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GAO

United States General Accounting Office
Washington, DC 20548

Human Resources
Division

B-200144

OCTOBER 22, 1980


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The Honorable Patricia Roberts Harris
The Secretary of Health and Human Services

Dear Mrs. Harris:

Subject: Reasonable Charge Reductions Under Part B of Medicare (HRD-81-12)

Pursuant to a request from Senator Lawton Chiles, Chairman, Senate Special Committee on Aging, we examined whether Medicare beneficiaries are being properly reimbursed for doctors' bills under the program.

The Committee is concerned that Part B of the Medicare program--which primarily covers the cost of physician services--is paying an increasingly smaller portion of the elderly's total cost for physician services. There are two principal reasons for this. First, on the average the charges submitted by doctors are reduced by the program for payment purposes by about 20 percent because they do not meet Medicare's "reasonable charge" criteria. Second, the percentage of claims where the program reimburses the beneficiary (unassigned claims) rather than the doctor (assigned claims) has increased from about 35 percent (in the early years of Medicare) to about 50 percent.

Where the program pays the beneficiary, he or she in turn is liable for the difference between the submitted charges and Medicare's "reasonable charges" in addition to the normal 20-percent coinsurance amounts. During fiscal year 1979, the beneficiaries' liability for the difference between submitted and allowed charges on unassigned claims was about $1.1 billion--an increase from $882 million in fiscal year 1978. In contrast, on assigned claims (where Medicare pays the physician) the physician agrees to accept

Medicare's allowed charge as full payment and the beneficiary is liable only for the coinsurance on the allowed charges. 1/

Given these expressed concerns about the adequacy of Medicare's coverage, we performed onsite work at seven Medicare carriers or paying agents in five States and the District of Columbia. They are (1) Virginia--Travelers Insurance Company, (2) Florida--Blue Shield of Florida and Group Health Incorporated (GHI), (3) Mississippi--Travelers Insurance Company, (4) Texas--Group Medical and Surgical Service, (5) Oregon--Aetna Life and Casualty, and (6) District of Columbia--Medical Service of D.C. (D.C. Blue Shield).

Our initial work was done at D.C. Blue Shield, and our general approach was to identify aberrant payment transactions by reviewing claims in the Health Care Financing Administration's (HCFA's) quality assurance program sample. 2/ After identifying such transactions, we obtained computer printouts of all similar transactions at Blue Shield or other selected carriers for specific periods to determine the extent of the problem. In summary, we identified four areas where we believe beneficiaries are being subjected to inequitable reasonable charge reductions. These areas are

--physician markups on laboratory procedures performed by independent laboratories,

--the use of "fee and one-half" reimbursement policies for pricing surgical procedures,

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1/Under section 4 of Public Law 95-142, enacted October 25, 1977, the Congress made it a misdemeanor for a physician to "knowingly, willfully, and repeatedly" violate the assignment agreement not to charge a Medicare patient more than the coinsurance on the allowed charges.

2/The quality assurance program is designed to measure the accuracy and overall quality of claims processing under Part B of Medicare. To achieve this objective, a sampling of actual claims that have been processed is routinely reviewed by both the carrier and HCFA.

--the use of relative value schedules for computing a physician's customary charge for a procedure he or she rarely performs, and

--inadequate scrutiny of claims as they are processed by carriers.

Our findings, conclusions, and recommendations are discussed below.

PHYSICIANS' MARKUP ON LABORATORY PROCEDURES

Physicians frequently have their laboratory work done by laboratories independent of their offices. In turn, the physicians' charges to the Medicare program often include significant markups over their costs or the fee charged by the laboratory. For example, an independent laboratory might charge a physician $5 to do a blood count, and in turn the physician will charge the Medicare program $10.

