UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

April 30, 1982

B-207260

The Honorable Richard S. Schweiker
The Secretary of Health and Human
Services

Dear Mr. Secretary:

Subject: Need to Recover Medicare Part B Duplicate Payments in Illinois (GAO/HRD-82-67)

In our December 1, 1981, report, 1/ we recommended that you direct the Health Care Financing Administration (HCFA) to analyze the large amount of Medicare part B overpayments in Illinois detected through the quality assurance program--estimated to be about $27.7 million from April 1979 through June 30, 1981--because we believed that such an analysis might identify patterns to these overpayments and assist in the recovery of some of this money. The Department agreed with our recommendation.

As part of our review of Medicare contracting, we developed a computer program which identified a substantial number of actual and potential duplicate payments made by the Illinois carrier--Electronic Data Systems Federal Corporation (EDSF). This report summarizes the results of this effort, which was not complete at the time we issued our December 1981 report and testified on December 3, 1981, before the Subcommittee on Health, Senate Committee on Finance. Specifically, 57 percent (284 of 499) of the line items 2/ we reviewed represented duplicate payments with allowed amounts 3/ totaling about $21,000. We also identified more than 24,000 potential duplicate line-item payments with allowed amounts

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1/"Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare" (HRD-82-17).

2/A line item is a service or series of services for the same beneficiary having the same medical or surgical procedure code.

3/"Allowed amount" is the amount on which Medicare payments are computed. Generally, Medicare pays 80 percent of the allowed amount.

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totaling more than $2 million and believe most of these are also duplicate payments. According to EDSF records, very few of these payments had been returned by the beneficiary or provider or otherwise recovered.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to identify specific cases of duplicate payments and to help facilitate the recovery of these overpayments. We focused on duplicate payments in Illinois not only because of the relatively large amount of estimated overpayments, but also because we believed that the conditions during EDSF's first year of operations were conducive to a high number of duplicate claims being paid. These conditions were principally caused by (1) claims processing delays, which generally lead to repeated claims submissions from beneficiaries and providers, and (2) a high clerical error rate in entering information in the claims processing system, which can lead to identical claims being processed differently and possibly not being detected as duplicates.

Medicare claims can involve one or more services rendered over a period of days, weeks, or months. Information describing each service is coded by carrier personnel and entered into the carrier's computer system as an individual line item. To analyze these claims, we obtained copies of 25 reels of computer tape which contained claims history for 1,010,573 beneficiaries. EDSF records showed that payments to or on behalf of these beneficiaries in allowed amounts of about $613 million had been made by it or its predecessor carriers for the period October 1978 through July 1980.

We developed a computer program to identify potential duplicate payments by analyzing EDSF's payment history for claims that matched our criteria. In developing our criteria, we used several variations of key claims data to identify potential duplicate payments. (See enc. I.) Our objective was to continually refine our criteria until the claims we reviewed had a significantly high percentage of actual duplicates (generally, greater than 70 percent).

We selected a random sample of about 10 percent of the beneficiaries and analyzed their claims histories for payments matching the characteristics of our criteria. We then randomly selected about 3 percent of the pairs of potential duplicate payments identified from our sample and reviewed claims documentation submitted to the carrier in order to determine if a duplicate payment occurred. To determine if duplicate payments were later refunded or otherwise voided, we also reviewed the Explanation Of Medicare Benefits (EOMB) and canceled checks for claims with allowed amounts over $100.

After completing this work, we ran our program against all of EDSF's claim history for the period October 1978 through July 1980 for payments that matched the characteristics for three types of payment categories included in our program. 1/ These categories were chosen since they had a high percentage of actual duplicate payments ranging from 73 to 93 percent based on our review of sample claims in these categories.

Our review was made at EDSF's facility in Des Plaines, Illinois, and at HCFA's Baltimore, Maryland, headquarters and Chicago regional office. The review was performed in accordance with the Comptroller General's current standards for audit of governmental organizations, programs, activities, and functions.

