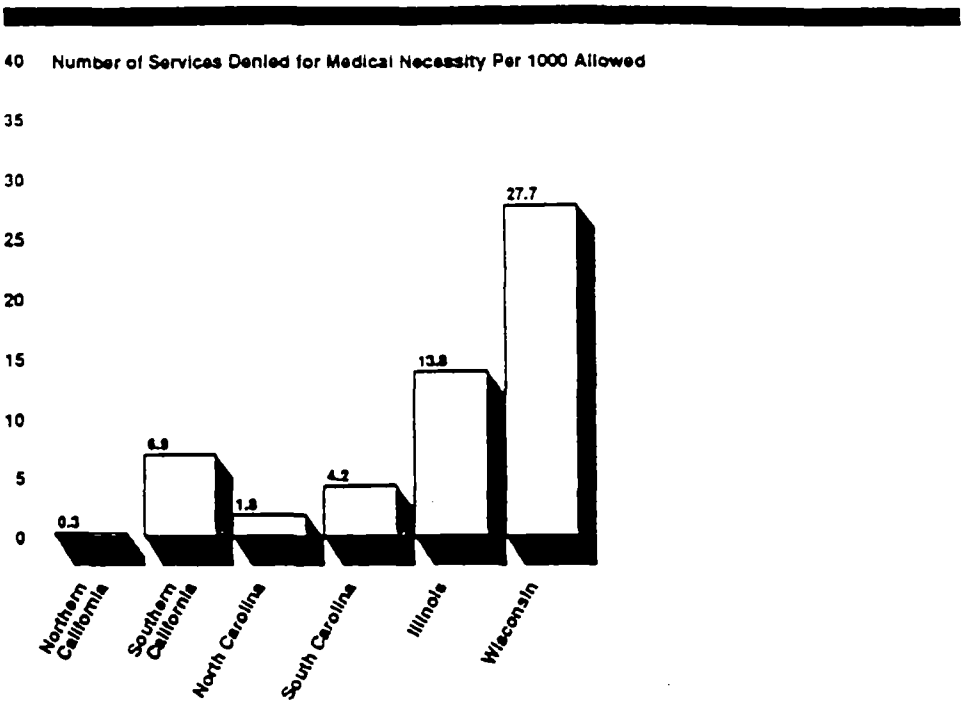
(Filename: C.OPCMEDFIG3)

Figure 2: Variation in Denial Rates for Medical Necessity—Percutaneous Transluminal Coronary Angioplasty.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B Claims.

Figure 3: Variation in Denial Rates for Medical Necessity—Critical Care.



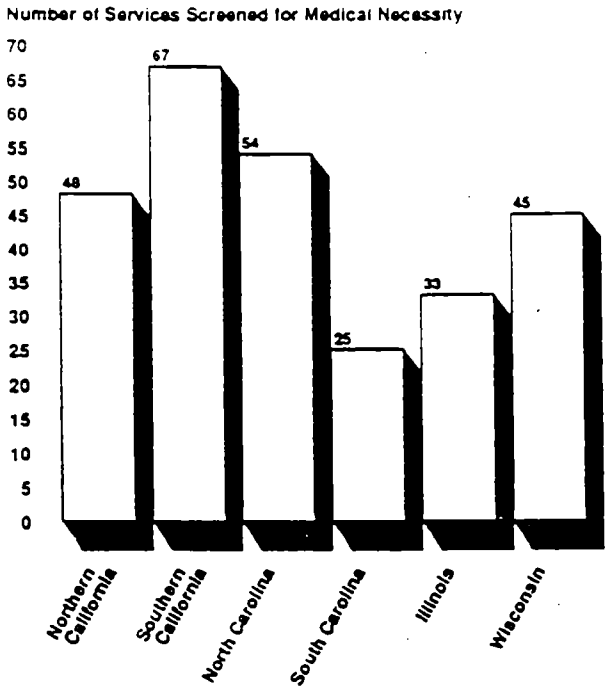
Note. Rates based on a 5 percent sample of 1992 Medicare Part B claims.

Second, we found that the number of services that carriers screened for medical necessity varied markedly. As shown in figure 4, some carriers had screens in place for almost all of the top 71 services, while others screened for little more than one third of these codes.[2]

Finally, our third finding is that the overall denial rate for medical necessity also differed among these six carriers. As shown in figure 5, at one extreme, one carrier denied as few as 1 service per 1,000 allowed, while at the other extreme, another carrier denied 23 services per 1,000 allowed.

[2]Service codes are also referred to as procedure codes.