In 1979 HCFA--recognizing that full reimbursement for these laboratory charges was not reasonable--took several actions to limit Medicare reimbursement. For example, for 12 common laboratory procedures, reimbursement was limited to the 25th percentile of all physician customary charges in a given locality. Also, a special laboratory-to-physicians screen was established for those laboratory procedures where the physician indicated on the claims form that the procedure was performed by an independent laboratory. This screen is a fourth criterion that is used in determining reimbursement, in addition to Medicare's standard criterion, that is, the lowest of the actual, customary, or prevailing charges. The screen is set at the 75th percentile of laboratory charges to physicians based on laboratory price lists. In addition, Medicare allows the physician up to a $3 handling charge for tests performed by an independent laboratory.

While actions have been taken to preclude unreasonable reimbursements from program funds, Medicare beneficiaries are vulnerable to excessive physician markups on unassigned claims. Our work at GHI in Miami, Florida, illustrates this point.

At the carrier, we took a random sample of 197 unassigned claims having one or more laboratory procedures done by independent laboratories but billed by physicians. The sample was drawn from claims received during November and December 1979 on which there was a reasonable charge reduction involved. According to the carrier, these months were representative of the year.

To compute the markup for the two laboratories that accounted for about half the claims in our sample, we compared the physician's submitted charge to the laboratories' actual charge as verified by laboratory records. For the other claims, we compared the submitted charge to the laboratories' published price lists. Our analysis showed that

--during the November-December period, there were 3,464 unassigned claims that had reasonable charge reductions and contained one or more laboratory procedures performed by independent laboratories, but billed by physicians;

--the 3,464 claims represented about 2.5 percent of the unassigned claims processed during the period; 1/

--for 26 claims in our sample of 197 taken from the 3,464 claim universe, we were unable to compute a markup because laboratory prices or actual charge data were not available for various reasons;

--for the 171 claims in which we were able to compute a markup, physicians marked up in 159, or 93 percent, of the cases;

--the average markup was 105 percent of the laboratory charge or about $13.23;

1/Because of physician and carrier error in coding place of service on the claim forms, HCFA and GHI representatives felt that this percentage should be much higher. (Our work at independent laboratories disclosed instances where physicians or carriers miscoded place of service.)

--allowing Medicare's allowance of $3 for handling charges for those cases where the physicians did not charge a handling fee produced an average markup (net) of 101 percent, or $12.74 1/; and

--projected on an annualized basis, physician markup (net) was about $213,000 2/ for beneficiaries served by GHI.

Physician markups were noted at the three other carriers where we reviewed this problem. At Blue Shield of Florida, the net markup was 95 percent; at Travelers of Mississippi, 54 percent; and at the Texas Group Medical and Surgical Service, 89 percent.

The American Medical Association has stated that physician markups are unethical. Under the laboratory services section of its opinions and reports of the judicial council, it states:

> "As a professional man, the physician is entitled to a fair compensation for his services. He [however] is not engaged in a commercial enterprise and he should not make a markup, commission, or profit on the services of others."

We noted that H.R. 4000, Medicare and Medicaid Amendments of 1980, reported out of the House Interstate and Foreign Commerce Committee on April 23, 1980, and S. 590, Clinical Laboratory Improvement Act of 1979, approved by the Committee on Labor and Human Resources on April 11, 1979, would require HCFA to take additional measures to eliminate Medicare reimbursement for physician markups on laboratory procedures.

For example, H.R. 4000 provides that, if a claim does not specifically indicate who performed a laboratory test or indicate that the test was performed by a laboratory, but did not

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1/This markup was computed to be plus or minus $1.60 at the 95-percent confidence level.

2/This projection was computed as follows:
Total qualifying claims for 2 months (3,464) divided by claims sampled (197) = 17.58 x the total sample markup ($2,025.67) = $35,611 x 6 months = $213,666.

identify the laboratory or the related charge, the carrier could base its payment on the lowest charge that the carrier estimates that the test could have been provided by a laboratory in the locality. Also, in recognition that beneficiaries, not physicians, may absorb the impact of new reimbursement limits, H.R. 4000 would require the Secretary of Health and Human Services to determine the extent of such impact and report to the Congress 24 months after enactment.