BACKGROUND

Medicare is a Government program which helps pay the health care costs of eligible persons who are 65 years of age and over or are disabled. The program provides two forms of coverage: part A (hospital insurance) and part B (supplementary medical insurance benefits). Part B is a voluntary program financed by enrollees' premiums and Federal contributions covering physician services and many other health services. As of July 1, 1980, about 27.1 million individuals were enrolled for part B benefits. Benefit payments for part B in fiscal year 1980 amounted to $10.1 billion, of which 70 percent was for physician services, 20 percent for outpatient hospital services, and 10 percent for other services.

The Medicare program is administered by HCFA, which is responsible for establishing policy and operating the program. HCFA administers the portion of the part B program involving payments for the services of noninstitutional providers with the assistance of 40 carriers under prime contract with the Government. Title XVIII of the Social Security Act requires that the Department of Health and Human Services (HHS) enter into cost reimbursement contracts with carriers. Section 222 of Public Law 92-603, enacted in October 1972, gave HHS the authority to experiment with incentive reimbursement arrangements and fixed-price contracts to determine whether such arrangements would induce more effective, efficient, and economical contractor performance. HCFA has three ongoing fixed-price experiments, one of which is in Illinois, that are intended to test the viability and impact of competitive procurements of claims processing services in part B of Medicare.

1/Exact duplicates over $25 (0A), exact duplicates over $25 except procedure code is different (1A), and exact duplicates over $25 except provider number is different (2A).

EDSF was awarded a fixed-price contract and began processing Medicare claims in Illinois in April 1979. EDSF assumed the responsibilities of two previous carriers and was to be paid about $42 million to process claims for about a 5-year period.

DUPLICATE PAYMENTS MADE BY EDSF IN ILLINOIS

We identified a substantial number of both actual and potential duplicate payments made by EDSF from the start of its contract through July 31, 1980. According to EDSF records very few of these payments had been returned by the beneficiary or provider or otherwise recovered.

Presented below is a discussion of (1) HCFA's requirements for identifying or preventing a payment of duplicate claims, (2) the results of our control sample to identify actual duplicate payments, (3) EDSF's action on the initial sample, and (4) the total potential duplicates identified in the universe of part B claims.

HCFA's requirements for carrier claim processing to identify duplicate claims

HCFA instructions specify computer editing criteria to be used by carriers in screening claims to identify (1) duplicate claims to be disallowed without clerical intervention and (2) potential duplicate claims to be reviewed manually.

Specifically, Medicare instructions provide for the computer to automatically deny a line item if it is an exact duplicate of a line item that has already been processed. Exact duplicate line items are defined as those in which the beneficiary and provider numbers, the date and place of service, the amount charged, the type of service, and the procedure code have all been coded the same.

In some cases, two line items may not be entered exactly the same even though both represent the same service. Recognizing this, carriers are required to have edits for potential duplicate claims. In these edits, the computer compares line items for specified similarities. If these similarities are met, the suspect line items are reviewed manually by carrier clerical personnel, but the specific actions necessary are not delineated.

Duplicate payments in initial sample

We ran our computer program against EDSF's paid claims history for a sample of about 10 percent of the Medicare beneficiaries and

identified 19,706 pairs 1/ of line items which met our criteria of possible duplicate payments with allowed amounts totaling about $550,000. (See enc. I for a discussion of our duplicate payment logic.) To determine if they were duplicate payments, we randomly sampled 515 pairs (or about 3 percent) and obtained copies of the claims documentation submitted to the carrier.

We reviewed 499 of the 515 line items selected for review since EDSF could not locate the original claim or claim microfilm for 16 cases. As shown in enclosure II,

--21 percent (104) of the claim line items we reviewed represented "correct" payments of allowed amounts totaling about $4,000,

--57 percent (284) represented duplicate payments of allowed amounts totaling about $21,000, and

--22 percent (111) represented questionable payments 2/ involving allowed amounts of about $2,000.