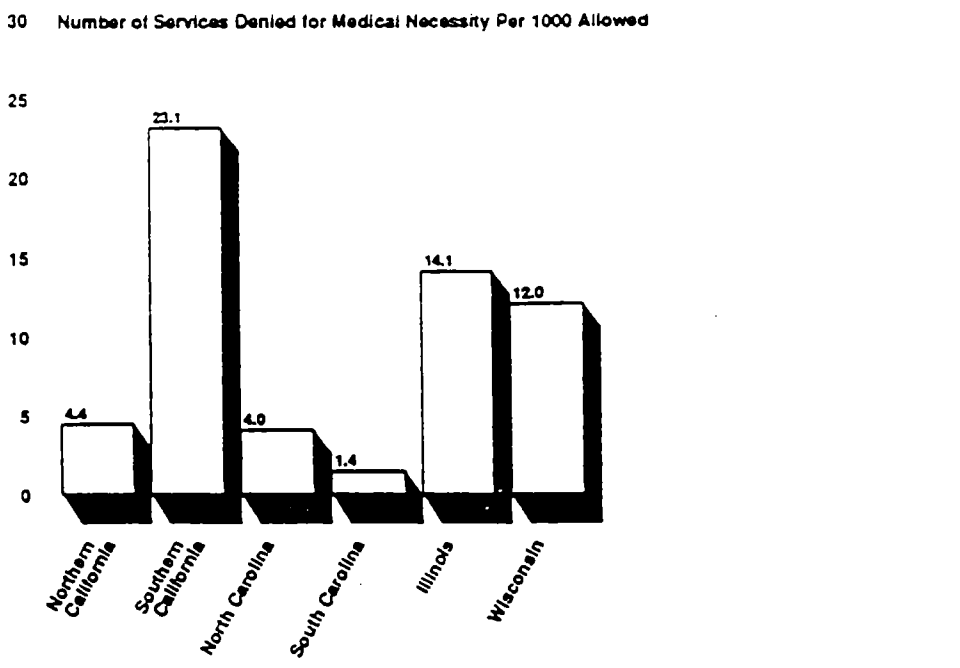
Figure 4: Number of Top 71 Services Screened for Medical Necessity by Carrier



Note. Percentages based on a 5 percent sample of Medicare Part B claims processed in 1992. Top 71 services based on allowed charges.

(Filename: C:CPCMEDFIG5)

Figure 5: Variation in Denial Rates Among Carriers.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B claims.

CONCLUSIONS

Significant variations exist among six Medicare Part B carriers in the ratio of medical necessity denials for 58 of the top 71 services. What do such differences in denial rates among carriers mean? The answer to this question depends on how these variations arise. Two plausible explanations have been advanced--with each having a different policy implication. One explanation focuses on differences in the medical policies used by carriers, while the other focuses on the billing practices of providers.

Variation Due to Differences in Medical Policy

The Social Security Act mandates that carriers pay only those Medicare Part B claims that are reasonable and medically necessary. Medicare law recognizes regional and local differences in medical practice and thus gives carriers broad latitude in defining the criteria for determining medical necessity. However, this latitude, in and of itself, produces some degree of variability in how similar claims are treated across carriers representing different geographic areas. That is, a policy cannot, at the same time, both allow for local variation in what is or is not viewed as medically necessary and also produce uniform results.

As our results show, carriers have in fact exercised this latitude. We found significant differences in both the number and types of services that are screened for medical necessity. Moreover, even when screening the same type of service, carriers used different working definitions of what is medically necessary.

For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation (code: A2000) must meet certain basic HCFA coverage criteria such as the following: An x ray must be available, if requested; signs and symptoms must be stated; and the precise level of subluxation must be reported. The carriers we spoke to had all incorporated these criteria into their medical policy for chiropractic spinal manipulation. HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier set the number of additional visits allowed based on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while they reviewed additional visits beyond the 12th, they usually did not require additional documentation until the 30th visit.

Given the broad variations found in denial rates across the

six carriers we examined, it would seem reasonable to conclude that some portion of that variance is due to differences in medical policies. Thus, one unintended consequence of setting medical policy locally is that, while it attempts to promote congruence between local medical policy and practice, viewed from a national perspective, it has also produced inconsistent treatment of Medicare providers and beneficiaries from one region to another, and one carrier to another.

Variations in Billing Practices

In our discussions with HCFA officials and representatives of the six carriers, it was asserted that difference in medical policy is but one possible explanation for variation in denial rates. Both the carriers and HCFA pointed to a second potential source for the observed variation in denial rates, one that focuses on differences in the billing practices of providers. Their explanation has several variants, which we summarize below:

- the various regions of the country have different levels of fraud and abuse, which in turn produce different denial rates;

- differences in denial rates could be due to aberrant billing practices by as few as two or three providers;

- in certain regions of the country, providers disregard the feedback they receive from denied claims--that is, they continue to bill for services they know are not medically necessary in the hope that some will be approved; and

- certain carriers do a better job of educating providers in how to submit Medicare claims correctly.