FEE AND ONE-HALF REIMBURSEMENT PRACTICES

The phrase "fee and one-half" refers to a unique reimbursement practice that is used for multiple surgical procedures. HCFA requires that, for procedures done on the same day, carriers are to base reimbursement upon the major procedure only, or the major procedure plus partial amounts for other procedures. The purpose is to limit reimbursement for closely related procedures, under the presumption that a full charge for each service is not justified for closely related multiple procedures performed at the same time.

According to HCFA officials, the specific details for implementing fee and one-half reimbursement are left to the discretion of the carriers and local medical groups. In the 1974 California Relative Value Schedule, 1/ we noted that, for multiple procedures, full value is to be allowed for the first or major procedure, 50 percent for the second procedure, 25 percent for the third, etc.

During our review of the quality assurance sample of claims at D.C. Blue Shield, we noted several claims where the half-fee allowance produced high reductions to the submitted charge. To gain a better perspective on the frequency and impact of the half-fee rule, at our request, D.C. Blue Shield gave us a printout showing the frequency and extent of the reasonable charge reductions for unassigned claims involving half fee for a 2-week period in June 1980. We found that:

--Half fee was applied to procedures on 603 claims, totaling $69,544, or about 2.6 percent of the unassigned claims processed during that period.

1/Developed by the California Medical Society.

--The average reasonable charge reduction involved was about 52.8 percent, or about $61; D.C. Blue Shield's overall average reasonable charge reduction for Medicare claims during the same period was 25 percent or $27.19.

--For claims that involved one or more procedures where the submitted charge was $100 or more (112 or 19 percent of the claims), the average reasonable charge reduction was 46 percent or $472.

--On an annualized basis, we estimate that, where the half-fee rule is used with a 52.8-percent reduction to submitted charges, D.C. Blue Shield's Medicare beneficiaries are liable for about $402,000 a year more than they would be liable for by applying the carriers' average reasonable charge reduction of 25 percent. 1/

According to D.C. Blue Shield, its fee and one-half rule under Medicare was adopted from the reimbursement practices that the carrier used in its private business.

1/This projection was computed as follows:

	Average reduction at 25 percent	Reduction using fee and 1/2 at 52.8 percent
Total value of qualifying claims	$69,544	$69,544
Less reasonable charge reduction	17,386	36,719
Amount allowed	52,158	32,825
Payment at 80 percent	41,726	26,260
Payment difference		$15,466

($15,466 x 26 weeks = $402,116)

RELATIVE VALUE SCHEDULES FOR COMPUTING CUSTOMARY CHARGES

Under Medicare, physicians or beneficiaries are reimbursed the lowest of three charges--the actual, the customary, or the prevailing charge. The lowest of the three is referred to as Medicare's "reasonable charge" or allowed charge. The customary charge represents the individual physician's usual charge for a given medical procedure, while the prevailing charge represents the fee level at or above what most physicians in a given locality usually charge.

For some medical procedures, a customary charge is not available. For example, new physicians would not have had the opportunity to establish a charging pattern. This is also true for established physicians who rarely perform a medical procedure and have generated insufficient charge data to establish a customary charge.

When a customary charge is not available, Medicare requires its carriers to compute one. For new physicians the 50th percentile of all physicians' customary charges is used. For established physicians, however, carriers are authorized to use relative value schedules, which--to the beneficiary's disadvantage--frequently cause larger reasonable charge reductions than would result from applying the 50th percentile method.

Relative value schedules are a means of measuring numerically the characteristics of a medical procedure in terms of complexity, skill required, and other factors. In the past, they have been used by third-party payors and physicians to determine the reasonableness of payment rates for the many different services and procedures which physicians perform.

The following example illustrates how the application of relative value schedules might work. A routine office visit by an established physician is assigned a relative value of one, whereas a prolonged office visit is assigned a relative value of two. By applying the relative value concept, a physician's fee for the prolonged visit would be two times the fee for a routine office visit.