To determine if the duplicate payments were later refunded or otherwise voided, we requested copies of the EOMBs and canceled checks when either or both of the duplicate line items had an allowed amount over $100. EDSF could provide complete information on only 32 of the 39 pairs for which we requested this additional information. Our analysis of these 32 cases showed that in only 4 cases was any collection action taken after the checks were issued. Checks were cashed by the beneficiary or provider for the other 28 duplicate payments, and these moneys were still outstanding according to EDSF records as of January 1982.

Several examples of the duplicate payment situations we found follow:

--Beneficiary A underwent a coronary artery bypass operation on July 30, 1979. Two claims were submitted to the carrier within 57 days of each other. Even though these claims

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1/These pairs do not correspond to an equal number of beneficiaries. One beneficiary can account for more than one pair of line items.

2/In these cases the microfilm of the claims either was unreadable or included several line items with similar procedure codes and billed amounts. For the latter cases, we could not easily determine if there were duplicate payments for the same service or correct payment for two different services billed at the same rate.

were coded exactly the same, EDSF paid for the operation twice. The beneficiary cashed both checks, each in the amount of $2,480.

--Beneficiary B was operated on for rectal polpectomy and repair on May 18, 1979. The carrier received two claims for the administration of anesthesia 31 days apart. Both claims had similar descriptions, but neither had procedure codes. EDSF claims processing personnel coded the claims differently. As a result, two separate checks in the amounts of $109.12 and $101.20 were issued to and cashed by the beneficiary.

--Beneficiary C was hospitalized and placed in traction. The carrier received two claims 157 days apart for doctor's care during this hospital stay. One claim was marked "Second Request Please Contact Us." In processing these claims, EDSF's personnel entered two different provider numbers for the same doctor. Although this claim was suspended for clerical review, it was later paid. Two checks were issued and cashed. The overpayment amounted to $112.

--Beneficiary D received care for acute emergency hemodialysis on November 29, 1978. Two claims were received 434 days apart. While the service was rendered by the same physician, the claims contained different provider numbers. The two providers (renal centers) received separate checks paying $400 and $353.60 for this service. One renal center endorsed its check over to the other renal center. Both checks were cashed.

These examples and others were discussed and reviewed with EDSF officials, who agreed that they were duplicate payments.

We noted that 34 of the 37 duplicate line-item payments we found in categories OA and OB 1/ were exact matches according to HCFA criteria and, therefore, should have been automatically denied without clerical review. We could not determine why all these payments were not automatically denied.

EDSF's manual claims review procedures do not require in all cases that claims examiners be given copies of both claims when a claim is suspended for manual review. Medicare requirements do not address whether copies of these claims should be obtained. When copies of both claims are not obtained, carrier clerical personnel would be unable to accurately determine if the second claim should be paid. We were able to make these determinations because we reviewed copies of both claims.

1/Line items with allowed amounts less than $25.

Our analysis showed that a significant number of the duplicate payments we identified were paid by EDSF between December 10 and 13, 1979. Documentation available to us suggests that this problem occurred because all the prior claims history for an unknown number of beneficiaries was not in the EDSF system when the claims were processed. According to an EDSF official: "The effect on claims, * * * would be that these claims would not be either automatically denied or suspended for review."

Except for the exact duplicates, the duplicate payment cases we identified resulted in large part from clerical errors in data entry (i.e., wrong provider number or procedure code), inadequate manual claims review, and/or EDSF's failure to match claims suspended because they were potential duplicates against copies of the prior claim included in the claims history.

EDSF initiated action to recover the duplicate payments we identified in initial sample

In January 1982, we discussed with EDSF and HCFA Chicago regional office officials the methodology we used to identify cases of duplicate payments in order to facilitate the recovery of overpayments. We also gave them a list of the potential duplicate payments identified for 10 percent of the beneficiaries we sampled, which included the 515 individual pairs of claims we randomly selected for review, including those we found to be duplicate payments.