In sum, although at least two hypotheses can thus be advanced to explain the wide variation we found in the denial rates of our six carriers, it is important to note that (1) these findings are new: the size of this variation had not been previously examined by HCFA; and (2) HCFA is only now beginning to conduct evaluations to determine which, if either, of the above major explanations (that is, medical policy or billing practice) best accounts for the inconsistency we observed in denial rates. Given this lack of information, it has been difficult for HCFA to take a position on the question of whether a high or a low denial rate represents better public policy. HCFA officials told us that, although low denial rates are desirable from the standpoint that they imply less trouble for providers and beneficiaries, they are only desirable insofar as providers appropriately bill only for what is medically necessary. If providers are inappropriately billing Medicare, high denial rates are desirable.

The issue here, however, is not the size of denial rates, but rather their consistency. Medicare is not a local initiative. It is a national program under which beneficiaries should not receive different benefits solely because their place of residence differs. Yet we found that beneficiaries and providers have in fact been treated with considerable inconsistency by six carriers making individual determinations concerning what is and is not medically necessary. While it may be essential for Medicare to allow for local determination of medical policy, we found that this allowance, left to itself, leads to inconsistent treatment of beneficiaries and providers.

Carrier representatives told us they believe that inter-carrier variation would be reduced if HCFA established more national medical policies that define specific parameters for what is medically necessary. What is clear from our work to date, however, is that denial rates provide useful insight into how effectively Medicare contractors are managing program dollars and serving beneficiaries and providers. We believe that HCFA needs to play a greater role in using such data to oversee carriers' claims review activities to better assure that beneficiaries and providers are equitably treated.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.

METHODOLOGY

To develop the information in this testimony, we visited six carriers and analyzed claims processed by each of them. In selecting carriers, we considered two factors: geographic location and the number of claims processed.[3] Table I.1 lists the carriers we visited and the number of claims they processed in fiscal year 1992.

Table I.1: Selected Medicare Part B Carriers (Data for 1992)

Carrier	Geographic location	Number of claims processed (in millions)
California B/S	West	24
California-Occidental	West	25
Illinois B/S	Midwest	22
Wisconsin-Physician Srv.	Midwest	10
North Carolina-Conn. Gen.	Southeast	18
South Carolina B/S	Southeast	8

Taken together, these six carriers processed about 19 percent of all Part B claims in fiscal year 1992; however, because of our judgmental selection process, we cannot generalize our findings to the universe of carriers.

[3]Our sample included two carriers from each of the following three regions: the Southeast, the Midwest, and the West. In making this selection, we sought to maximize the geographic distance between regions, while at the same time retaining the potential for examining intraregional variation in medical policies. In terms of the number of claims processed, the frequency distribution of carriers is essentially bimodal--that is, there are two large clusters of carriers, those that annually process between 2 and 13 million claims and those that process between 18 and 29 million claims (2 carriers processed over 46 million claims each). Our sample included two carriers from the former cluster and four from the latter.

Source of Data

To compare medical necessity denial rates among carriers, we obtained from HCFA a 5 percent sample of 1992 Medicare Part B claims for the above six carriers. This information was abstracted from the physician/supplier portion of the Common Working File, which serves as a repository for all Medicare claims.

The Common Working File contains information on many claims-related variables, including the type of billed service and the action that was taken as a result of the claim review process. Medicare claims can contain submitted charges for more than one service; a claim for a simple medical checkup, for example, may include both the doctor's fee as well as the charge for lab tests performed during the visit. On the Medicare claim form, each billed service, or line item, appears as a separate charge with a corresponding five-digit service code that describes the type of service provided (for example, office visit, chiropractic treatment, and so on). Each of these services listed as a separate line item is subject to approval or denial by the carrier. During claims processing, carriers assign an action code to each line item that indicates that it was paid or, if denied, the reason for denial.[4]

In our analysis, we focused on two line item variables--the service and the action code. In calculating denial rates presented in our statement, we contrasted the number of services denied for lack of medical necessity with the total number of services allowed for a given service. Services denied for other reasons were excluded from the analysis.

Because there are more than 10,000 different service codes, we ranked service codes in terms of the total of allowed charges (in 1992), and then restricted our analysis to the top 71 codes.[5] Services that rank high in allowed charges are those that have high utilization rates and/or high cost per service. The top 71 service codes constitute approximately 50 percent of all Medicare Part B allowed charges.