The following actual claim--which we identified in the D.C. Blue Shield quality assurance sample of claims--illustrates the detrimental results that relative value

schedules can have on the beneficiary. The submitted charge on an unassigned claim for a surgical procedure was $450, and the prevailing charge for the procedure was $480. However, the carrier allowed only $336 because this was the customary charge as computed by using the carrier's relative value schedule. Had the 50th percentile of physicians' customary charges been used--as would be the case if the procedure were performed by a new physician--the entire $450 would have been allowed. Thus, the beneficiary was actually liable for $181 ($450 - $336 = $114 + $67 (the 20-percent coinsurance on $336) = $181) instead of $90 (the 20-percent coinsurance on the $450).

At D.C. Blue Shield, we obtained a computer printout of unassigned claims for a 1-week period in April 1980 and found that payment was based on computed customary amounts using relative value schedules for 205 separate charges. The charges were made on a total of 190 claims which represent about 1.6 percent of all unassigned claims processed during the week.

To compare the use of relative value schedules (for established physicians) with the 50th percentile method (for new physicians), we substituted the latter for each of the 205 charges. Our analysis shows that the allowance would have been greater in 136 or 66 percent of the separate charges, ranging from less than $1 to more than $31. Conversely, the allowance would have been reduced in 61 or 30 percent of the cases, ranging from less than $1 to more than $24. In the remaining 4 percent, the allowed charge would have been the same. Using the 50th percentile method, allowed charges would have increased a net total of $627. On an annualized basis, this amounts to about $32,604 in increased allowed charges for beneficiaries served by D.C. Blue Shield and increased payments of about $26,083. 1/

HCFA allows carriers to use the 50th percentile of customary charges in lieu of relative value schedules, if they can demonstrate that the relative value schedules produce unreasonable results. In a survey of four HCFA regional offices, 9 of 23 carriers had discontinued the

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1/This projection was computed as follows:
Total increase in allowed charges ($627) x 52 weeks = $32,604 x 80 percent = $26,083.

use of relative value schedules. 1/ The other 14, however, were still using them, but according to HCFA regional officials, the carriers had not studied the impact that the schedules have on reasonable charge reductions.

NEED FOR MORE SPECIFIC CLAIMS PROCESSING STANDARDS

To test the quality of claims processing and to determine whether beneficiaries were being underpaid, we reviewed a sample of claims at D.C. Blue Shield. We found a high incidence of underpayments on claims with relatively large reasonable charge reductions and believe our findings underscore the need for HCFA to establish more specific claims processing standards to provide assurance that beneficiaries are not underpaid.

The following explains our sampling methodology. First, we selected only unassigned claims because in these instances, in addition to the coinsurance, the beneficiary is liable for the difference between the submitted charge and what Medicare considers a reasonable charge.

Our second concern was that, if underpayments are identified, they be relatively significant. Medicare carriers cannot expend a large effort to save a small amount of money, whether it is for the beneficiary, the physician, or the program. Accordingly, we selected claims where there was a significant difference between the submitted charge and what Medicare allowed. To meet this criterion, the claims selected were those that had one or more medical procedures where the submitted charge exceeded the physicians' customary charge by 150 percent or more. For example, if a doctor normally charged $100 for a given medical procedure, we selected for review only cases where the doctor charged $250 or more for the same procedure. In this case, the claim would have met our criterion because Medicare would reduce the claim by at least $150, or 150 percent of the $100 customary charge.

1/Five of these carriers discontinued using the California Relative Value Schedule because the Federal Trade Commission ruled that its use was conducive to price fixing.

This example's unusual charging pattern brings us to our third concern--that the claims reviewed have what would appear to be high potential for something to be wrong and should be developed further. Here our hypothesis was that a charging pattern of this nature could indicate any of several things which could lead to an underpayment. For example, possibly the medical procedure was coded wrong, some key information was missing, or the charged amount was typed incorrectly.