On February 2, 1982, we were told that EDSF (1) was reviewing the 284 duplicate line-item payments we identified and (2) would institute collection action in accordance with prior Medicare policies to recover overpayments. 1/ As of March 29, 1982, EDSF had instituted collection action totaling $5,441 for the 13 line items it had reviewed. Based on subsequent information provided to us by HCFA, EDSF expects to complete its review of the 284 duplicate payments we identified and institute collection action by May 14, 1982. Moreover, EDSF was requested to provide HCFA with biweekly progress reports on this effort.

EDSF officials also said they would take corrective action on any duplicate payment they identify that may have been made because of the December 1979 claims processing problems. (See above.) In this regard, EDSF later advised us that it had identified 7,310 claims that were not processed against all of the claims

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1/EDSF is required to collect identified overpayments of $15 or more.

history for all the applicable beneficiaries. Therefore, EDSF plans to review these claims and institute collection action as appropriate to recover overpayments. On April 7, 1982, EDSF told HCFA that it would not begin reviewing these claims until after it completed action on the 284 duplicate payments we identified.

Total potential duplicate payments in three categories

Three types of potential duplicate situations had a high percentage of actual duplicates (each in excess of 70 percent) based on our analysis of sample claims. As shown in enclosure II, these three situations involved line-item payments, each involving allowed amounts of $25 or more, that were (1) exact matches--our category 0A, (2) exact matches except for the procedure code--our category 1A, and (3) exact matches except for the provider number--our category 2A.

After giving HCFA and EDSF officials the results of our analysis for the 10-percent sample of the beneficiaries, we ran our program against all of EDSF's claims history for the period October 1978 through July 1980 for payments that matched the characteristics for the above three categories of claims. 1/ As shown below, our computer program identified 24,053 potential line-item duplicate payments with allowed amounts totaling more than $2 million.

Category	Number of line-item pairs of potential duplicate payments identified	Range of allowed amounts (note a) Low	High
Exact match (0A)	1,529	$ 119,927	$ 122,115
Procedure code different (1A)	18,588	1,675,952	2,312,167
Provider number different (2A)	3,936	285,124	316,400
Total	24,053	$2,081,003	$2,750,682

a/The range is the result of taking either the lower or the higher of the allowed amounts of the pair of line items and summing those figures.

1/There were 192 beneficiaries whose individual histories were so large they had to be processed separately. An analysis of sample claims for these beneficiaries did not show a high percentage of duplicate payments, so they were excluded from our subsequent computer analysis.

We cannot project the results of our review of a small sample of claims in these categories to these totals. However, we believe it is reasonable to assume, lacking any evidence to the contrary, that a substantial number of these line items represent actual duplicate payments. The duplicates we found in our sample per category ranged from 73 percent (2A) to 93 percent (1A).

On March 19, 1982, we gave HCFA a detailed list of the potential duplicate payments for the period October 1978 to July 1980 because we believed a review of them would identify a substantial number of duplicate payments and facilitate the recovery of overpayments. HCFA officials told us that no decision had been made as of April 22, 1982, on exactly what action would be taken concerning these payments.

CONCLUSIONS AND RECOMMENDATION

We believe that EDSF should take action to identify and recover overpayments made because of its failure to have complete beneficiary histories in the computer in December 1979. We believe also that a review by HCFA or EDSF of the 24,000 line items of potential duplicate payments that we provided HCFA on March 19, 1982, would result in identification of a substantial number of duplicate payments.

Accordingly, we recommend that you ensure that timely action is taken to (1) review the more than $2 million in potential duplicate payments we identified along with those claims EDSF experienced processing problems with in December 1979 and (2) recover the overpayments identified.

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As you know, 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 and 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.