---

[4]Reasons for line item denial included in the Common Working File are: benefits exhausted, non-covered care, invalid care, duplicate line item, medically unnecessary, reprocessed adjustment, secondary payer, and other.

[5]The "allowed charge" is set by HCFA. The amount actually paid by HCFA is 80 percent of the allowed charge less deductible and/or co-payment.

Sampling Considerations

The 5-percent sample used in our analysis was extracted from the Common Working File by keying on the last two digits of the beneficiary identification number. This method is commonly used by HCFA, and while we have no reason to believe that it is biased, it is not, strictly speaking, a random sample, but rather an approximation of a random sample. Consequently, the tests of statistical significance presented in this testimony are included mainly for heuristic purposes: that is, to identify those codes where carriers had especially large differences in denial rates.

To avoid unstable estimates of denial activity for certain service codes with low frequencies, we focused on the top 71 services (based on allowed charges). This group of services generally has high utilization rates and thus sufficiently large frequencies for making inter-carrier comparisons of denial rates.

LIST OF TOP 71 PROCEDURE CODES RANKED BY ALLOWED CHARGES FOR 1992

Procedure Code/ Narrative Description
99213 Office or other outpatient visit
66984 Extracapsular cataract removal
99232 Subsequent hospital care, per day
99214 Office or other outpatient visit
99231 Subsequent hospital care, per day
99212 Office or other outpatient visit
99233 Subsequent hospital care, per day,
A0010 Ambulance service, basic life support
93307 Echocardiography, real-time with image documentation (2D)
88305 Level IV - surgical pathology, gross and microscopic examination
99223 Initial hospital care, per day
99215 Office or other outpatient visit
99254 Initial inpatient consultation for a new or established patient
66821 Discussion of secondary membranous cataract
A0220 Ambulance service, advanced life support
71020 Radiologic examination, chest, two views, frontal and lateral
90844 Individual medical psychotherapy by a physician
99222 Initial hospital care, per day
92014 Ophthalmological services: medical examination and evaluation
27447 Arthroplasty, knee, condyle and plateau
E1400 Oxygen concentrator
99238 Hospital discharge day management
93547 Combined left heart catheterization, selective coronary angiography
80019 A.tomated multichannel test
99244 Office consultation for a new or established patient
A2000 Manipulation of spine by chiropractor
B4150 Enteral formulae; category I
77430 Weekly radiation therapy management
B4035 Enteral feeding supply kit; pump fed, per day
99255 Initial inpatient consultation for a new or established patient,
J9217 Leuprolide acetate, for depot suspension, 7.5MG
90995 End stage renal disease (ESRD) related services, per full month
93005 Electrocardiogram, routine ECG with a least 12 leads
92982 Percutaneous transluminal coronary angioplasty
99284 Emergency department visit
99285 Emergency department visit
45385 Colonoscopy, fiberoptic, beyond splenic flexure
92012 Ophthalmological services: medical examination and evaluation
45378 Colonoscopy, fiberoptic, beyond splenic flexure
99311 Subsequent nursing facility care, per day
71010 Radiologic examination, chest
00142 Anesthesia for procedures on eye

E1401 Oxygen concentrator, manufacturer specified maximum rate greater than 2
E1403 Oxygen concentrator, manufacturer specified maximum rate greater than 4
33512 Coronary artery bypass, autogenous graft
99291 Critical care, including the diagnostic and therapeutic services
Q0043 Stationary liquid oxygen system rental, includes contents (per unit)
93320 Doppler echocardiography, pulsed wave and/or continuous wave
99253 Initial inpatient consultation for a new or established patient,
52601 Transurethral resection of prostate
99312 Subsequent nursing facility care, per day
99204 Office or other outpatient visit
93549 Combined right and left heart catheterization
99203 Office or other outpatient visit
43235 Upper gastrointestinal endoscopy including esophagus
43239 Upper gastrointestinal endoscopy including esophagus
A0020 Ambulance service, (BLS) per mile, transport, one way
33513 Coronary artery bypass, autogenous graft
99283 Emergency department visit
90843 Individual medical psychotherapy by a physician
27130 Arthroplasty, acetabular and proximal femoral
85025 Blood count
A0150 Non-emergency transportation, ambulance, base rate one way
84443 Thyroid stimulating hormone (TSH), RIA or EIA
93880 Duplex scan of extracranial arteries
36415 Routine venipuncture for collection of specimen(s)
99205 Office or other outpatient visit
00562 Anesthesia for procedures on heart, pericardium
76091 Mammography;
83720 Lipoprotein cholesterol fractionation calculation by formula
99245 Office consultation for a new or established patient