In addition to identifying significant underpayments, our approach was also designed to provide insight into the adequacy of the carriers' claims processing system. Generally carriers are required to develop claims, that is, to fill in missing information and/or to reconcile inconsistencies noted while reviewing claims. Also, carriers are required to have processing systems which make reasonable charge reductions automatically within established safeguards. These safeguards are to identify and reject inordinate extremes between submitted charges and allowed charges and to permit manual scrutiny and further development. Because the claims selected for review represented what we believed to be inordinate extremes in submitted charges, we believed that our analysis could provide insight into the quality of the carrier's claims processing.

We selected for review the unassigned claims processed during a 2-week period in June 1980. Our selection criterion was met by 250, or about 1 percent of the total unasssigned claims. From these claims we randomly selected 50 for review with the following results:

--For 21 cases, or 42 percent of the claims reviewed, we found, and the carrier concurred, that the beneficiary had been underpaid. 1/

--The amounts allowed for covered services were understated on the average by about $32. 2/

1/D.C. Blue Shield told us that the beneficiaries involved would be reimbursed the amount of underpayment.

2/This underpayment was computed to be plus or minus $7.40 at the 95-percent confidence level.

--On an annualized basis, we estimate that amounts allowed on 2,730 claims were understated by about $87,000 which represent about $70,000 in underpayments. 1/

The most common reasons for the underpayments were (1) wrong procedure code, (2) omission of procedures, and (3) incomplete description of the diagnosis and/or procedures performed.

After our sample was selected and we received copies of the claims forms, the amount of time to identify the underpayments was minimal. Basically, we (1) reviewed the original claim and (2) called the physician's office, if necessary.

To comply with Medicare's claims processing requirements, D.C. Blue Shield has established an automatic edit which "flags" for data entry personnel medical procedures where the submitted charge is reduced by 33 percent or more. After a charge is flagged, a clerk is required to check the information entered against the information on the claim. If the data were entered correctly, but the submitted charge is greater than $75, the clerk is to submit the claim for manual review by his or her unit leader. If the submitted charge is less than $75, the clerk is to process the claim routinely. 2/

Of the 21 underpaid claims in our sample, 3 claims exceeded the $75 criterion and 18 claims were under the $75 criterion. The fact that 18 claims were under the $75 criterion suggests that the criterion may be too high. The three claims that exceeded the $75 criterion were supposed to have been manually scrutinized by the unit leader. If they were reviewed, they apparently were not adequately reviewed.

While it appears that the $75 screen may be too high, it also appears that carrier personnel were not doing a good job in reviewing claims. Twelve of the 21 claims were not properly coded by carrier personnel when first received.

1/This projection was computed as follows:
Total qualifying claims for 2 weeks (250) x 26 weeks = 6,500 claims x 42 percent = 2,730 x $32 = $87,360 x 80 percent = $69,888.

2/All claims that exceed the reasonable charge screen that are for podiatry, durable medical equipment, or surgery procedures are automatically subject to manual review by the unit leader.

Another claim we noted in HCFA's quality assurance program sampling of claims at D.C. Blue Shield serves to underscore our concern about the quality of claims processing. The claim involves a medical procedure (code 8907) used to analyze skin cancer. A skin specimen is divided into sections, each of which is placed on a slide and examined under a microscope. According to D.C. Blue Shield, each slide that is prepared constitutes a separate medical service for Medicare reimbursement purposes.

The claim in question was processed in July 1979 and included the following charges by a physician.

Date of service (1979)	Procedure code	Submitted charge
June 4	8907	$ 80
June 5	8907	60
June 6	8907	20
June 7	8907	10
Total		$170

Medicare allowed $10 per procedure, or $40 for the four procedures. The allowance was based on the physician's customary charge, and because the claim was unassigned, the beneficiary was liable for $130 plus 20-percent coinsurance ($8) and any deductible that may not have been met.

The above claim raises two questions. First, why would the charge vary so much--from $10 to $80? Second, if the physician's customary charge is $10, why would he charge $60 or $80? These questions and the fact that the beneficiary incurred significant out-of-pocket costs prompted us to request from D.C. Blue Shield a computer list of the physician's charging pattern for 1 year. An analysis of the list disclosed the following:

--During the year, 67 claims were processed which contained 1 or more charges for the 8907 procedure.