We are sending copies of this report to your Inspector General; the Administrator of HCFA; and the Director, Office of Management and Budget. In addition, because of their interest in the operation of experimental contractors, we are sending copies to the Chairmen, Subcommittee on Health, Senate Finance Committee; Subcommittees on Health and Oversight, House Ways and Means Committee; and other appropriate committees.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 3

ENCLOSURE I

GAO DUPLICATE PROGRAM LOGIC

In analyzing line items, we separated them into two categories according to allowed amounts: category A--$25 or more, and category B--less than $25. Accordingly, for each of the following categories, there is an A and a B. We matched each paid line item against every other paid line item in the beneficiary's claims history. Critical elements in this matching process are outlined below:

	Category	Billed amount	Number of services billed	Date of service	Provider number	Procedure code
Exact match	(0)	X	X	X	X	X
Procedure code different	(1)	X	X	X	X	O
Provider number different	(2)	X	X	X	O	X
Procedure code and provider number different	(3)	X	X	X	O	O
Date of service different	(4)	X	X	± 27 days	X	X
Date of service and procedure code different	(5)	X	X	± 27 days	X	O
Date of service and provider number different	(6)	X	X	± 27 days	O	X

Legend: X = data element the same on both line items.
O = data element different on each line item.

After identifying our universe of potential duplicates by category, we eliminated cases meeting specific criteria. These criteria include:

All categories

--Adjustments	- At least one line item in the pair was an adjustment which was made to correct an error in the original claim.
--Non-EDSF	- Both line items in the pair were paid by a prior (non-EDSF) carrier.
--Same claim	- Both line items in the pair were from the same claim.
--Voids	- At least one line item in the pair had a status of denied for payment or voided.
--Rentals	- At least one line item in the pair involved a rental of durable medical equipment rather than medical procedure because these services frequently recur on a monthly basis.

Selected categories

--Split claims (categories OA, OB, 1A, and 1B only) 1/	- The line items in the pair were from the same split claim. These cases were not likely to be duplicate payments because they represented one claim from a beneficiary or provider.
--Categories 3B, 4B, 5B, and 6B	- All line items in categories 3B, 4B, 5B, and 6B were totally eliminated due to the unlikelihood that they were duplicate payments.

After a partial review of a sample of claims in categories 4A, 5A, and 6A, these categories were eliminated because of the relatively low percentage of duplicate claims found in our initial sample.

1/Split claim is a claim which contains more than 13 line items on the claim. The claim must be split and processed as several claims.

ENCLOSURE II

RESULTS OF GAO ANALYSIS OF LINE-ITEM PAYMENTS REVIEWED

	Exact match		Procedure code different		Provider number different		Procedure code and provider number different	
	(0A)	(0B)	(1A)	(1B)	(2A)	(2B)	(3A)	Total
Number of pairs in sample	32	46	90	100	73	90	84	515
Less missing	0	6	2	2	4	1	1	16
Number reviewed	32	40	88	98	69	89	83	499
Duplicates	25	12	73	33	49	58	34	284
Correct payments	5	13	6	15	13	8	44	104
Questionable (note a)	2	15	9	50	7	23	5	111
Percent of duplicates	78	30	83	34	71	65	41	57

a/In these cases the microfilm of the claims either was unreadable or included several line items with similar procedure codes and billed amounts. For the latter cases, we could not easily determine if these were duplicate payments for the same service or correct payments for two different services billed at the same rate.

ADJUSTED GAO ANALYSIS OF LINE-ITEM PAYMENTS IN CATEGORIES 0A, 1A, AND 2A

	Exact matches (0A)	Procedure code different (1A)	Provider number different (2A)	Total
Number of pairs excluding missing in original sample (see enc. II)	32	88	69	189
Less: Large beneficiary histories	5	29	10	44
Number reviewed	27	59	59	145
Duplicate payments	24	55	43	122
Correct payments	2	1	11	14
Questionable (note a)	1	3	5	9
Percent of duplicate payments reviewed	89	93	73	84

a/In these cases the microfilm of the claims either was unreadable or included several line items with similar procedure codes and billed amounts. For the latter cases, we could not easily determine if these were duplicate payments for the same service or correct payments for two different services billed at the same rate.