--Forty-nine (or 73 percent) of the claims were unassigned.

--The 67 claims contained a total of 279 "8907" procedures.

--The actual charges for each procedure ranged from about $9 to $235.

Because of the unusual charging pattern, it was apparent to us that there were errors in counting or describing the services rendered, and we asked the physician for an explanation. We found--by examining the records for 22 patients--that charges were correct but that the claims failed to note the number of slides made. For example, a submitted charge of $100 actually involved 10 slides and not just 1.

For the 67 claims, we estimate that during the year the physician and the beneficiaries were underpaid by $1,153 and $2,868, respectively. D.C. Blue Shield told us that it would correct the underpayments for 1979 and check to see if underpayments occurred for other years.

Relating the code 8907 experience to D.C. Blue Shield's claims processing safeguards shows that the safeguards were ineffective in detecting the underpayments. On 68 occasions, the procedures exceeded the 33-percent reasonable charge reduction screen, and on 41 occasions, the $75 criterion was exceeded whereby a manual review should have been made by the unit leader. Furthermore, the initial claim that prompted our interest in this matter (see p. 13) was reviewed by carrier and HCFA quality assurance personnel; however, neither questioned the abnormal charging pattern.

We did not make the same analysis of claims processing practices of other carriers visited. However, we did obtain information which we believe points to the need for HCFA to develop more specific and detailed claims processing standards.

Claims requiring development by the carrier inherently require more time to process and accordingly cost more. Carriers we visited, however, stated that HCFA's emphasis on claims processing costs and timeliness act as a disincentive to careful claims development. We believe that the carriers' observations are generally consistent with HCFA's published performance measurements which place considerable emphasis on costs and timeliness of claims processing.

The carriers have considerable latitude in complying with HCFA's claims processing standards. For example, while D.C. Blue Shield's screen to isolate large reasonable charge reductions was set at 33 percent of submitted charges, officials in HCFA's Dallas Region said that four of their six Medicare carriers had the same screen established at 66 percent. One carrier--Group Medical and Surgical Service--had its reasonable charge screen set at nearly 80 percent or about 2-1/2 times that of D.C. Blue Shield.

In developing more specific claims processing standards, we believe that HCFA should give recognition to the fact that, in making payments under Part B, carriers are dealing with two different groups--physicians on assigned claims and beneficiaries on unassigned claims. In processing claims, however, carriers generally do not make any distinction between the two groups.

Carriers take special care to explain to physicians how Medicare claims are to be filed. At the same time, physicians routinely submit Medicare claims for payment; accordingly, it would seem that physicians should know program requirements quite well, as well as what procedures or services were actually rendered, and the related reimbursement levels.

However, beneficiaries, although they receive some training on how to fill out Medicare forms, do not receive the level of instruction and guidance that physicians receive. Furthermore, given the mental and physical impairments that many of the elderly have, and the fact that many infrequently fill out a Medicare claim, we believe that the elderly cannot be expected to know the details of claims processing requirements.

A simple example will serve to illustrate our point. Under Medicare, there are three basic types of office visits--brief, intermediate, and extended. Several carriers' claims processing procedures provide that an office visit is assumed to be brief unless otherwise indicated. For an assigned claim, this would seem to be a fair assumption on the basis that the physician should know actually what kind of service was rendered. For unassigned claims, however, particularly where there is a significant difference between submitted charges and customary charges or allowed charges, we believe that carriers should take additional steps to assure that the

beneficiary receives what he or she is entitled to be paid. These steps could include contacting the doctor's office or, as we did in the case of procedure code 8907, obtaining a history of prior charges.

Our concern that the current claims processing standards may not adequately protect the elderly is supported by a May 1977 HCFA Management Survey entitled "Service to Medicare Beneficiaries." In discussing the need to revise the basic Medicare claims forms, the report states:

> "Although the professional health care supplier/ physician has little difficulty utilizing and properly completing the form, service reps and claims processing personnel at contractors cite continued improper/incomplete execution of the form by beneficiaries as the major obstacle to effective/efficient claims processing in the Medicare program."

CONCLUSIONS AND RECOMMENDATIONS

There are significant gaps in Medicare's reimbursement for the cost for health care, and consequently, all reasonable steps should be taken to assure that the elderly receive the benefits to which they are entitled. The four issues addressed in this report have the potential to affect many Medicare beneficiaries. While we did not attempt to measure the extent of this effect nationwide, the potential is significant when considering that in fiscal year 1979 about 130 million claims were processed under Part B, about half of which were unassigned.

HCFA has acted prudently in taking steps to limit Medicare reimbursement for excessive charges by physicians for laboratory procedures. However, what is still needed is some type of action to protect beneficiaries who remain liable for payment to physicians on unassigned claims. In this respect it would appear that some type of legislative action is needed. Given the longstanding views of the American Medical Association and the various congressional concerns expressed about this matter, we therefore recommend that you develop a legislative proposal to address this problem. In developing the proposed legislation, we recommend that consideration be given to including provisions which would (1) make it a misdemeanor for physicians to mark up laboratory charges similar

to section 4 of Public Law 95-142 pertaining to assignment violations to the detriment of beneficiaries and/or (2) require laboratories to bill Medicare directly. The latter would eliminate physician participation in the reimbursement process and the accompanying markups.

The reasonable charge reductions associated with using the fee and one-half rule for surgery procedures are significant. We recommend that D.C. Blue Shield be instructed to work with the local medical society(s) and resolve the differences in physicians' charging practices and Medicare's pricing for multiple surgical procedures. While we did not gather data on the charging practices of physicians in other areas of the Nation, similar reductions are probably occurring. We also recommend that Medicare carriers be instructed to determine the extent of such reductions and, if significant, take action to reduce or eliminate them.

Concerning the two different methods for computing customary charges (see p. 8), we believe that beneficiaries in the same area should be treated equally whether they are seeing an established physician or a new physician. Using relative value schedules at D.C. Blue Shield unfairly penalizes beneficiaries because their physicians are performing a new procedure although they have an established practice. Therefore, when it is necessary to compute a customary charge, we recommend that D.C. Blue Shield use the 50th percentile of physicians' customary charges as is done for new physicians. Because similar situations may exist at other carriers, we recommend that carriers still using the schedules be required to study their effect on reasonable charge reductions. Where similar patterns in reasonable charge reductions are noted, we recommend that the relative value schedules for computing customary charges be discontinued.

The area that offers the greatest potential to assure that beneficiaries are not underpaid is quality claims processing. While the standard that carriers process claims automatically within established safeguards is a sound one, carriers are given considerable latitude in meeting this standard. Such latitude can result in program underpayments because, given the option and the emphasis placed on processing costs and timeliness, carriers have a built-in disincentive to careful claims development. Therefore, we recommend that more specific claims processing standards be established, that is, when claims are to be manually reviewed and what specific action is to be taken as part of the review.

We also recommend that the claims processing standards be more stringent for unassigned claims. Beneficiaries should be more fully protected from underpayments that occur because (1) they are not fully acquainted with program requirements or the specific services that physicians render or (2) carriers make errors.

Section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report. The act also requires that the statement be submitted to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. Because this report was prepared at the request of the Senate Special Committee on Aging, we are asking that you also send the Committee a copy of your statement of actions taken.

We are sending copies of this report to the Chairmen of the five above-mentioned Committees, the cognizant legislative committees, and the House Select Committee on Aging. A copy is also being sent to the Director, Office of Management and Budget, and other interested parties.

We appreciate your staff's courtesy and cooperation during our review and welcome the opportunity to discuss these matters with you or your staff.

Sincerely yours,

Edward A Densmore

for Gregory J. Ahart
Director